Neath Port Talbot and Singleton Service Group
Infection Prevention Improvement Plan 2024/25

Goal	Key Metrics	Outcome	Responsibility	Timescales	Progress update Q1	Progress update Q2	Progress update Q3	Progress update Q4
Improving the Culture								
All staff are trained, educated and competent in IPC as appropriate for their role	Achieve compliance with national training target for infection prevention & control-related mandatory training (all available staff). Working toward IP&C Training, Level 1 and Level 2 – ≥85% (available staff) by staff groups	≥85% compliance with mandatory training	Divisional Triumvirates	Q3				
	Staff who undertake aseptic technique are trained and can demonstrate competency	≥85% compliance with ANTT training in staff who undertake aseptic technique and these staff have been assessed as competent	Divisional Triumvirates	Q3				
	Each clinical area will have access to a Hand Hygiene Competence Assessor supporting education, training and assessment	All clinical areas will have a Hand Hygiene Competence Assessor	Divisional Triumvirates	Q3				
There is an organisational culture that promotes reporting of infection-related and decontamination-related incidents	Infection-related, and decontamination-related incidents within the Service Group are reported, monitored and investigated in a timely way	Infection-related, and decontamination-related incidents are reported, monitored and investigated appropriately, with learning shared across the organisation	Divisional Triumvirates	In place - ongoing monitoring				
	Service Groups feedback lessons learned from the investigation of incidents through their Quality & Safety Groups	Service Group Quality & Safety meeting minutes	Group Medical and Nurse Directors	In place - ongoing monitoring				
	Multi-disciplinary reviews of healthcare associated infections (HCAI) are undertaken in a timely way, with engagement of relevant clinical leads, that demonstrate an understanding of avoidability, with key lessons learned shared across Service Groups and the Health Board	MDT reviews of HCAI is undertaken and lessons learned shared	Heads of Nursing / Midwifery, Clinical Directors / Clinical Leads	In place - ongoing monitoring				
	Medical and Nurse Directors monitor performance against Tier 1 reduction goals and progress against their Infection Reduction Improvement Plans	There is a process of high level assurance relating to HCAI	Service Group Directors	In place - ongoing monitoring				
Leadership								
Service Groups have a governance structure and processes for Infection Prevention & Control and Decontamination of re-usable medical devices	Infection Prevention & Control Groups terms of reference to be reviewed and updated to reflect Service Group Changes. Co-chaired by Medical Director and Nurse Director, with multi-disciplinary engagement,	Established Service Group governance structures and management systems for IPC are in place	Divisional Triumvirates	Jun-24				
	There are designated Divisional Leads for Infection Prevention & Control and Decontamination	There is a clearly identified Divisional lead for Decontamination and there are appropriate governance structures in place	Divisional Triumvirates	Jul-24				
There is a programme of regular IPC-related audit	Infection Prevention & Control-related audits (Hand Hygiene, Standard Infection Prevention & Control Environment are undertaken and reported locally, and there is a system in place to monitor associated recommendations and actions	The IPC audit programme is established on AMaT and Service Groups review, monitor and track progress	Divisional Triumvirates	Jul-24				
Service Groups develop leadership and empowerment to drive improvement in reducing episodes of harm	Divisions to identify Link Champions for IPC and Decontamination	All clinical areas will have IPC champion, high risk areas will have nominated decontamination champions	Divisional Triumvirates	Jul-24				

Clean & Safe Healthcare Environment								
The physical environment is maintained and cleaned to a standard that facilitates effective IPC and minimises the risk of infection	Maintain cleanliness compliance score >90%	Maintain >95% compliance with cleaning scores	Support Services / Matrons	In place - ongoing monitoring				
	Service Groups to review options for workforce redesign to strenthen standards of cleanliness within wardsg	Improvement in Standard Infection Control Precautions compliance scores	Group Nurse Director, Clinical Director of Midwifery, and Heads of Nursing and Midwifery					
	Ensure safe systems exist for providing safe storage, distribution, monitoring and decontamination of foam mattresses and bed frames	There is a certificate of decontamination for every bed and mattress that provides assurance for Divisions and the Service Group that every patient will be assured of having a clean mattress	Ward Managers / Matrons	Jul-24				
Infection prevention and control is considered as a core element at the planning and design stages of a new builds, refurbishments, repurposing and redesign schemes	The IPC team is involved at every stage of new builds, refurbishments, repurposing and redesign schemes to facilitate IPC being "designed-in"	IPC and related risks are considered at all stages of new builds, refurbishments, repurposing and redesign schemes	Service Group Directors, Assistant Director of Capital Planning, Corporate IPC Lead					
There is an annual programme of decant and deep clean within Service Groups	Development an annual programme of decant and deep clean.	A programme of decant and deep clean is established	Service Group Directors, Estates and Support Services	Jun-24				
Antimicrobial Stewardship								
Reduce volume of antibiotics prescribed to reduce risks associated with antimicrobial resistance and *C. difficile*	Reduce the volume of antibiotics prescribed across the health board, but particularly within Primary Care	Minimum 5% year-on-year reduction	Group Medical Directors / Associate Medical Directors / Clinical Directors / Clinical Leads	Q4				
Improve clinical understanding of the role of antibiotic prescribing in development of *C. difficile* infection	Where there are Periods of Increased Incidence of C. difficile, associated medical teams undertake an audit of antibiotic prescribing within the ward / speciality using the audit tool in AMaT (Antibiotic audit_ QIP package.docx (sharepoint.com)).	Improved compliance with Start Smart Then Focus standards	Group Medical Directors / Associate Medical Directors / Clinical Directors / Clinical Leads	Monitor each quarter				
Reduce risks of *C. difficile* and antimicrobial resistance	Improve compliance with the 72-hour switch from intravenous to oral antibiotics to equal the Welsh average as a minimum.	Equal the Welsh average as a minimum	Group Medical Directors / Associate Medical Directors / Clinical Directors / Clinical Leads	Monitor each quarter				

IMPROVEMENT PLAN

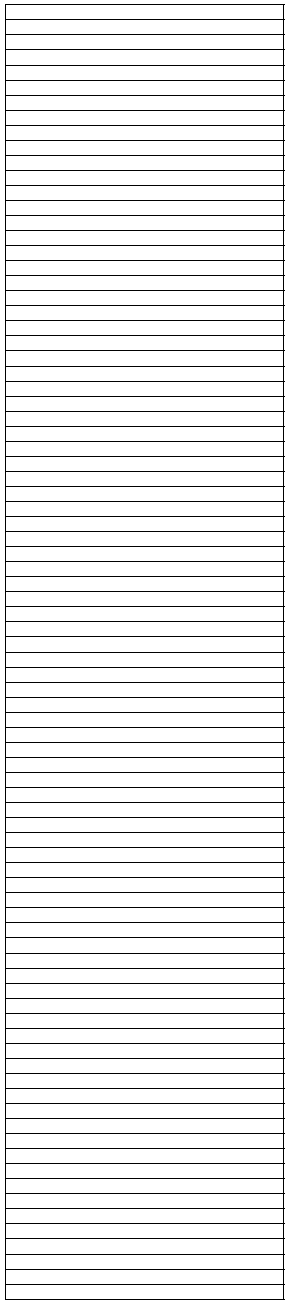
Goal	Method	Q1	Q2	Q3	Q4	Outcome	Responsibility	RAG STATUS
Improving the Culture								
All staff are trained, educated and competent in IPC as appropriate for their role	**Level 2 is now mandatory training all staff are required to complete and automatically gives L1. Already 70%. Assistance to be given to new staff with ESR.**	Bespoke training to be continued at the 10@10 sessions when concerns identified. 80% compliance with IPC L2 expected.	IPC L2 compliance expected to be 85%. Staff who require assistance with Esr to be identified and relevant training arranged.	IPC L2 compliance expected to be 90%.	IPC L2 compliance expected to be 95%, allowance for long term sick & maternity leave. Assurance that all staff have received training on ipc and are competent with IPC precautions and roles and responsibilities, to reduce infection rates.		DHoN, Matron, Medical Leads, Ward sisters, PDNs	
	Identify which staff are required to complete ANTT training and assessment so any staff who do not require this (eg clerical) can be identified in reporting . Assistance to be given to new staff with ESR.	Ensure all areas have ANTT assessors if appropriate. Where staff are limited PDN team will support assessments. Expected compliance with ESR & face to face competency assessment 50%. Ensure robust monitoring processes (bugstop) in place to ensure compliance with HB bundles to evidence ANTT in practice.	Expected compliance with ESR & face to face competency assessment 75%. Continue to monitor compliance with HB bundles which evidence ANTT compliance in practice.	Expected compliance with ESR & face to face competency assessment 85%. Review HCAI levels in comparison with bugstop audits and ANTT compliance. Bespoke training to be done where issues have been highlighted.	Expected compliance with ESR & face to face competency assessment 95%, allowance for LTS & maternity leave.Training levels to be reviewed at the beginning of the quarter to ensure all areas are aware of training requirements for target compliance to be maintained.		DHoN, Matron, Medical Leads, Ward sisters, PDNs	
	All staff are required to have a hand hygiene DOPs assessment yearly following completion of IPC L2. All MDT teams to be made aware of the hand hygiene assessors in their areas or of drop in sessions. Relevant audits to be completed monthly to ensure training is reflected in practice which includes bare below elbow, hand hygiene opportunities and PPE.	All areas to have a hand hygiene assessor or to have identified someone to attend the trainer session. Where staff are limited PDN team will support. Drop in sessions arranged for staff to attend. Expected compliance with face to face competency assessment 50%	Expected compliance with face to face competency assessment 75%. Relevant audits to be completed monthly to ensure training is reflected in practice.	Expected compliance with face to face competency assessment 85%. Bespoke training to be done where issues have been highlighted.	Expected compliance with face to face competency assessment 95%, allowance for long term sick & maternity leave. Training levels to be reviewed at the beginning of the quarter to ensure all areas are aware of training requirements for target compliance to be maintained. Further drop in sessions to be arranged if required.		DHoN, Matron, Ward sisters, medical leads, PDNs	
There is an organisational culture that promotes reporting of infection-related and decontamination-related incidents	**Current process is that there is an MDT approach to reviewing HCAIs. This is now happening in real time as the majority of historic cases have been reviewed and closed. Following MDT review cases are then taken to scrutiny panel for peer review and shared learning.**	72 hour reviews to take place in real time. Improved engagement in MDT review from pharmacy team required, discussion to be held to discuss barriers to this happening.	Review of datix cases to ensure no incidents have been missed. Assurance that lessons learned have been fed back to the relevant areas. Bespoke training if any issues highlighted in review	Review of HCAIs to ensure directorate remains on target and to see if there are any themes arising. Bespoke training if any issues highlighted in review	Assureance review of all previously noted in Q1, Q2 & Q3		DHoN, Matron, Ward sisters, medical leads, PDNs	

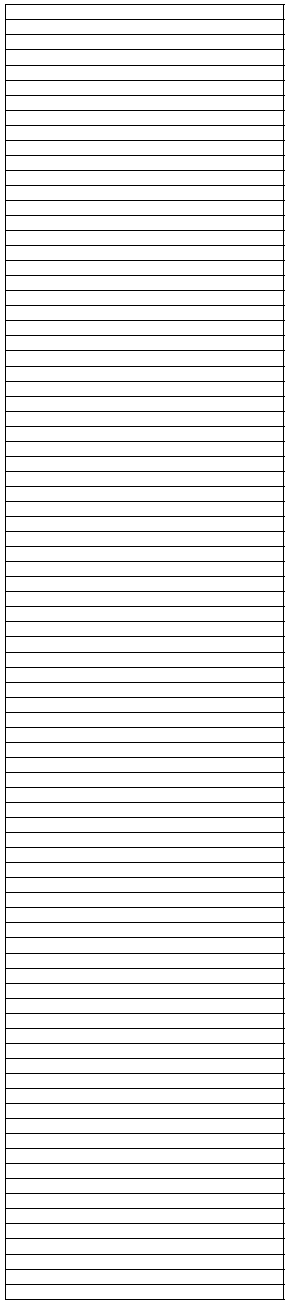
	Current process all divisions have a dedicated IPC & decontamination lead. All information with regards to IPC is included into the monthly directorate IPC & QSR report.	Assurance that all relevant information is being reported to the designated lead. Wards and departments to be aware of information required and the dates required by.	Assurance that all information from HB and service group meetings is being disseminated to the wards/departments for learning.	Staff consultation to ensure relevant information is being disseminated and that they understad the relevance, as well as finding out what information they would like to have.	Overall review of Q1, Q2 & Q3 improvements for assurance.		DHoN, Matron, Ward sisters, medical leads, PDNs	
	Specific decontamination monitoring	Ensure all staff are aware of decontamination processes for equipment following manufactoring guidelines. Use of Specific clinell wipes which include patient wipes and enviromental wipes ensuring correct training is undertaken. Assurance around appropriate don and doffing of PPE. Corridor free from PPE monitored	Assurance audits to be completed monthly to monitor Q1 improvement plan which will include the envirommental audits and domestic services advice.	Bespoke training to be put in place if any issues highlited in Q2 audits.	Overall review of Q1, Q2 & Q3 improvements for assurance.		DHoN, Matron, Ward sisters, medical leads, PDNs	
Leadership								
Service Groups have a governance structure and processes for Infection Prevention & Control and Decontamination of re-usable medical devices	**Current process directorate IPC meeting feeds into the main corporate meeting. Empowering wards/department leads to develop their own improvement plans around IPC. Monthly auditing to ensure compliance.**	Champions to be indentified for each area and role requirements identified. Monthly enviromental audits, Matron audits and results to be disseminated to ward/deparments. Champions to be given a role in auditing and presenting data.	Bespoke training when issues highlighted from audits. Monthly audits	Champions role to be developed by attending scrutiny panel to see where areas of concern are.	Overall review of Q1, Q2 & Q3 improvements for assurance.		DHoN, Matron, Ward sisters, medical leads, PDNs	
Clean & Safe Healthcare Environment								
The physical environment is maintained and cleaned to a standard that facilitates effective IPC and minimises the risk of infection	**Currently no redesign plans for cancer services but IPC engagement would be sort if required. Working with domestics and estates teams to ensure compliance with cleanliness and storage.**	Monthly IPC, HH, & environmetal audits to ensure cleanliness within all areas remains above 90%. Feedback to be given in realtime and issues highlighted actioned. Assurance of staffs knowledge around cleaning processes following infections	Staff consultation to ensure relevant information is being disseminated and that they understad the relevance, as well as finding out what information they would like to have and to be involved with action planning which would take into account area based cleaning schedules for staff.	Explore the option of piloting rapid cleaning team as has been trialed in Morriston. Continued staff engagement. Bespoke training when issues identified.	Overall review of Q1, Q2 & Q3 improvements for assurance.		DHoN, Matron, Ward sisters, medical leads, Domestic services, Estates	
	PPE free corridors	Implement on all in patient area's				Ward Manager /Matron/MDT		
	IPC audits to be completed within all area's including Outpatient area's. Monthly Ward manager and Matron. Weekly or more if in outbreak. (including HH audits)	Monitor compliance and outcomes				Ward manager/Matron		
	Create peer review audit timetable for both Matron and managers, to give additional assurance for IPC and HH.	Matron/Ward Manager to devise timetable				Ward managers/ Matron		
	Continue monthly Matron Audits for inpatient area's highlighting IPC issues. Include regular bi-monthly audit for outpatient area's. AMAT system.	Monitor compliance and outcomes				DHON		
	Address issues of clutter on inpatient wards	Review current position				Matron/Ward manager		
	Storage - Review stock management, ensure appropriate storage of equipment and stock	Review current position				Matron/Ward manager		

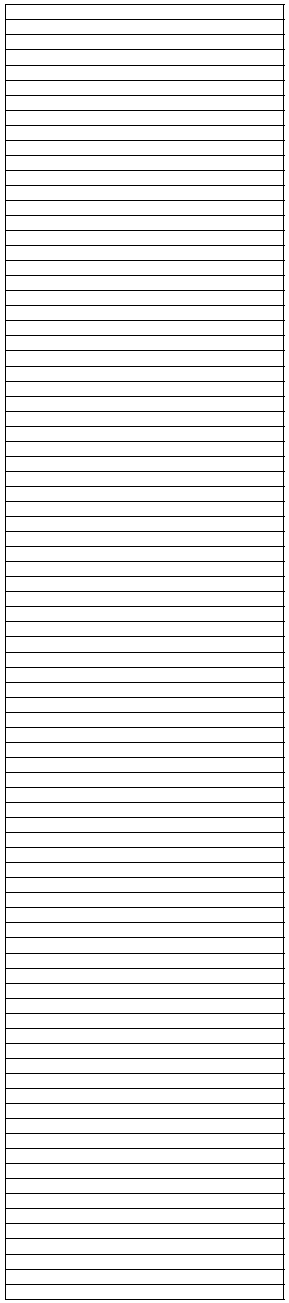
	There is an annual programme of decant and deep clean within Service Groups	Liaise with site management to devise a rolling programme for decant				Site team/DHON		
Antimicrobial Stewardship								
Reduce volume of antibiotics prescribed to reduce risks associated with antimicrobial resistance and *C. difficile*.	**Current process is that antibiotic prescribing should be in line with HB recommendations for specific infection treatments.**	Baseline antimicrobial status for service group to be disseminated so improvement can be measured. Baseline understaning of staffs knowledge around antimicrobial prescribing and where information such as antimicrobial reports can be found. Assurance that sepsis protocols are being followed when potential infection noted. Antimicrobial guidelines to be followed and microbiology advice taken.	Review Antimicrobial useage to see if improvement seen from baseline data. Bespoke training for staff involved in antimicrobial useage to understand this relevance for the 72 hour review.	MDT review via audit to evidence any improvement and action plan any issues highlighted. Relook at staff understanding and compliance with regards to antibiotic prescribing. Bespoke training if required.	Overall review of Q1, Q2 & Q3 improvements for assurance.		DHoN, Matron, Ward sisters, medical leads, Pharmacy	
Improve clinical understanding of the role of antibiotic prescribing in development of *C. difficile* infection	**Where there are Periods of Increased Incidence of C. difficile, associated medical teams undertake an audit of antibiotic prescribing within the ward / speciality using the audit tool in AMaT (Antibiotic audit_ QIP package.docx (sharepoint.com)).**	New Clinical Director for Division to work with Triumvrate, to lead on improvements to audit data.						
Reduce risks of *C. difficile* and antimicrobial resistance	**Improve compliance with the 72-hour switch from intravenous to oral antibiotics to equal the Welsh average as a minimum.**							

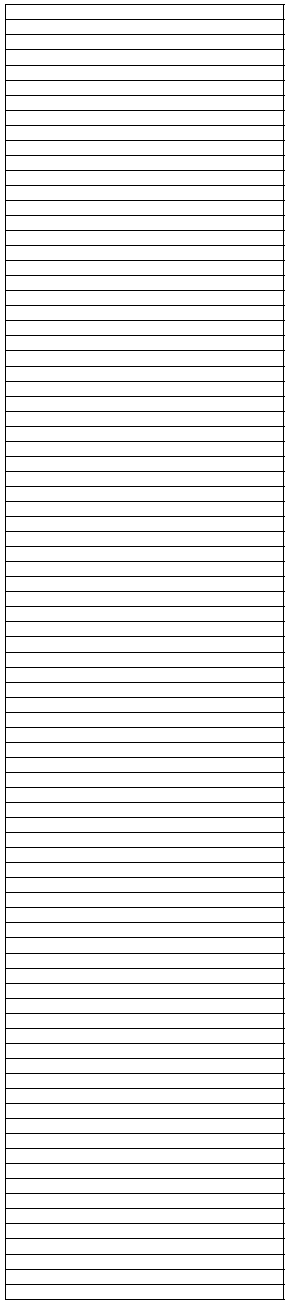
Goal	Method	Q1	Q2	Q3	Q4	Responsibility of
Improving the culture						
Provide a robust clinical governance framework for the division of Hospital operations	**Ensure robust scruitny meetings of all HCAI's is undetaken. Provide appropriate challenge and scrutiny of all cases diagnosed. MDT review and completion of RCA within 72 hours of diagnosis/notification.**	Current scrutiny processes in place. Now in real time investigation following completion of backlog. Ensure timely review of any HCAI cases, completed within 72 hours	100% complinace for 72 Hour review of any HCAI	Continuous monitoring of complinace	monitor	DHON
	Ensure robust feedback method to share learning with wider members of MDT, including nurses and medical staff and AHP's.	Improved communication, feedback and learning across the multi professional groups to prioritise IPC and patient safety. Create Division wide process.	Ensure capture professional wide sharing and monitor progress	Monitor progress and ensure consistent approach	Monitor progress and ensure consistent approach	DHON/Matron/Medical team/AHP
	Ensure appropriate compliance, monitoring and evidence of decontamination of equipment. - Standard equipment - Naso-endoscopes	Matron for designated area to provide assurance that correct processes and documentation in use	Monitor through audit processes. Action plan creation for any area not in compliance	Monitor continuously	Monitor	Matron
	Ensure appropriate compliance, monitoring and evidence of water safety checks in all area's across both sites.	Matron for desigated area to provide assurance that correct processes and documentation in use	Monitor Via Matron Audit on AMAT. Ensure Action plans undertaken for any area not in compliance	Monthly compliance monitoring via Matron audit	Monthly compliance monitoring via Matron audit	Matron
	Ensure robust processes in place to support culture of reporting infection-related and decontamination-related incidents	Discuss, re-iterate and set expecations at divisional IPC meeting	Monitor, review at each IPC divisional meeting. Ensuring escalation where appropriate. Create culture of openess and encourage reporting of any issues as a learning opportunity	Monitor and review at bi-montly IPC meeting	Monitor and review at bi-montly IPC meeting	DHON
	Ensure all patients with an indwelling device have the appropriate insertion and maintenance bundle in place. Weekly bug stop audit.	Involve Registered nurse as part of normal buisness in bug stop audit. To ensure undertanding and encourage opportunity for professional challenge and descision making. Involve MDT as appropriate.	Monitor compliance and understanding during IPC audits. Agenda item in Ward meetings.	Monitor compliance	Monitor compliance	Ward Manager Sister Charge nurse
Leadership						
Service Groups have a governance structure and processes for Infection Prevention & Control and Decontamination of re-usable medical devices	**All staff to be fully compliant with IPC training. Target 85%. Include all staff groups. -IPC Level 2 -ANTT**	Review current position	IPC L2 compliance expected to be 85%. Staff who require assistance with Esr to be identified and relevant training arranged.	IPC L2 compliance expected to be 90%.	IPC L2 compliance expected to be 95%, allowance for long term sick & maternity leave. Assurance that all staff have received training on ipc and are competent with IPC precautions and roles and responsibilities, to reduce infection rates.	Ward Manager/ Matron
	All staff to be fully compliant with practical IPC competancy training as appropriate. Including all professional groups. - Hand Hygiene - ANTT	Review current position	IPC competancies to be 75% across all professional bodies	Monitor compliance	Monitor compliance	Ward manager/matron
	Urgent training programme roll out for fit testing of FFP3 masks.	Urgent review by Matrons and Education team current position. Ensure adequate levels of trainers availible.	Ensure training and accurate records. Compliance to increase urgently.	Monitor compliance	Monitor compliance	Matron team
	Review and monitor MMR position of workforce ahead of Measles outbreak.	Undersand current position and MMR process.	Monitor in line with measles position	Monitor in line with measles position	Monitor in line with measles position	DHON
	Ensure training and compliance is in place for decontamination of equipment.	Matron to monitor with Ward Manager for their area's. Maintain acurate log	Ensure audit programme captures compliance.	Monitor via audit	Monitor via audit	Matron/ Ward/unit Manager
Physical Environment						
The physical environment is maintained and cleaned to a standard that facilitates effective IPC and minimises the risk of infection	**The physical environment is maintained and cleaned to a standard that facilitates effective IPC and minimises the risk of infection**	Monitor and ensure clinical area cleaning scores greater than 90%	Review position regularly with hotel services and at IPC bi monthly divisional meeting	Review position regularly with hotel services and at IPC bi monthly divisional meeting	Monitor	Ward manager/Matron
	IPC audits to be completed within all area's including Outpatient area's. Monthly Ward manager and Matron. Weekly or more if in outbreak. (including HH audits)	Monitor compliance and outcomes	Monitor compliance and outcomes	Monitor compliance and outcomes	Monitor compliance and outcomes	Ward manager/Matron
	Create peer review audit timetable for both Matron and managers, to give additional assurance for IPC and HH.	Matron/Ward Manager to devise timetable	Monitor position	Monitor position	Monitor position	Ward managers/ Matron
	Continue monthly Matron Audits for inpatient area's highlighting IPC issues. Include regular bi-monthly audit for outpatient area's. AMAT system.	Monitor compliance and outcomes	Monitor compliance and outcomes undertake action plans as applicable	Monitor compliance and outcomes undertake action plans as applicable	Monitor compliance and outcomes undertake action plans as applicable	DHON
	PPE free corridors	Implement on all in patient area's	Monitor compliance	Monitor	Monitor	Ward Manager /Matron/MDT
	Address issues of clutter on inpatient wards	Review current position	Review position with managers and matron	Monitor	Monitor	Matron/Ward manager
	Storage - Review stock management, ensure appropriate storage of equipment and stock	Review current position. New implementatio	Ward managers to monitor position	Ward managers to monitor position	Ward managers to monitor position	Matron/Ward manager
	There is an annual programme of decant and deep clean within Service Groups	Liaise with site management to devise a rolling programme for decant	Ensure plan is Implemented	Monitor progress of Q1 & Q2 with site teams	Review position with site teams	Site team/DHON
Antimicrobial Stewardship						

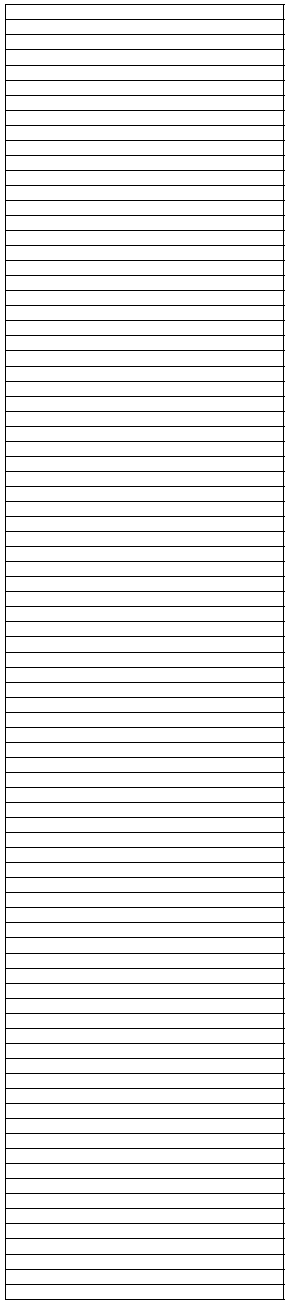
Reduce volume of antibiotics prescribed to reduce risks associated with antimicrobial resistance and *C. difficile.*	**Current process is that antibiotic prescribing should be in line with HB recommendations for specific infection treatments.**	Baseline antimicrobial status for service group to be disseminated so improvement can be measured. Baseline understaning of staffs knowledge around antimicrobial prescribing and where information such as antimicrobial reports can be found. Assurance that sepsis protocols are being followed when potential infection noted. Antimicrobial guidelines to be followed and microbiology advice taken.	Review Antimicrobial useage to see if improvement seen from baseline data. Bespoke training for staff involved in antimicrobial useage to understand this relevance for the 72 hour review.	MDT review via audit to evidence any improvement and action plan any issues highlighted. Relook at staff understanding and compliance with regards to antibiotic prescribing. Bespoke training if required.	Overall review of Q1, Q2 & Q3 improvements for assurance.	DHoN, Matron, Ward sisters, medical leads, Pharmacy
Improve clinical understanding of the role of antibiotic prescribing in development of *C. difficile* infection	**Where there are Periods of Increased Incidence of C. difficile, associated medical teams undertake an audit of antibiotic prescribing within the ward / speciality using the audit tool in AMaT (Antibiotic audit_ QIP package.docx (sharepoint.com)).**	Engage medical colleagues to ensure such practices undertaken	Monitor compliance, link with CD & pharmacy for any targeted work	Monitor compliance	Monitor	Clinical lead, DHON, Matron, Ward Managers, Pharmacy
Reduce risks of *C. difficile* and antimicrobial resistance	**Improve compliance with the 72-hour switch from intravenous to oral antibiotics to equal the Welsh average as a minimum.**	Review current position. Share antibitoic presentation with clinical staff. Agree process for auditing with pharmacy/medical colleagues	Monitor compliance and current position. What	Monitor	Monitor	Pharmacy, Clinical/medical leads, DHON, Matron, Ward Managers

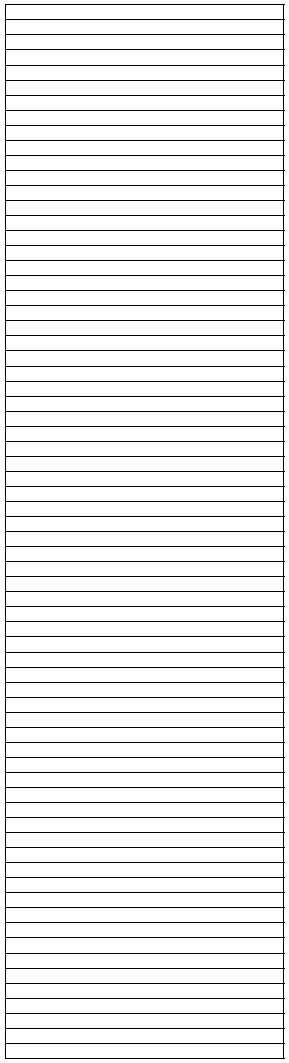












IMPROVEMENT PLAN 2024-2025

Goal	Method	Q1	Q2	Q3	Q4	Outcome	Responsibility	RAG STATUS
To have a robust Clinical Governance structure for Infection Prevention and Control within the Surgical Division/TOSTA	**To expand on the membership of the current Scrutiny panel meetings.**	Engagement from clinicians, pharmacy and microbiology collegues. As well as nursing collegues from other divisions to promote learning events.	To monitor attendance and ensure that learning is shared across the division.	Continue to monitor and escalate poor attendance to the HON for Surgical Specialities.	continue to monitor attendance		DHon of all Divisions	
	To develop a Terms of Refernce for IPC within the division to now include Theatres and anesthetics.	To amend and share within the Division and ratify at QSR	Continue to review and amend where required. To share with other divisons.	continue to review TOR	continiue to review and update TOR if required.		DHoN	
	To Maintain a live reporting and review process. Root cause anaylasis to be completed within 72 hours of incident being reported with full MDT engagement.	Full engagement from the MDT required. This is to be discussed during board rounds to ensure all MDT are aware.	To monitor attendance at the review of any cases requiring RCA.	Contiue to Monitor	continue to monitor attendance.		DHoN, Matron, ward managers/sisters/IPC/ Clinicians/ Allied professionals.	
	Commencement of Peer reviews, with support from other divisions.	To develop a task and finish group to develop a peer audit programme with a clear timeline for each clinical area. To include all outpatient areas.	To ensure that PEER reviews are taking palce and fed back post review and any finding escaulated to Matrons/ DHoN/ Estates/ domestic teams.	Continue to monitor	Continue to monitor.		DHoN of all divisons, Matrons of all divisons	
	Continue monthly IPC Environmental and HH/BBE Audits. In all clinical areas including the outpatient areas.	Peer reviews to comenece and engage with IPC collegues.	for Peer reviews to continue and any poor compliance to be escaulated to Ward Managers/ Matrons/ Clinical leads	continue to monitor	Continue to monitor.		Ward Managers and Matrons, IPC	
	To provide assurance that all patients with indwelling devices have the insertion and maintence bundles in place.	To have weekly bugstop audits to monitor compliance. All clinical and nursing staff to sign up to being compliant with the use of bundles. To add this to the agenda at each Scrutiny meeting.	To audit compliance and uptake from all staff/departments to provide assurance that as a Division we are compliant with the use of bundles.	continue to monitor and discuss at divisonal IPC meeting.	continue to monitor and discuss at divisonal IPC Meeting.		DHoN, Matrons and ward Managers.	
	To start to explore the numbers of Surgical Site infections with 28 days of discharge. To ensure that patients are aware of the possibilty of SSI and how to inform us.	To set up a Task and finish group membership to include Ward Managers, Speciallist nurses, Consultants , IPC leads and collegues.	Task and finish group to meet monthly with support form IPC collegues. TOR to be written and approved.	To of started collecting SSI data. Feed back to divisonal and service group IPC meeting progress and findings.	To feed back at IPC divisonal and service group IPC meetings findings/outcomes and improvements.		Ward Managers and Matrons. DHoN, IPC Collegues, Consultants.	
Leadership								
To be 100% compliant with all IPC training across all areas within the division of Surgery/TOSTA	**Training needs analysis currently taking place, preliminary data shows and improving picture of compliance across the out patient areas, and surgical Ward teams.**	Clinical teams to engage in this and to maintain compliance across all areas.	To maintain high levels of training and understanding of the Health boards/ Service group/Divisional IPC priorities.	To monitor training levels	Continue to Moitor training compliance.		DHoN, Matrons and Ward sisters	
	ANTT training both electronic and face to face assessment compliance has greatly improved .	Identify assessors and champions for each clinical area and to focus on improved compliance.	To maintain high levels of training and understanding of the Health boards/ Service group/Divisional IPC priorities.	To monitor training levels	Continue to Moitor training compliance.		Matrons, IPC, PDN and ward managers	
	IPC Level 2 compliance has improved.	To matintain high level of compliance across all area of the division.	To maintain high levels of training and understanding of the Health boards/ Service group/Divisional IPC priorities.	To monitor training levels	Continue to Moitor training compliance.			
	Recommence FFP3 training	Obtain baseline training figures via TNA. Assess current FITT trainers and provide updates were required.	To maintain high levels of training and understanding of the Health boards/ Service group/Divisional IPC priorities.	To monitor training levels	Continue to Moitor training compliance.		Ward Manager, Kerry Griffiths and PDN	
	Water safety -daily flushing to be completed, communication pathway to be improved between estates/ ward staff re: results of tests.	To ensure that this is being maintained as standard practice.	To add to as an agenda item at the Divisonal IPC meeting. Continue to Monitor compliance	Continue to monitor.	continue to monitor		DHoN, Matron, Ward sisters, Estates, Domestics	
	Ensure training and compliance is in place for decontamination of equipment and that correct cleaning methods are used.	Locate equipment and audit processes / TNA	Ensure all staff are trained and competent with Tristal and Trophon decontamination.	Monitor decontamination audits and training compliance.	Continue to monitor		DHoN , Matrons, Ward managers, IPC.	
Inpatient areas for elective surgery to be aware pre-admission of any previous infections.	**To ensure that pre-assessment/Pre-Admit (Ward E only) have a screening question that is being asked to all patients regarding previously known infections.**	To Discuss with Pre-assessment Clinics.	Monitor outcomes of pre-admit/assessment questioning known previous infections.	to monitor previous infection data in pre-assessement documentation	Continue to monitor		DHoN's/ Matrons/ Clinic and Ward Managers.	
	To ensure that the ward and clinic environments maintiain the high standards of cleanliness and good repair.	To escualte any concerns regarding cleaning hours/standards and estates issues as soon as they become apparent.	Continue To escualte any concerns regarding cleaning hours/standards and estates issues as soon as they become apparent.	Monitor the environement by completing audits and perform quartly environmental walkthroughs with estates and IPC.	Continue to monitor		Matrons / ward managers and sisters.	
Environment								
The physical environment is maintained and cleaned to a standard that facilitates effective IPC and minimises the risk of infection	**The physical environment is maintained and cleaned to a standard that facilitates effective IPC and minimises the risk of infection**	Monitor and ensure clinical area cleaning scores greater than 90%	Continue to monitor	Continue to monitor	Continue to monitor	Ward manager/Matron		
	IPC audits to be completed within all area's including Outpatient area's. Monthly Ward manager and Matron. Weekly or more if in outbreak. (including HH audits)	Monitor compliance and outcomes	Monitor compliance and outcomes	Monitor compliance and outcomes	Monitor compliance and outcomes	Ward manager/Matron		
	Create peer review audit timetable for both Matron and managers, to give additional assurance for IPC and HH.	Matron/Ward Manager to devise timetable	Monitor compliance and outcomes	Monitor compliance and outcomes	Monitor compliance and outcomes	Ward managers/ Matron		

	Continue monthly Matron Audits for inpatient area's highlighting IPC issues. Include regular bi-monthly audit for outpatient area's. AMAT system.	Monitor compliance and outcomes	Monitor compliance and outcomes	Monitor compliance and outcomes	Monitor compliance and outcomes	DHON		
	PPE free corridors	Implement on all in patient area's	Monitor compliance	Monitor compliance	Monitor compliance	Ward Manager /Matron/MDT		
	Address issues of clutter on inpatient wards	Review current position	Monitor compliance	Monitor compliance	Monitor compliance	Matron/Ward manager		
	Storage - Review stock management, ensure appropriate storage of equipment and stock	Review current position	continue to monitor	continue to monitor	continue to monitor	Matron/Ward manager		
	There is an annual programme of decant and deep clean within Service Groups	Liaise with site management to devise a rolling programme for decant.	Liaise with site management to devise a rolling programme for decant.	Liaise with site management to devise a rolling programme for decant.	Liaise with site management to devise a rolling programme for decant.	Site team/DHON		
Antibiotic Stewardship								
Reduce volume of antibiotics prescribed to reduce risks associated with antimicrobial resistance and *C. difficile.*	**Current process is that antibiotic prescribing should be in line with HB recommendations for specific infection treatments.**	Baseline antimicrobial status for service group to be disseminated so improvement can be measured. Baseline understaning of staffs knowledge around antimicrobial prescribing and where information such as antimicrobial reports can be found. Assurance that sepsis protocols are being followed when potential infection noted. Antimicrobial guidelines to be followed and microbiology advice taken.	Review Antimicrobial useage to see if improvement seen from baseline data. Bespoke training for staff involved in antimicrobial useage to understand this relevance for the 72 hour review.	MDT review via audit to evidence any improvement and action plan any issues highlighted. Relook at staff understanding and compliance with regards to antibiotic prescribing. Bespoke training if required.	Overall review of Q1, Q2 & Q3 improvements for assurance.		DHoN, Matron, Ward sisters, medical leads, Pharmacy	
	Improve clinical understanding of the role of antibiotic prescribing in development of *C. difficile* infection	for all staff to review the CDI policy and have training on the risks of CDI to our patients.	understanding. For staff to feel empowered to challenge and query the use of ABX.	Continue to monitor	Continue to monitor			
	Reduce risks of *C. difficile* and antimicrobial resistance	for all staff to review the CDI policy and have training on the risks of CDI to our patients.	monitor compliance and understanding. For staff to feel empowered to challenge and query the use of ABX.	Continue to monitor	Continue to monitor			

Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Neath Port Talbot and Singleton Service Group
Infection Prevention Improvement Plan 2024/25

Goal	Key Metrics	Outcome	Responsibility	Timescales	Q1	Q2	Q3	Q4
Improving the Culture								
All staff are trained, educated and competent in IPC as appropriate for their role	Achieve compliance with national training target for infection prevention & control-related mandatory training (all available staff). Working toward IP&C Training, Level 1 and Level 2 – ≥85% (available staff) by staff groups	≥85% compliance with mandatory training	Divisional Triumvirates	Q3	Ensure individuals are allocated study time to complete e-learning modules.	Monitor compliance consider action plan if compliance has not improved.	Continue to allocate study time. Audit training compliance	Audit training compliance. Improved compliance
	Staff who undertake aseptic technique are trained and can demonstrate competency	≥85% compliance with ANTT training in staff who undertake aseptic technique and these staff have been assessed as competent	Divisional Triumvirates	Q3	Provide nominated ANTT trainers time to complete training.	Increased number of trainers within the division to improve training compliance.	Maintain sufficent numbers of ANTT trainings to meet the needs of CYP DOPS assessments . Assess the need to train further nurses. Monitor hand training compliance	Maintain sufficent numbers of ANTT trainings to meet the needs of CYP DOPS assessments . Assess the need to train further nurses. Monitor hand training compliance
	Each clinical area will have access to a Hand Hygiene Competence Assessor supporting education, training and assessment	All clinical areas will have a Hand Hygiene Competence Assessor	Divisional Triumvirates	Q3	Provide nominated hand wash trainers time to complete training.	Increased number of hand wash trainers within the division. improved hand washing training compliance.	Maintain sufficent numbers of hand washing trainings to meet the needs of CYP. Assess the need to train further nurses. Monitor handwashing training compliance	Maintain sufficent numbers of hand washing trainings to meet the needs of CYP. Assess the need to train further nurses. Monitor handwashing training compliance
There is an organisational culture that promotes reporting of infection-related and decontamination-related incidents	Infection-related, and decontamination-related incidents within the Service Group are reported, monitored and investigated in a timely way	Infection-related, and decontamination-related incidents are reported, monitored and investigated appropriately, with learning shared across the organisation	Divisional Triumvirates	In place - ongoing monitoring	focus on all department to ensure allinfection related incidents are reported and investigated .Monitor in weekly incidents meeting for neonates , acute and community	Monitor all investigation and review themes and trends . Ensure shared learning within the divison	Monitor all investigation and review themes and trends . Ensure shared learning within the divison	Monitor all investigation and review themes and trends . Ensure shared learning within the divison
	Service Groups feedback lessons learned from the investigation of incidents through their Quality & Safety Groups	Service Group Quality & Safety meeting minutes	Group Medical and Nurse Directors	In place - ongoing monitoring	Ensure all DATIX investogations and concerns are shared in Quality and safety and action plans to be circulated and shared across the division	Ensure all DATIX investogations and concerns are shared in Quality and safety and action plans to be circulated and shared across the division	maintain action plans and shared learning	maintain action plans and shared learning
	Multi-disciplinary reviews of healthcare associated infections (HCAI) are undertaken in a timely way, with engagement of relevant clinical leads, that demonstrate an understanding of avoidability, with key lessons learned shared across Service Groups and the Health Board	MDT reviews of HCAI is undertaken and lessons learned shared	Heads of Nursing / Midwifery, Clinical Directors / Clinical Leads	In place - ongoing monitoring	Monitor compliance with Multi-disciplinary reviews of healthcare associated infections (HCAI) are undertaken in a timely way	Update action plan submitted to CYP IPC meeting and divisional Quality and safety and tema briefs	Up date action plan submitted to CYP IPC meeting and divisional Quality and safety and tema briefs . Addres any issues within division and revoew action plans.	ensure these are embedded into practice for shared learning and continued
	Medical and Nurse Directors monitor performance against Tier 1 reduction goals and progress against their Infection Reduction Improvement Plans	There is a process of high level assurance relating to HCAI	Service Group Directors	In place - ongoing monitoring	monthly IPC meeting and ensure all HCAI are discussed	monthly IPC meeting and ensure all HCAI are discussed	monthly IPC meeting and ensure all HCAI are discussed	monthly IPC meeting and ensure all HCAI are discussed
Leadership								
Service Groups have a governance structure and processes for Infection Prevention & Control and Decontamination of re-usable medical devices	Infection Prevention & Control Groups terms of reference to be reviewed and updated to reflect Service Group Changes. Co-chaired by Medical Director and Nurse Director, with multi-disciplinary engagement,	Established Service Group governance structures and management systems for IPC are in place	Divisional Triumvirates	Jun-24	Scope all departmental cleaning scedhules are in place acorss the division and compliance with all SOP for medical devices and decontamination protocols	Monitor compliance against all cleaning scedules and action plans if plan if compliance is not mainatined	Monitor compliance against all cleaning scedules and action plans if plan if compliance is not mainatined	Monitor compliance against all cleaning scedules and action plans if plan if compliance is not mainatined
	There are designated Divisional Leads for Infection Prevention & Control and Decontamination	There is a clearly identified Divisional lead for Decontamination and there are appropriate governance structures in place	Divisional Triumvirates	Jul-24	All Ward Sister/matrons must ensure that all IPC audits are completed in the different departments and maintain governance in relation to IPC monitoring	All Ward Sisters/ matrons/clinical leads maintain governance in relation to IPC monitoring	All Ward Sister matrons are IPC leds in the different departments and maintain governance in relation to IPC monitoring	All Ward Sisters/matrons are IPC leds in the different departments and maintain governance in relation to IPC monitoring
There is a programme of regular IPC-related audit	Infection Prevention & Control-related audits (Hand Hygiene, Standard Infection Prevention & Control Environment are undertaken and reported locally, and there is a system in place to monitor associated recommendations and actions	The IPC audit programme is established on AMaT and Service Groups review, monitor and track progress	Divisional Triumvirates	Jul-24	ensure a robust system in plance for all IPC audits inclusing Matrons Audits and present in monthly assurance audits. Share results with DHoN.	ensure compliance and maintaining IPC matrix on the monthly IPC forum with presented action plans	ensure compliance and maintaining IPC matrix on the monthly IPC forum with presented action plans	ensure compliance and maintaining IPC matrix on the monthly IPC forum with presented action plans
Service Groups develop leadership and empowerment to drive improvement in reducing episodes of harm	Divisions to identify Link Champions for IPC and Decontamination	All clinical areas will have IPC champion, high risk areas will have nominated decontamination champions	Divisional Triumvirates	Jul-24	Provide the IPC champion role and protected time to complete training/audits and action plans .	review training/audits and action plans .	review training/audits and action plans .	review training/audits and action plans .
Clean & Safe Healthcare Environment								
The physical environment is maintained and cleaned to a standard that facilitates effective IPC and minimises the risk of infection	Maintain cleanliness compliance score >90%	Maintain >95% compliance with cleaning scores	Support Services / Matrons	In place - ongoing monitoring	Address issues within division estates and hotel services and review any monthly action plans. Monitor improvements . To aim for compliance >95%	To aim for compliance >95%	To aim for compliance >95%	To aim for compliance >95%
	Service Groups to review options for workforce redesign to strenthen standards of cleanliness within wardsg	Improvement in Standard Infection Control Precautions compliance scores	Group Nurse Director, Clinical Director of Midwifery, and Heads of Nursing and Midwifery		Business options represented and appraised. For refurbishment to imporvment departments , storage and cubicles	monitor refurbishment planning and RAG audits	monitor refurbishment planning and RAG audits	monitor refurbishment planning and RAG audits
	Ensure safe systems exist for providing safe storage, distribution, monitoring and decontamination of foam mattresses and bed frames	There is a certificate of decontamination for every bed and mattress that provides assurance for Divisions and the Service Group that every patient will be assured of having a clean mattress	Ward Managers / Matrons	Jul-24	ensure monthly audits and scedules are maintained and reported into IPC meetings	ensure monthly audits and scedules are maintained and reported into IPC meetings	ensure monthly audits and scedules are maintained and reported into IPC meetings . Monitor compliance	ensure monthly audits and scedules are maintained and reported into IPC meetings . Monitor compliance
Infection prevention and control is considered as a core element at the planning and design stages of a new builds, refurbishments, repurposing and redesign schemes	The IPC team is involved at every stage of new builds, refurbishments, repurposing and redesign schemes to facilitate IPC being "designed-in"	IPC and related risks are considered at all stages of new builds, refurbishments, repurposing and redesign schemes	Service Group Directors, Assistant Director of Capital Planning, Corporate IPC Lead					
There is an annual programme of decant and deep clean within Service Groups	Development an annual programme of decant and deep clean.	A programme of decant and deep clean is established	Service Group Directors, Estates and Support Services	Jun-24				
Antimicrobial Stewardship								
Reduce volume of antibiotics prescribed to reduce risks associated with antimicrobial resistance and *C. difficile*	Reduce the volume of antibiotics prescribed across the health board, but particularly within Primary Care	Minimum 5% year-on-year reduction	Group Medical Directors / Associate Medical Directors / Clinical Directors / Clinical Leads	Q4				
Improve clinical understanding of the role of antibiotic prescribing in development of *C. difficile* infection	Where there are Periods of Increased Incidence of C. difficile, associated medical teams undertake an audit of antibiotic prescribing within the ward / speciality using the audit tool in AMaT (Antibiotic audit_ QIP package.docx (sharepoint.com)).	Improved compliance with Start Smart Then Focus standards	Group Medical Directors / Associate Medical Directors / Clinical Directors / Clinical Leads	Monitor each quarter				
Reduce risks of *C. difficile* and antimicrobial resistance	Improve compliance with the 72-hour switch from intravenous to oral antibiotics to equal the Welsh average as a minimum.	Equal the Welsh average as a minimum	Group Medical Directors / Associate Medical Directors / Clinical Directors / Clinical Leads	Monitor each quarter				

Neath Port Talbot and Singleton Service Group
Infection Prevention Improvement Plan 2024/25

Goal	Key Metrics	Outcome	Responsibility	Timescales	Q1	Q2	Q3	Q4
Improving the Culture								
All staff are trained, educated and competent in IPC as appropriate for their role	Achieve compliance with national training target for infection prevention & control-related mandatory training (all available staff). Working toward IP&C Training, Level 1 and Level 2 – ≥85% (available staff) by staff groups	≥85% compliance with mandatory training	Divisional Triumvirates	Q3	PDM/Matrons to monitorand action aim xx% compliance	Ongoing monitoring to achieve set compliance	To ensure ≥85% compliance achieved	Maintain compliance ≥85% compliance
	Staff who undertake aseptic technique are trained and can demonstrate competency	≥85% compliance with ANTT training in staff who undertake aseptic technique and these staff have been assessed as competent	Divisional Triumvirates	Q3	PDM/Matron to allocate training for staff aim for xx compliance	Ongoing monitoring	To ensure ≥85% compliance achieved	Maintain compliance ≥85% compliance
	Each clinical area will have access to a Hand Hygiene Competence Assessor supporting education, training and assessment	All clinical areas will have a Hand Hygiene Competence Assessor	Divisional Triumvirates	Q3	To have two Hand Hygiene Assessor in each clinical area	Ongoing monitoring	raining for each area assessor to be comp	hygiene assessors to be in each c
There is an organisational culture that promotes reporting of infection-related and decontamination-related incidents	Infection-related, and decontamination-related incidents within the Service Group are reported, monitored and investigated in a timely way	Infection-related, and decontamination-related incidents are reported, monitored and investigated appropriately, with learning shared across the organisation	Divisional Triumvirates	In place - ongoing monitoring	In place- ongoing monitoring	In place- ongoing monitoring	In place- ongoing monitoring	Ensure incidents are reviewed and learning shared
	Service Groups feedback lessons learned from the investigation of incidents through their Quality & Safety Groups	Service Group Quality & Safety meeting minutes	Group Medical and Nurse Directors	In place - ongoing monitoring	In place ongoing monitoring	In place- ongoing monitoring	In place- ongoing monitoring	Ensure fed through Q&S through exemption reporting by DHOM
	Multi-disciplinary reviews of healthcare associated infections (HCAI) are undertaken in a timely way, with engagement of relevant clinical leads, that demonstrate an understanding of avoidability, with key lessons learned shared across Service Groups and the Health Board	MDT reviews of HCAI is undertaken and lessons learned shared	Heads of Nursing / Midwifery, Clinical Directors / Clinical Leads	In place - ongoing monitoring	In place ongoing monitoring	In place- ongoing monitoring	In place- ongoing monitoring	In place- ongoing monitoring
	Medical and Nurse Directors monitor performance against Tier 1 reduction goals and progress against their Infection Reduction Improvement Plans	There is a process of high level assurance relating to HCAI	Service Group Directors	In place - ongoing monitoring	In place ongoing monitoring	In place- ongoing monitoring	In place- ongoing monitoring	In place- ongoing monitoring
Leadership								
Service Groups have a governance structure and processes for Infection Prevention & Control and Decontamination of re-usable medical devices	Infection Prevention & Control Groups terms of reference to be reviewed and updated to reflect Service Group Changes. Co-chaired by Medical Director and Nurse Director, with multi-disciplinary engagement,	Established Service Group governance structures and management systems for IPC are in place	Divisional Triumvirates	Jun-24	DHOM to review Maternity IPC and reflect service group changes	To ensure TOR are reviewed to reflected outcome.	All governace structures and management systems to be in place	DHOM to ensure all IPC goverance and management systems reflected in monthly audits
	There are designated Divisional Leads for Infection Prevention & Control and Decontamination	There is a clearly identified Divisional lead for Decontamination and there are appropriate governance structures in place	Divisional Triumvirates	Jul-24	Deputy Head of Midwifery	Reviewed to reflect outcome	Lead identified governance structure in place	
There is a programme of regular IPC-related audit	Infection Prevention & Control-related audits (Hand Hygiene, Standard Infection Prevention & Control Environment are undertaken and reported locally, and there is a system in place to monitor associated recommendations and actions	The IPC audit programme is established on AMaT and Service Groups review, monitor and track progress	Divisional Triumvirates	Jul-24	Undertaken monthly reviewd and actioned by ward managers, any concerns escalated into maternity IPC monthly meeting	DHOM to continue to monitor action plans	Established programme on Amat	Monitor track progress
Service Groups develop leadership and empowerment to drive improvement in reducing episodes of harm	Divisions to identify Link Champions for IPC and Decontamination	All clinical areas will have IPC champion, high risk areas will have nominated decontamination champions	Divisional Triumvirates	Jul-24	to ensure each ward has IPC link champio	IPC champions to be in place	IPC champions in place	IPC champions in place
Clean & Safe Healthcare Environment								
The physical environment is maintained and cleaned to a standard that facilitates effective IPC and minimises the risk of infection	Maintain cleanliness compliance score >90%	Maintain >95% compliance with cleaning scores	Support Services / Matrons	In place - ongoing monitoring	Monthly audit	DHOM to continue to monitor action plans	DHOM to continue to monitor action plans	Review compliance if not above 95% action plan required.
	Service Groups to review options for workforce redesign to strenthen standards of cleanliness within wardsg	Improvement in Standard Infection Control Precautions compliance scores	Group Nurse Director, Clinical Director of Midwifery, and Heads of Nursing and Midwifery		Risk assessment of cleaning arrangements	DHOM to review monitor and action monthly audits	DHOM to continue to monitor action plans	DHOM to continue to monitor action plans via monthly IPC
	Ensure safe systems exist for providing safe storage, distribution, monitoring and decontamination of foam mattresses and bed frames	There is a certificate of decontamination for every bed and mattress that provides assurance for Divisions and the Service Group that every patient will be assured of having a clean mattress	Ward Managers / Matrons	Jul-24	DHOM to review current processes for monitoring	DHOM to continue to monitor action plans	DHOM to continue to monitor action plans	DHOM to continue to monitor action plans via monthly IPC
Infection prevention and control is considered as a core element at the planning and design stages of a new builds, refurbishments, repurposing and redesign schemes	The IPC team is involved at every stage of new builds, refurbishments, repurposing and redesign schemes to facilitate IPC being "designed-in"	IPC and related risks are considered at all stages of new builds, refurbishments, repurposing and redesign schemes	Service Group Directors, Assistant Director of Capital Planning, Corporate IPC Lead		IPC team involvement as required	Review as required	Review as required	Review as required
There is an annual programme of decant and deep clean within Service Groups	Development an annual programme of decant and deep clean.	A programme of decant and deep clean is established	Service Group Directors, Estates and Support Services	Jun-24	DHOM to develop plan to facilitate annually	Annual plan to have allocated dates for deep clean	Evidence of decant and deep clean in progress	All area have had decant and deep clean, action if not completed
Antimicrobial Stewardship								
Reduce volume of antibiotics prescribed to reduce risks associated with antimicrobial resistance and *C. difficile*	Reduce the volume of antibiotics prescribed across the health board, but particularly within Primary Care	Minimum 5% year-on-year reduction	Group Medical Directors / Associate Medical Directors / Clinical Directors / Clinical Leads	Q4	DHOM to liaise with pharmacy to audit current use.	Ongoing monitoring and action plan if concerned	On going monitoring	Review current data to achieve 5% reduction
Improve clinical understanding of the role of antibiotic prescribing in development of *C. difficile* infection	Where there are Periods of Increased Incidence of C. difficile, associated medical teams undertake an audit of antibiotic prescribing within the ward / speciality using the audit tool in AMaT (Antibiotic audit_ QIP package.docx (sharepoint.com)).	Improved compliance with Start Smart Then Focus standards	Group Medical Directors / Associate Medical Directors / Clinical Directors / Clinical Leads	Monitor each quarter	Monitor rates (minimal)	Ongoing monitoring	Ongoing monitoring	Ongoing monitoring
Reduce risks of *C. difficile* and antimicrobial resistance	Improve compliance with the 72-hour switch from intravenous to oral antibiotics to equal the Welsh average as a minimum.	Equal the Welsh average as a minimum	Group Medical Directors / Associate Medical Directors / Clinical Directors / Clinical Leads	Monitor each quarter	DHOM to liaise with pharmacy to audit.	Ongoing monitoring and action plan if co	Ongoing monitoring	Review data with pharmacy

Infection Prevention Improvement Plan
Neath Port Talbot & Singleton Hospitals Service Group
2024/25

Goal	Method	Baseline position	3 month	6 month	9 month	12 month	Outcome	Responsibility	Q1 Progress	Q2 Progress	Q3 Progress	Q4 Progress
Infection Prevention & Control Infection Prevention and Control (IPC) and reduction of HCAIs as per the Health Board refreshed IPC Improvement plan 2024/25	Achieve reduction in 5 key healthcare associated infections through application of evidence-based practice and best practice guidance	Baseline for 23/24: C. difficile: 32 cases	Cumulative total to Q1: C. difficile: 5 cases	Cumulative total to Q2: C. difficile: 9 cases	Cumulative total to Q3: C. difficile: 12 cases	Cumulative annual total: C. difficile: 15 cases	Cumulative annual total: C. difficile: 15 cases	Service Group Directors, reporting via Infection Prevention & Control Groups				
		Baseline for 23/24: Staph. aureus bacteraemia: 35 cases	Cumulative total to Q1: Staph. aureus bacteraemia: 4 cases	Cumulative total to Q2: Staph. aureus bacteraemia: 7 cases	Cumulative total to Q3: Staph. aureus bacteraemia: 9 cases	Cumulative annual total: Staph. aureus bacteraemia: 10 cases	Cumulative annual total: Staph. aureus bacteraemia: 10 cases					
		Baseline for 23/24: E. coli bacteraemia: 46 cases	Cumulative total to Q1: E. coli bacteraemia: 10 cases	Cumulative total to Q2: E. coli bacteraemia: 18 cases	Cumulative total to Q3: E. coli bacteraemia: 25 cases	Cumulative annual total: E. coli bacteraemia: 32 cases	Cumulative annual total: E. coli bacteraemia: 32 cases					
		Baseline for 23/24: Klebsiella bacteraemia: 14 cases	Cumulative total to Q1: Klebsiella bacteraemia: 4 cases	Cumulative total to Q2: Klebsiella bacteraemia: 7 cases	Cumulative total to Q3: Klebsiella bacteraemia: 9 cases	Cumulative annual total: Klebsiella bacteraemia: 11 cases	Cumulative annual total: Klebsiella bacteraemia: 11 cases					
		Baseline for 23/24: Pseudomonas aeruginosa bacteraemia: 8 cases	Cumulative total to Q1: Pseudomonas aeruginosa bacteraemia: 2 cases	Cumulative total to Q2: Pseudomonas aeruginosa bacteraemia: 3 cases	Cumulative total to Q3: Pseudomonas aeruginosa bacteraemia: 4 cases	Cumulative annual total to Q4: Pseudomonas aeruginosa bacteraemia: 6 cases	Cumulative annual total to Q4: Pseudomonas aeruginosa bacteraemia: 6 cases					