12 Month Plan

Goal	Method	Baseline position	3 month (Q1)	6 month (Q2)	9 month (Q3)	12 month (Q4)	Outcome	Responsibility	Digital & Finance Implications	IP&C Methodology Support Lead	Progress @ end Q2
Service Groups to review IPC governance arrangements & structures and submit to Health Board Infection Control Committee.	Service Delivery Groups to establish a **Service Group Infection Control Committee** (with appropriate MDT clinical representation), with HCAI Quality Priority a focus, that reports into the Health Board's Infection Control Committee.	Previously established within most Service Groups, but frequency of meetings has slipped during Pandemic.	Established, with meetings planned up to March 2023 in all Service Groups.	Development and agreement of clear roles and responsibilities from Board to ward and reflected within Service Group improvement plans.			Strengthened local ownership, governance arrangements for IPC at Service Group level.	Service Group Directors		Support for each Service Group ICC.	
	Service Groups to establish a process for **high level scrutiny and learning** for Staph. aureus bacteraemia and C. difficile infection, with local clinical teams presenting to the Group Medical and Nursing Directors.	High level scrutiny of nosocomial (NI) cases of key infections not well established	Each Service Group will have established a process of scrutiny of nosocomial C. diff and Staph. aureus bacteraemia.	**Each Service Group will identify top 5 areas with highest incidence of infection and implement QI programmes to reduce infections.**	Clear evidence of improvement strategies.	Clear evidence of improvement strategies.	Improved scrutiny and shared learning from these key harm events.	Service Group Directors		Support provided as required for scrutiny of cases. Matron for IPC chairs Quality Priority C. diff Group.	
	Service Group Medical & Nursing Directors to present findings from this scrutiny process, and lessons leaned, monthly to Executive Medical and Nursing Directors.	Meetings being held with each Service Group Triumvirate to confirm process expectations.	Regular senior leadership scrutiny meeting dates established.	Clear evidence of improvement strategies.	Clear evidence of improvement strategies.	Clear evidence of improvement strategies.	Clear expectation that Service Groups have improved compliance, assurance of earlier identification of infection, improved assessment of severity of disease and management of cases . Identification from lessons learned which inform improvement actions.	Executive & Service Group Medical & Nursing Directors.		Support for process and attendance at Exec review meetings.	
Reduce incidence of the following key infections: Staph. aureus and Gram negative bacteraemias, and C. difficile infection.	**Using strategies outlined below: Need to rotate nurse / medical management responsibilities to understand key areas of work. Need to ensure staff at all levels are clear that IPC is everyone's responsibilities. What does good practice look like by being clear on our clinical pathways and evidence based practice.**	**C. difficile infection** **WG Improvement Goal: <8 cases/month (NI & CAI)** HB average 11 NI cases/month; 5 Community acquired (CAI)/month Average 7 NI cases/month Morriston Average 3 NI cases/month Singleton 5 NI cases in 11 month PCTG	**WG Improvement Goal: <8 cases/month** **Minimum improvement goals:** HB average 6 NI cases/month; average 2 CAI cases/month Average ≤4 NI cases/month Morriston Average 2 NI cases/month Singleton 1 NI case/quarter NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <8 cases/month** **Minimum improvement goals:** HB average 6 NI cases/month; average 2 CAI cases/month Average ≤4 NI cases/month Morriston Average 2 NI cases/month Singleton 1 NI case/quarter NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <8 cases/month** **Minimum improvement goals:** HB average 6 NI cases/month; average 2 CAI cases/month Average 3 NI cases/month Morriston Average 1 NI cases/month Singleton 1 NI case/quarter NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <8 cases/month** **Minimum improvement goals:** HB average 6 NI cases/month; average 2 CAI cases/month Average 3 NI cases/month Morriston Average 1 NI cases/month Singleton 1 NI case/quarter NPTH 0 NI cases/month PCTG	**Annual percentage reduction to achieve adopted HB reduction goal - 50%**				Average 15 cases/month ↑ Av. 10 HAI case/mth (**+4/mth**) ↑; Av. 5 CAI/mth (**+3/mth**) **Morr** - 7/mth (**+3/mth**)↑; **Sing**- 3/mth (**+1/mth**)↑; **NPTH** 1/qtr (on-track)
		Staph. aureus bacteraemia **WG Improvement Goal: <6 cases/month (NI & CAI)** HB average 6 NI cases/month; 5 Community acquired (CAI)/month Average 4 NI cases/month Morriston Average 2 NI cases/month Singleton 1 NI case in 11 months NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <6 cases/month** **Minimum improvement goals:** HB average 3 NI cases/month; average 3 CAI cases/month Average 2 NI cases/month Morriston Average 1 NI cases/month Singleton 0 NI cases/month NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <6 cases/month** **Minimum improvement goals:** HB average 3 NI cases/month; average 3 CAI cases/month Average 2 NI cases/month Morriston Average 1 NI cases/month Singleton 0 NI cases/month NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <6 cases/month** **Minimum improvement goals:** HB average 3 NI cases/month; average 3 CAI cases/month Average 2 NI cases/month Morriston Average 1 NI cases/month Singleton 0 NI cases/month NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <6 cases/month** **Minimum improvement goals:** HB average 3 NI cases/month; average 3 CAI cases/month Average 2 NI cases/month Morriston Average 1 NI cases/month Singleton 0 NI cases/month NPTH 0 NI cases/month PCTG	**Annual percentage reduction to achieve adopted HB reduction goal - 45%**	Service Group Directors	Band 6 WTE Digital Intelligence resource for	Head of Nursing IPC leading with Digital Intelligence on	Average 13 cases/month ≡ Av. 7 HAI case/mth (**+4/mth**); Av. 6 CAI/mth (**+3/mth**)↑ **Morr** - 5/mth (**+3/mth**) ≡; **Sing** - 2/mth (**+1/mth**) ≡; **NPTH +2 cases by Qtr 2**

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		E. coli bacteraemia **WG Improvement Goal: <21 cases/month (NI & CAI)** HB average 8 NI cases/month; 16 Community acquired (CAI)/month Average 4 NI cases/month Morriston Average 2 NI cases/month Singleton 1 NI case in 11 months NPTH 0 NI cases/month PCCT	**WG Improvement Goal: <21 cases/month** **Minimum improvement goals:** HB average 6 NI cases/month; average 15 CAI cases/month Average 3 NI cases/month Morriston Average 2 NI cases/month Singleton 1 NI case/month NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <21 cases/month** **Minimum improvement goals:** HB average 6 NI cases/month; average 15 CAI cases/month Average 3 NI cases/month Morriston Average 2 NI cases/month Singleton 1 NI case/month NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <21 cases/month** **Minimum improvement goals:** HB average 6 NI cases/month; average 15 CAI cases/month Average 3 NI cases/month Morriston Average 2 NI cases/month Singleton 1 NI case/month NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <21 cases/month** **Minimum improvement goals:** HB average 6 NI cases/month; average 15 CAI cases/month Average 3 NI cases/month Morriston Average 2 NI cases/month Singleton 1 NI case/month NPTH 0 NI cases/month PCTG	**Annual percentage reduction to achieve adopted HB reduction goal - 15%**		dashboard.	development of digital solution and dashboard.	Average 23 cases/month ≡ Av. 8 HAI case/mth (**+2/mth**)↓; Av. 15 CAI/mth (**on-track**) **Morr** - 4/mth (**+1/mth**)↓; **Sing** - 3/mth (**+1/mth**) ≡; **NPTH +2 cases by Qtr 2**
		Klebsiella spp. bacteraemia **WG Improvement Goal: <6 cases/month (NI & CAI)** HB average 5 NI cases/month; 3 Community acquired (CAI)/month Average 3 NI cases/month Morriston Average 1 NI cases/month Singleton 2 NI cases in 11 months NPTH 0 NI cases/month PCCT	**WG Improvement Goal: <6 cases/month** **Minimum improvement goals:** HB average 3 NI cases/month; average 3 CAI cases/month Average 1 NI case/month Morriston Average 1 NI case/month Singleton Average 1 NI case/month NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <6 cases/month** **Minimum improvement goals:** HB average 3 NI cases/month; average 3 CAI cases/month Average 1 NI case/month Morriston Average 1 NI case/month Singleton Average 1 NI case/month NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <6 cases/month** **Minimum improvement goals:** HB average 3 NI cases/month; average 3 CAI cases/month Average 1 NI case/month Morriston Average 1 NI case/month Singleton Average 1 NI case/month NPTH 0 NI cases/month PCTG	**WG Improvement Goal: <6 cases/month** **Minimum improvement goals:** HB average 3 NI cases/month; average 3 CAI cases/month Average 1 NI case/month Morriston Average 1 NI case/month Singleton Average 1 NI case/month NPTH 0 NI cases/month PCTG	**Annual percentage reduction to achieve adopted HB reduction goal - 25%**				Average 9 cases/month ↑ Av. 4 HAI case/mth (**+1/mth**) ↓; Av. 4 CAI/mth (**+1/mth**)↑ **Morr** - 3/mth (**+2/mth**) ≡; **Sing** -2/mth (**+1/mth**) ≡; **NPTH** 1 case by Qtr 2 (on-track)
	Service Groups will ensure a process of **Multi-disciplinary team (MDT) rapid review of cases,** to ensure appropriate management, and identification of improvement actions.	The current process of Root Cause Analysis is protracted and not timely.	Service Group Medical and Nurse Directors will agree and establish a rapid review process to ensure that these clinical reviews are undertaken in a timely manner.	All inpatient cases will have rapid MDT review undertaken. Lessons identified will be shared and improvement actions implemented using Quality Improvement methodologies.	All inpatient cases will have rapid MDT review undertaken. Lessons identified will be shared and improvement actions implemented using Quality Improvement methodologies.	All inpatient cases will have rapid MDT review undertaken. Lessons identified will be shared and improvement actions implemented using Quality Improvement methodologies.	MDT Rapid Review process results in optimal treatment of cases and in quality improvement leading to the reductions identified above.	Service Group Nursing & Medical Directors		IP&C will participate in the MDT Rapid Review process.	Rapid review systems refreshed and commencing by end of Qtr 2. All Service Groups should achieve demonstrable achievement of goal during Qtr 3.
	Reduce **unnecessary use of peripheral vascular cannulae (PVC)**, and **urinary catheters**, utilising **STOP** protocol or from the point of assessment and admission	Currently incidence of use of PVC and urinary catheters unknown. Currently, scoping with Digital Intelligence feasibility of identifying incidence from existing DI systems (e.g. SIGNAL or WNCP).	Scoping completed, with proposals for methodology for obtaining baseline and agree how data will be presented. If a digital solution is not available, a manual point prevalence survey will need to be undertaken in Service Groups.	Data on incidence of presence of PVC and urinary catheters by ward, specialty and site available on Ward to Board dashboard. Utilise baseline data on PVC and urinary catheter incidence to agree improvement goal.	Incidence of PVC and urinary catheter use is routinely monitored and scrutinised at ward and divisional/specialty group. Service Group Infection Control Committees (ICC) to monitor progress against improvement goals.	Incidence of PVC use is routinely monitored and scrutinised at ward and divisional/specialty group. Service Group Infection Control Committees (ICC) to monitor progress against PVC incidence improvement goal.	Minimum 10% reduction in incidence of PVC and urinary catheters.	Service Group Nursing & Medical Directors	Band 6 WTE Digital Intelligence resource for dashboard.	IP&C Head of Nursing and IPC Quality Improvement Matron will develop methodology for reporting, using national processes where these exist.	Baseline Point Prevalence audit undertaken manually. Development of more refined Point Prevalence Tool to identify not the prevalence of invasive devices, but the prevalence of unnecessary devices to be able to set outcome measures.
	For every patient with a PVC or urinary catheter there will be a **completed insertion bundle** and **completed maintenance bundle** for every day that the device is in situ.	Recorded on Ward Metrics in January 2022: compliance with completion of PVC insertion bundle - 69%; compliance with completion of PVC maintenance bundle - 75%. compliance with completion of urinary catheter insertion bundle - 87%; compliance with completion of urinary catheter maintenance bundle - 87%. WNCR Quarter 3 planned development & implementation of PVC Care Bundles. Ward Manager / Matron to review and maintain	Service Groups provide assurance Compliance with all relevant bundles will be reported and monitored at Service Group ICC to ensure good compliance or any hot stop areas for improvement. Where appropriate, Service Groups will implement improvement strategies, with agreed step-improvements	Clear progress on Improved compliance reported quarterly with clear plan to deliver on 100% compliance. Service Group ICC to review progress against improvement goals.	Clear progress on Improved compliance reported quarterly with clear plan to deliver on 100% compliance. Service Group ICC to review progress against improvement goals.	Clear progress on Improved compliance reported quarterly with clear plan to deliver on 100% compliance. Service Group ICC to review progress against improvement goals.	Continuous improvement on compliance with PVC & urinary catheter insertion and maintenance bundles, with goal of 100% compliance.	Service Group Nursing & Medical Directors	Band 6 WTE Digital Intelligence resource for all service groups / IPC.	IPC Quality Improvement Matron continues to work with WNCR Project Leads to inform current and future developments which can provide digital solutions to surveillance and monitoring	Compliance recorded in Nursing Metrics dashboard,Sep-22: PVC insertion bundle - 82% ↑; PVC maintenance bundle - 84% ≡. Urinary catheter insertion bundle - 94%↑; Urinary catheter maintenance bundle - 97%↑.

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	Clinical staff will be **compliant with mandatory ANTT training** and will be **ANTT competence assessed** (3-yearly) (applicable for PVC and urinary catheters)	ANNT training compliance @ 31/01/22: Nursing Morriston Service Group: 23% NPTH & SH Service Group: 21% PCCT Service Group: 16% Medical & Dental: 3.37% Nursing & Midwifery Registered: 36.85%	Undertake and complete scoping by Service Groups to identify which clinical staff are required to comply with mandatory ANTT training and agree programme for improvement.	Clear progress on Improved compliance reported quarterly with clear plan to deliver on 100% compliance. Service Group ICC to review progress against improvement goals.	Clear progress on Improved compliance reported quarterly with clear plan to deliver on 100% compliance. Service Group ICC to review progress against improvement goals.	Clear progress on Improved compliance reported quarterly with clear plan to deliver on 100% compliance. Service Group ICC to review progress against improvement goals.	All Service Group staff who undertake aseptic procedures will be compliant with ANTT training (3-yearly) and will have been competence assessed in the 3-year period.	Service Group Nursing & Medical Directors	Obtained through ESR.	IPC Quality Improvement Matron on national working groups to promote better recording of compliance with ANTT training and competence. Support will be provided to Service Groups to develop internal processes for monitoring compliance. IPC team will provide support in delivering training as an adjunct to eLearning.	ANNT training compliance @ 12/10/22: Morriston Service Group: 23% = NPTH & SH Service Group: 22%↓ PCCT Service Group: 16% = Medical & Dental: 3.31%↑ Nursing & Midwifery Registered: 37%↓ ESR remains unreliable for accurate recording - requires ESR work on standardising position numbers
	Review the pathway and interactions to aid reduction of incidence of **catheter associated urinary tract infection (CAUTI)**.	Baseline data unreliable (total number of cases reported via DATIX since December 2019 = 6) Surveillance programme not available currently.	Scope with Digital Intelligence ability to identify CAUTI utilising existing DI systems, e.g. WNCR, HEPMA, or LIMS (using positive urine cultures from catheter samples of urine).	Scoping completed, with agreement on a way forward and methodology agreed.	Cases of CAUTI are reported on Ward to Board dashboard.	Cases of CAUTI are reported on Ward to Board dashboard.	20% reduction in CAUTI,	Service Group Nursing & Medical Directors	Band 6 WTE Digital Intelligence resource	IP&C Head of Nursing and IPC Quality Improvement Matron will support Service Groups in developing surveillance criteria and processes and work with Digital Intelligence on providing a digital solution to surveillance.	Off-track. Digital Intelligence Partner commenced post June 2022. CAUTI reported on Nursing Metrics: 12 cases recorded in Q1. 3 cases reported in Q2. Validity of data to be tested in Q3.
	Reduce **hepatobiliary-related E.coli and Klebsiella spp. bacteraemia ca**ses.	Hepatobiliary disease an associated underlying cause for 21% of E. coli bacteraemia and 20% Klebsiella spp. bacteraemia.	Undertake risk based review of patients awaiting surgery or procedures related to hepatobiliary disease. Service Groups to link review to IMTP and Surgical Services plans.	Monitored through IMTP process.	Monitored through IMTP process.	Monitored through IMTP process.	Reduction in waiting lists for hepatobiliary related surgery or interventions, and a reduction in associated E. coli and Klebsiella bacteraemia.	Service Group Directors		IPC will continue to undertake analysis of bacteraemia data and provide data on proportion of bacteraemia with hepatobiliary source.	Significant backlog of elective surgery following COVID pandemic and this impacts on those awaiting hepato-biliary surgery.
	Improve compliance with **'Start Smart Then Focus' (SSTF)** antimicrobial stewardship programme, with timely feedback of results to Service Groups	Quarterly audits undertaken by Pharmacy, with feedback to Service Groups and Infection Control Committee. Currently scoping with Digital Intelligence the development of a ward dashboard, utilising HEPMA as the source of data.	Continue with quarterly audits. Complete scoping and draft version of dashboard available.	Continue with quarterly audits. Testing and refinement of dashboard, with Go Live date agreed.	Data available via dashboard for Singleton and NPTH (currently using HEPMA). Continue with quarterly audits in Morriston until HEPMA roll-out completed.	Data available via dashboard for Singleton and NPTH (currently using HEPMA). Continue with quarterly audits in Morriston until HEPMA roll-out completed.	Continuous improvement in SSTF compliance. Improved antimicrobial stewardship	Service Group Medical Directors	Band 6 WTE Digital Intelligence resource	Lead for this is Consultant Antimicrobial Pharmacist.	Quarterly audit & feedback continues. Digital dashboard draft off-track. Digital Intelligence Partner commenced post June 2022.
	Reduce incidence **of hospital acquired pneumonia (HAP)**	Currently incidence of HAP unknown. Currently, scoping with Digital Intelligence feasibility of identifying baseline through Clinical Coding	Agree methodology for obtaining baseline, or for undertaking point prevalence survey to obtain baseline prevalence.	Validation of data and review of cases to identify contributory factors & causes. Agree quality improvement initiatives.	Implement agreed methodology. Service Groups monitor infection data, and review progress against improvement actions at Service Group Infection Control Committee.	Service Groups monitor infection data, and review progress against improvement actions at Service Group Infection Control Committee.	Reduction in cases of HAP.	Service Group Medical Directors	Band 6 WTE Digital Intelligence resource	IP&C Head of Nursing and IPC Quality Improvement Matron will support clinicians to develop surveillance criteria and processes and work with Digital Intelligence on provding a digital solution to surveillance.	Off-track due to resource limitations within IP&C team.
	Reduce the incidence of **surgical site infection (SSI).**	Currently incidence of SSI unknown. Currently, scoping with Digital Intelligence feasibility of identifying incidence from existing DI systems (e.g. TOMS and LIMS, & WNCP).	Develop a risk based approach process for surveillance of surgical site infection (SSI) - with a focus on high consequence SSI (those involving a readmission or a return to theatre as a consequence of infection). Agree methodology for obtaining baseline, or for undertaking point prevalence survey to obtain baseline prevalence.	Validation of data and review of cases to identify contributory factors & causes. Agree quality improvement initiatives and methodology. Initial cut of data to review and validate	Service Groups monitor infection data, and review progress against improvement actions at Service Group Infection Control Committee.	Service Groups continue to monitor infection data, and look for outcomes including reduce LOS and antibiotic use.	Reduction in cases of high consequence SSI. Reduction in investigation, treatment and theatre costs, and reduction in increased length of stay. Reduction in readmissions. Improved patient outcomes.	Service Group Medical Directors	Band 6 WTE Digital Intelligence resource	IP&C Head of Nursing and IPC Quality Improvement Matron will support Surgical Services to develop surveillance criteria and processes and work with Digital Intelligence on providing a digital solution to surveillance.	Cardiothoracic services piloting surveillance tool. Off-track. Service Groups will need to scope priorities and resources for SSI surveillance.

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	Prioritise in Capital Funding Programme **Decant Facilities** to allow for refurbishment, repair, improvements to compliance with required mechanical ventilation standards, increasing single room capacity, maintenance.	Currently, there are no dedicated decant facilities available on acute hospital sites. Singleton is currently using empty sections in wards to facilitate the decant of patients for cladding replacement work to take place.	If approval obtained to support a capital programme for provision of dedicated Ward decant facilities, initially at Morriston, commence to capital planning and costing stage.	If funding approved, work up capital development programme			Provision of dedicated decant facility at Morriston (long-term plan).	Assistant Director Capital Planning and Morriston Service Directors.	Capital funding requirements in long-term	IPC Team will be involved at planning and delivery stages to ensure specifications meet requirements of Infection Control in the Built Environment.	Capital Planning progressing option appraisal for decant solution. This will be a longer-term programme extending beyond April 2023
Improve safety of patient care environment	Robust programme of **Planned Preventive (PPM)** and monitoring to maintain the integrity and functioning of engineering aspects of infection prevention, e.g. water safety, mechanical ventilation, etc.	Funding challenges and limited access to clinical areas for PPM	Scoping of requirements across inpatient locations.	Service Groups build into operational plans access for PPM to be undertaken. Challenges to progress will be risk assessed and escalated.	Service Groups build into operational plans access for PPM to be undertaken. Challenges to progress will be risk assessed and escalated.	Service Groups build into operational plans access for PPM to be undertaken. Challenges to progress will be risk assessed and escalated.	Safe patient care environment	Assistant Director of Estates	Additional revenue funding requirement to be provided by Assistant Director of Estates	IPC Team support Water Safety, and Ventilation Safety Groups, and provide input to ensure IPC standards are met.	Limited capital funding received by Health Board for Estates across the Heath Board
	Improve quality of ventilation in existing inpatient areas.	Majority of inpatient bed areas have inadequate air supply to meet existing WHTM and WHO standards for mitigating against airborne infections.	Scoping of requirements across inpatient locations.	Business case development. If funding approved, procurement of short-term air purification systems until long-term mechanical ventilation solutions are possible.	Solutions are available in preparation for peak seasonal respiratory illnesses	Solutions are available in preparation for peak seasonal respiratory illnesses	Safe patient care environment	Assistant Director of Estates	Capital funding requirements in long-term and short-term (free-standing air purification equipment)	IPC Team support Ventilation Safety Groups, and provide input to ensure IPC standards are met.	Scoping assessment undertaken by Assistant Director of Estates and Head of Health & Safety. To achieve improved ventilation would require significant national investment to upgrade the NHS Wales estate. If funding were available across Wales to upgrade ventilation, this would necessitate closure of wards to enable the work to commence. This is not an option currently. The Health Board, in collaboration with Swansea university and commercial partnership, is participating in a trial of an air purification system on two wards in Morriston. The trial will commence in Quarter 3.
	Quarterly cleaning of ceiling-mounted ventilation grilles	Recommendation previously made and supported by Infection Control Committee but not progressed.	Develop a business case for provision of quarterly cleaning of ventilation grilles.	If approved, progress to implementation of quarterly programme.	Programme in place and progress reported to Service Group and Health Board Infection Control Committees	Programme in place and progress reported to Service Group and Health Board Infection Control Committees	Safe patient care environment	Assistant Director of Estates	Additional revenue funding requirement Assistant Director of Estates	IPC Team support Ventilation Safety Groups, and provide input to ensure IPC standards are met.	Paper prepared by Assistant Director of Estates
	Attain and sustain **minimum standards of cleanliness**	Cleaning monitoring audits are insufficient to provide assurance.	Support Services to ensure correct workforce requirements to undertake the appropriate numbers of audits.	Compliance with undertaking the correct number of audits of standards of cleanliness.	Compliance with undertaking the correct number of audits of standards of cleanliness.	Compliance with undertaking the correct number of audits of standards of cleanliness.	Safe patient care environment, and compliance with agreed standards.	Head of Support Services	No additional funding requirements	IPC support provided to Support Services to support risk assessments.	Resource in place.
	Establish funding a **Discharge/Transfer Response Team** in Morriston Hospital, to undertake all patient care equipment and environment cleaning & disinfection.	Currently, cleaning of patient beds, lockers, and all patient care equipment is undertaken by nursing staff prior to Domestic Services staff being able to undertake environmental cleaning. Particularly when there has been transfer or discharge of a patient with an infection, there can be a significant delay in the environmental cleaning process due to nursing staff correctly prioritising patient care activities. This can result in delays for available beds for emergency admissions.	Scoping to identify required resource. Second/recruit support service staff to response team.	Undertake training of identified staff on how to undertake effective cleaning of patient care equipment	Recruitment into posts.		Safe patient care environment and equipment, and compliance with agreed standards. Reduction in waiting times for beds.	Head of Support Services	Additional revenue funding requirement	IPC team will participate in training and monitoring service	Initial scoping undertaken. Wider resource paper developed and under consultation.
	Develop an **electronic system of requesting '4D' Cleaning**, with the ability to audit compliance with meeting recommended level of cleaning.	Currently, requesting '4D' Cleaning is a manual process. It is not possible to demonstrated whether the level of cleaning requested has been delivered.	Scoping with Digital Intelligence the development of an electronic requesting system and feasibility of utilising existing systems, such as SIGNAL.	Develop a proposal and business case for submission.	If business case supported, agree time-frames for development and implementation.	Digital solution live.	Improved compliance with undertaking the correct level of cleaning for the relevant infectious agent.	Head of Support Services.	Band 6 WTE Digital Intelligence resource	IPC Quality Improvement Matron will support Digital Intelligence and Support Services in developing specifications for digital solution	Off-track. Maintain current manual system. Hotel Service Project lead retired, but has since returned on a part-time basis and will pick this up during Q3.
	Patient equipment decontamination is undertaken in a **dedicated patient equipment decontamination unit.**	Currently, there are no dedicated decontamination facilities available on acute hospital sites for effective and efficient decontamination of patient care equipment and devices, e.g. bed frames, hoists, infusion & feeding pumps and drivers, etc. This is currently undertaken on the ward by nursing staff, with a variable standard of decontamination undertaken.	Concept approval.	If support of this unit is attained, develop a capital programme business case for consideration by the Health Board.	If business case supported, agree time-frames for development and implementation.	Progress to Capital Planning stage	Patient care equipment and devices will be effectively and efficiently cleaned, ensuring that these devices are not a vector of infection transmission.	Assistant Director Capital Planning and Service Directors.	Additional Capital funding requirement to be scoped and costed by Assistant Director Capital Planning and Service Directors.	IPC Operational Decontamination Lead will support at planning and development stages to ensure appropriate standards are included within plans.	Not agreed within capital programme.
	Each patient will have a single patient use patient medical devices, e.g. BP cuffs, oxygen saturation probes, glide sheets, hoist slings, cardiac monitoring leads , pressure bags, for the duration of the inpatient episode.	Shared patient equipment, such as BP cuffs, oxygen saturation probes, etc. are difficult to decontaminate effectively. Oxygen saturation probes have been identified as being contaminated with hGISA (highly resistant Staph. aureus) and with GRE in recent outbreaks of these infections.	Scoping of availability of disposable alternatives, which would be allocated to a patient for the duration of their inpatient episode. Estimation of numbers of items required and associated revenue costs. Review learning from previous outbreaks regarding disposable alternatives.	Develop a business case for funding for consideration by the Health Board. If business case supported, implementation of single patient use devices.			Patient observation equipment will not a potential source of infection transmission.	Procurement Head EBME Nominated Service Group Clinical Lead	Additional revenue funding requirement to be worked through by Procurement.	Support as required provided by IPC team.	Scoping underway by Service Groups. Suitable products for trial and compatibility with existing equipment.

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Review strategic and operational Corporate IP&C workforce, ensuring sustainability	Establish a Health Board role for a Medical **Director of Infection Control (DIPC)** with a background in microbiology/IPC to provide senior strategic and clinical leadership for IPC.	No position for DIPC currently.	Scope and submit business case for funding. If funding approved, commence recruitment process.	Appointment to DIPC post.			Provide senior clinical leadership , with clinical credibility, to drive through infection reduction strategies.	Executive Medical and Nursing Directors.	Additional revenue funding requirement	Support with development of business cases and Job Descriptions.	Post advertised but lack of suitable applicants. Further discussions held on next steps to progress.
	Establish a Health Board role for a **Consultant Practitioner in Infection Prevention** leading on the establishment of the Health Board as a centre for excellence and research in the field of IPC.	No position for Consultant Practitioner currently.	Scope and submit business case for funding. If funding approved, commence recruitment process.	IPC Service review to be undertaken			Lead on infection improvement and prevention research, and work collaboratively with partner universities and Public Health Wales Microbiology and Infectious Disease clinicians. Publication of research/study findings, sharing learning on the national and international stage, establishing the Health Board as a centre of excellence and a leader in the field of infection prevention.	Executive Director of Nursing, Assistant Director of Nursing (IPC lead), Head of Nursing IP&C.	Additional revenue funding requirement	Support with development of business cases and Job Descriptions.	Additional specific funding not approved in Management Board March 2022. IPC service review to be undertaken in Q2. No scope within current financial envelope to progress.
	Increase **IPC work-based training** and audit Healthcare Support staff to extend scope and frequency of this resource and to provide backfill and cross-cover.	The current 2.6 WTE Healthcare IPC Support staff provide service within the three acute sites. No available resource to provide cover for MH&LD or PCTG or to provide backfill or cross-cover. Currently, IPC Healthcare IPC Support deliver hand hygiene, PPE Donning & Doffing, and bed & commode decontamination training in workplace. Also undertake C. diff and IPC assurance checks, audit of clinical practice, with feedback of findings to departmental staff.	Develop and submit a business case to increase by 3.8 WTE the IPC Healthcare Support team to extend scope and frequency of activities of this resource. If funding approved, commence recruitment process.	Appointment of additional Healthcare workplace training and audit support staff. Development of an extended IPC work-based training , assurance and surveillance programme, with training and competence assessment of IPC Support staff. Commencement of extended programme once additional staff and training complete.	Delivery of extended programme within Service Groups	Delivery of extended programme within Service Groups	Extend activities undertaken by IPC Support staff to all Service Groups. Extended workplace training and audit programme to include: • Delivery of Standard Infection Prevention & Control, and ANTT training work-based training to support Service Groups in achieving improved compliance with mandatory training; • Delivery of work-based training to support Service Groups with HCAI Quality Priority focussed initiatives, e.g. training on correct microbiological sampling techniques to improve quality of sample and reliability of result, and avoid having to resample due to poor initial sample (getting it right first time). • Undertake point prevalence surveys of presence of invasive devices, and validation prevalence of key infections as quality assurance process of existing digital processes.	Executive Director of Nursing, Assistant Director of Nursing (IPC lead), Head of Nursing IP&C.	Funding for 3.8 WTE IPC Healthcare Support team.	Development and delivery of a work-based training programme to support Service Groups in delivery of improvement actions. Priority to be given to development and delivery of training programme for correct specimen taking and ANTT training and competence assessments.	Additional specific funding not approved in Management Board March 2022. IPC service review to be undertaken in Q2. No scope within current financial envelope to progress.

Goal	Method	Baseline position	3 month (Q1)	6 month (Q2)	9 month (Q3)	12 month (Q4)	Outcome	Responsibility	Digital & Finance Implications	IP&C Methodology Support Lead	Progress @ end Q2
	Review and strengthen **IP&C Business Hub** arrangements	Currently 0.79 WTE substantive Business/administration Manager for IPC: Duties include administering Health Board's Infection Control Committee, Decontamination Quality Priority Group, C. difficile Quality Priority Group, administers IPC team meetings, plans all IPC training sessions, undertakes preparatory work for initial drafts of HCAI update reports for Quality & Safety Committee, Quality & Safety Governance Group, and Infection Control Committee; development and administration of IP&C SharePoint; E-Roster administration; Trac administration and line management of current seconded admin support staff. Additionally, 1 WTE temporary contract Admin Support (until October 2022) for COVID surveillance and preparation of internal and WG reporting. Also, provides administrative support for the Health Board COVID Nosocomial Death & Harm Scrutiny Panel, updates C. difficile database with results of Whole Genome Sequencing; input onto Datix nosocomial C. difficile, Staph. aureus, E. coli, Klebsiella and Pseudomonas bacteraemia cases, and periods of increased incidents. Administers generic IPC training booking emails and books staff onto IPC delivered training. **Service risk when the funding for this post ceases.** Additional 1 WTE administration support staff on long-term deployment from the Director of Public Health's PHW team for the duration of the pandemic (until 31sst March 2022). Duties have included administrative support for the Health Board-based PHW Healthcare Epidemiologist with review of incidents and outbreaks; inputting training records for IPC training onto ESR for the whole Health Board. **Service risk when this resource is no longer delegated to support IPC business activities.**	Develop and submit business case for IPC Business Hub, to include 1.8 WTE Band 3 Administrative Support staff. If funding approved, commence recruitment process.	Appointment to posts			Sustainable IPC Business Hub, with ongoing service support as outlined in baseline. Maintain input of training records for Service Groups to demonstrate improved compliance with IPC-related training. Maintain input of nosocomial Tier 1 infections onto Datix to support Service Group assurance processes.	Executive Director of Nursing, Assistant Director of Nursing (IPC lead), Head of Nursing IP&C.	Funding for 1.8 WTE IPC Administration Support team.	Development of work plan, with emphasis on input of training data to support Service Groups in reporting training compliance.	Additional specific funding not approved in Management Board March 2022. IPC service review to be undertaken in Q2. One temporary administrative post has been extended to March 2023. Case being worked through for additional 1.0 WTE administrative support post.
Digital Intelligence resource to support the delivery of key improvement actions	Appointment of 1 WTE Band 6 Digital Intelligence officer to work on HCAI priorities.	Currently, support available but not dedicated to delivery of HCAI improvement goals.	If approved, Digital Intelligence will scope the work required to deliver on improvement plans.	Test iteration of a digital solution available	First iteration live and available for Service Groups demonstrating trends and compliance against agreed HB Targets. .	Development and delivery of second/third stage iterations.	Timely and reliable data available for surveillance, performance and improvement measures.	Head of Digital Intelligence	Funding for 1 WTE Band 6 Digital Intelligence officer.	IP&C Head of Nursing and IPC Quality Improvement Matron will working with Digital Intelligence to scope the projects, agree on criteria and the vision for the final products. Validation of data at each stage of development..	Digital Intelligence Partner for Corporate commenced post June 2022. Data validation work has been undertaken for a number of the Tier 1 infections. Test iteration for C. difficile available for testing during Q3 with a view to other infections being available for test version by end of Q3.
Strengthen IPC resources within Service Groups.	Review potential invest to save opportunity within Service Groups to support infection prevention resources and agree respective governance and management structures.	Service Groups currently do not have a dedicated infection prevention resource to drive infection reduction-related quality improvements.	Service Groups to undertake a scoping exercise to identify the resource required to lead on infection prevention and drive improvements.					Service Group Directors		Support as required provided by IPC team.	Morriston SG appointed Programme Lead but not in post by end of Q2. Funding unavailable for Care Home dedicated lead IP&C Team has reconfigured existing resource to provide improved WTE support for PCTG although this has meant a reduction in the resource available to secondary care.
		The central IP&C Service has identified IPC staff specific to each Service Group. Due to vacancies and maternity leave, there is cross-cover in place currently to ensure each Service Group has an identified IPC lead.	The central IP&C Service will re-circulate the current Service Group IP&C Support Structure to provide clarity in relation to named IPC Service Group leads.	The central IP&C Service will continue to provide support and expertise to all Service Groups	The central IP&C Service will continue to provide support and expertise to all Service Groups	The central IP&C Service will continue to provide support and expertise to all Service Groups	There will be clarity for Service Groups in relation to central IPC support, with named IPC Leads.	Service Group Directors		Head of Nursing IP&C to recirculate Service Group IP&C Support Structure.	See above. Redistribution of resource to provide improved support across primary care.
Effective communication strategy making IPC everyone's business	Multiple approaches including formal letters to senior leaders and clinicians, regular review at management board and key COMMS strategy to in reach all staff within the HB	No current COMMS strategy in place to support the HB IPC overarching IPC Plan	Outline strategy to facilitate go live in April 22 All key stakeholders including WG, CHC , Local Authorities to be advised	Review through Service Groups and up via new governance structures to Board. Revise plan if required and monitor success of comms strategy and engagement	Continue process to monitor and establish success and awards to maintain positive approach	Build in likely approach for 23-24	Informed and engaged staff of all disciplines and grades	Director of COMMS / DIPC		Support and provide information as required.	Leadership Touch Point IPC event on 28.06.22. IPC Improvement to be included within first HB Newspaper. Plan for regular updates via Newspaper and intranet.
	Key information on infection reduction performance will be published and available at the entrances to wards and units.	Currently, the publication of performance in relation to infection at ward entrances is variable.	Agreement on a standardised approach to publishing infection information at ward/unit entrances.	Infection performance, which is timely and current, is displayed at the entrances to wards & units. **Service Groups will establish a recognition programme to celebrate successes and will provide enhanced support to areas that require help to improve.**	Infection performance, which is timely and current, is displayed at the entrances to wards & units.	Infection performance, which is timely and current, is displayed at the entrances to wards & units.	Timely and reliable information on infection performance is available, ensuring confidence in the transparency of the Health Board and its commitment to quality improvement.	Service Group Directors/Director of COMMS/DIPC/Head of Digital Intelligence	Funding for 1 WTE Band 6 Digital Intelligence officer.	IP&C Head of Nursing and IPC Quality Improvement Matron will support Digital Intelligence in the provision of reliable and timely information on infections.	Off-track. Improved displays by wards of 'How we're doing' boards, although variation on how the information is displayed. Service Groups to consider standardisation.
	Excellence will be recognised within Service Groups and through executive team walkabouts. Support processes will be established to address areas of poor performance to provide support in the journey to excellence.	No current strategy for recognising excellence in relation to infections, nor a standardised process for supporting areas of poor performance on the journey to excellence.	Service Group Director and Executive Team Walkabouts established to recognise areas of excellence and poor performance.	Recognition of excellence and processes established to provide support in the quality improvement journey to excellence.	Recognition of excellence and processes established to provide support in the quality improvement journey to excellence.	Recognition of excellence and processes established to provide support in the quality improvement journey to excellence.	Provision of safe, quality care to our patients, with recognised reductions in infection.	Service Group Directors & Executive Nurse & Medical Director and DIPC		Central IP&C Service will support the processes for recognition and for quality improvements.	Service Groups to develop and agree a process for recognition of excellence.

Key:

Completed
Evidence of progress but not completed
Off-track