Infection Prevention & Control

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Limited Assurance

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Review Reference	HDU-2526-18
Fieldwork	December 2025 - February 2026
Executive Sign Off	2 June 2026
Audit Committee	23 June 2026
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Executive Summary

Purpose

To provide assurance over the controls in place for the management of key systems and risk areas in relation to Infection Prevention and Control (IPC).

Healthcare Associated Infections (HCAIs) are an important cause of avoidable morbidity and mortality and remain a key patient safety issue resulting in significant burden of disease and financial cost to the NHS in Wales.

NHS Wales is committed to zero tolerance of preventable Healthcare Associated Infections (HCAIs). WHC/2025/039 *Antimicrobial Resistance and HCAI Improvement Goals: 2025 to 2027* (published October 2025) reaffirms the improvement goals set out in WHC/2024/038 for Tier 1 HCAIs.

Consistent and effective governance and operational arrangements for IPC is fundamental in preventing HCAIs and ensuring the provision of a safe environment for staff and service users. The Health Board remains in Targeted Intervention (level 4) for infection control due to persistent challenges in managing HCAIs, and infection rates remaining above target.

HCAI	Improvement Goal (vs 2024 2025 counts)
C. diff	Reduction of at least 25%
E. coli	Reduction of at least 10%
Klebsiella	Reduction of at least 10%
Pseudomonas Aeruginosa	Reduction of at least 10%* ** 25% for HDUHB due to increases seen in 2024-25*
MSSA	Reduction of at least 20%
MRSA	Fewer cases in 2025-26

Overview

We have concluded **Limited** assurance on this area. The audit was undertaken during a period of transition, with revised operational governance arrangements implemented in April 2025 still embedding and work ongoing to address the new quality statement issued in February 2026. The overall assurance rating and issues identified need to be considered in that context. The matters requiring management attention include:

- Level 2 training compliance is below target, with particularly poor compliance within the Medical & Dental staff group.
- Lack of clarity regarding IPC audit arrangements, inconsistent completion of audits and limited evidence of follow up to confirm issues have been addressed.
- No IPC workplan or improvement programme in place – a responsibility of the IPSSG. An IP&C Assurance Framework is being developed involving a gap analysis against the Welsh Government Quality Statement and identification of actions required to achieve full compliance. The absence of a workplan or improvement programme for the period of review is reflected in the assurance rating for objective 3, although recognising the work now ongoing no further actions are raised.
- IPC governance arrangements require review and updating to clarify reporting arrangements and ensure that these are operating as intended. Attendance at the IPSSG is poor, and there is no evidence of reporting by subgroups.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	IPC policies and procedures are aligned with national standards and staff are appropriately trained to ensure compliance with the requirements	1	**Reasonable**
2	Mechanisms are in place to monitor compliance with IPC policies and procedures	2	**Limited**
3	A programme is in place to direct and deliver infection prevention and control improvements across the Health Board including at Clinical Care Group level	3	**Limited**
4	There is regular reporting of IPC performance with clear oversight arrangements to support escalation of risks and issues within the Clinical Care/Service Groups	4	**Limited**

Management Actions

2 High Priority

2 Medium Priority

Themes

Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: IPC policies and procedures are aligned with national standards and staff are appropriately trained to ensure compliance with the requirements — Reasonable

IPC Policies

IPC policies aligned with national standards are available to staff via the Health Board intranet; however, many date back to 2022, and several have had their review dates extended. There is an ongoing process to review and update these policies and a review of IPSSG meeting papers evidenced policy sign-offs. Policy review is recognised as a key priority within the IPC workplan, although at the time of audit fieldwork there was no schedule with deadlines, assigned leads, and approval routes. A policy review schedule has now been developed, consequently no findings are raised.

IPC Training

Training is accessed via the ESR learning platform (L2 training is in-person every 3 years) and compliance data is available to all teams through the Power BI dashboard. In-person training is facilitated by the IPC Team and attendance records are maintained, although line managers are responsible for ensuring compliance with training requirements. Compliance as of December 2025 is set out within table 1 below. Medical and dental staff group had the lowest compliance rate of all staff groups for both level 1 and 2 training. All other staff groups exceed 88% for level 1 and 71% for level 2. **[Finding 1]**

Training Level		Target	Compliance December 2025		
			Health Board Wide	Nursing & Midwifery Staff Group	Medical & Dental Staff Group
1	All Staff	85%	90.03%	93.60%	58.88%
2	Clinical Staff	85%	73.22%	76.93%	41.12%

Table 1

Mandatory training review is recognised as a key priority within the IPC workplan although it is not clear what this will entail. The IPC Workplan is covered in more detail under Objective 3. **[Finding 6]**

	Key Findings	Risk & Impact	Agreed Management Action
1	**IPC Training Compliance** IPC training compliance for Medical & Dental staff group is particularly low for both level 1 and 2 with 58.88% and 41.12% compliance respectively. All other staff groups exceed 88% and 71% respectively. Training compliance rates are included in the IPC reports to CCG Integrated Governance Group meetings, but this is high level and not sufficiently detailed to enable identification of areas and/or staff groups with poor compliance.	Non-compliance with IPC training increases the risk of HCAIs, potentially resulting in harm to staff and/or patients and increased service pressures.	**Agreed Action:** Escalation to the Chief Operating Officer to require that each CCG, through their IGG arrangements, when reviewing mandatory training compliance and specific topic related training compliance e.g. IPC, include more detailed breakdown of training compliance rates, sufficient to enable identification of areas and/or staff groups with poor compliance. Escalation to the Medical Director to ensure action is taken with clinical teams to reinforce the importance of compliance with IPC training requirements. **Expected Evidence of Implementation:** 1. Presentation of the Internal Audit report findings and actions to the IPSSG where a formal request will be made to each CCG. 2. Findings of this internal audit report to be shared with the Medical Director.

			3. Inclusion of additional IP&C related metrics on the Our Safety or Our Performance dashboard development log
		Medium Priority	**Officer:** Cathie Steele, Assistant Director of Nursing **Target Implementation Date:** Evidence 1 & 2 - 30 June 2026; Evidence 3 – 31 March 2027
	Theme: Training & Development	Control Design	

Objective 2: Mechanisms are in place to monitor compliance with IPC policies and procedures — Limited

According to the Health Board's *Standard Infection Prevention and Control Precautions (SICPS)* policy, the IPT is responsible for conducting regular compliance audits for feedback to wards, departments and Locality management teams. There is no plan or programme in place stipulating the audits/spot checks to be carried out, responsibilities and frequency of completion or monitoring and reporting arrangements. **[Finding 2]**

The Infection Prevention Team (IPT) Workplan 2025/26 identifies environmental audits as a key priority, and these recommenced (for the first time since COVID) during 2025 focusing on high-risk areas including oncology, maternity and emergency departments. Audits are multi-disciplinary involving the IPC team, Estates, Facilities and ward staff. However, there is no programme in place setting out the frequency and timing of audits and we found that audits are not being completed in all high-risk areas. We also identified delays in communicating audit results, instances where remedial action plans had not been completed, and instances where the records had not been updated to record completed audits. **[Finding 2]**

The IPT Workplan 2025/26 also references 'Start Smart Then Focus' (SSTF) audits, focusing on antimicrobial stewardship. Review of audit completion statistics up to November 2025 revealed variable engagement across sites - there has been some improvement at Bronglais following a revised approach with monthly antimicrobial pharmacist and middle grade doctor led spot checks, but persistently poor engagement at Glangwili and Prince Phillip. The IPAR presented to the November 2025 Board meeting highlighted that inconsistent completion of SSTF audits is a key challenge - this is reflected on the risk register and has been discussed at IPSSG. **[Finding 2]**

We were advised of monthly Senior Nurse & Midwifery Team (SNMT) led ward based spot checks Hand Hygiene, Bare Below the Elbow and Personal Protective Equipment audits based on all-Wales national tools. However, there is currently no oversight or assurance that these audits are being completed consistently across the Health Board and work is ongoing to establish which wards are required to undertake these audits and identify and target areas where they are not currently completed. **[Finding 2]**

We were also advised of Infection Prevention Indicator Audits which should be undertaken at inpatient wards twice yearly by the IPC nurse for each site. The audits cover compliance with isolation room, care bundle and water safety requirements. They are not reflected in the IPT Workplan, and audits are not routinely completed across all sites with gaps at Glangwili and Withybush and no audits undertaken at Bronglais or Prince Philip since March 2025. Where performance falls below 85% remedial action plans should be identified - sample testing identified that this is not consistently complied with. **[Finding 2]**

Cleanliness audits are undertaken by Facilities with results monitored via the Synbiotix dashboard at Operational Performance Delivery meetings. These audits have been subject to separate review as part of the 2024/25 Standards of Cleanliness audit (HDU-2425-11) with actions identified in relation to the frequency of audits and poor audit results.

Key Findings		Risk & Impact	Agreed Management Action
2	**IPC Audit Programme** Whilst a commitment to undertaking IPC related audits is reflected in the SICPS policy, there is no plan or programme in place stipulating what audits should be carried out. Responsibilities for completing audits, frequency of completion and monitoring and reporting arrangements also lack clarity. We observed examples of the different audits undertaken, although in all cases these are not consistently undertaken across all sites, and there was limited evidence of remedial actions to address issues identified.	Non-compliance with IPC policies and procedures is not identified and addressed, potentially increasing the risk of HCAIs, causing harm to staff and/or patients.	**Agreed Action:** IPC related compliance checks e.g. audits and spot checks will be made clear through appropriate workplans and will be confirmed in the reporting requirement detailed in the revised terms of reference for IPSSG. This will include clarifying what audits will be undertaken, responsibilities and frequency of completion, and monitoring and reporting arrangements. Audit conclusions and resulting remedial actions will be captured on AMAT to facilitate oversight of delivery of the compliance check programme and monitoring implementation of actions through the CCG governance arrangements and CCG reporting to IPSSG.
			Expected Evidence of Implementation: Reporting of audits including spot checks through CCG governance arrangements and upwards to IPSSG. Presentation of the Internal Audit report findings and actions to the IPSSG (where a formal request will be made to each CCG).
		High Priority	**Officer:** Rebecca Richards, Head of Infection Prevention (supported by the CCG Assistant Directors of Nursing - Patient Safety & Quality) **Target Implementation Date:** 30 June 2026
	Theme: Quality, Safety & Patient Experience	Control Operation	

Objective 3: A programme is in place to direct and deliver infection prevention and control improvements across the Health Board including at Clinical Care Group level	Limited

Terms of reference for the IPSSG identify the group as responsible for developing:

"..an annual Infection Prevention work plan, which ensures all relevant infection prevention standards for Health Services in Wales are achieved/being worked towards and which addresses operational priorities, consistent with the strategic direction of the organisation. This will be done in conjunction with the Clinical Care Groups who hold operational responsibility. The Group will monitor delivery of the organisational work plan and recommend to the clinical care groups mitigating actions where required."

There is no workplan or IPC improvement programme in place. Some improvement actions are identified within the Executive Improving Together session and Executive Recovery Meeting slide packs although these are not formally captured in an action plan with timescales and monitoring through to completion and assessment of impact. Internal escalation processes are currently under review following a separate internal audit review of this area. No further actions are raised within this report.

The Health Board is in the process of developing an IP&C Assurance Framework which will involve a gap analysis against the Quality Statement (published by Welsh Government in February 2026). The template for this has been developed and includes a requirement to identify the actions required to achieve full compliance. The absence of a workplan or improvement programme for the period of review is reflected in the assurance rating for this objective, although recognising the work now ongoing no further actions are raised.

The Infection Prevention Team Workplan 2025-26 is intended to provide direction for infection prevention activities across the Health Board. It outlines high level priorities and 'key phases' in relation to:

- Infection reduction expectation targets
- Environmental audit program
- Research and education/training
- Surveillance
- Antimicrobial resistance
- Reporting arrangements
- Policies

Actions are identified under each key phase but these lack detail and most are not SMART, some do not have responsible officers or target dates assigned, and in some cases the target dates are 2023. There is no evidence that the workplan has been approved by or is reported to/monitored by the IPSSG (or any other forum). **[Finding 3]**

A *Hospital Assurance Health Care Acquired Infection (HCAI) Scrutiny Group* has been established for each acute site to review HCAIs resulting in patient harm to identify to identify learning and drive improvement. See objective 4. **[Finding 4]**

Key Findings		Risk & Impact	Agreed Management Action
3	**IPT Workplan** Some actions within the IPT workplan are very high level, lack sufficient detail on deliverables and are not SMART. For example, "Mandatory IP&C Training". Some actions do not have responsible officers or target dates assigned, and some actions have target dates in 2023.	Failure to deliver IPC improvements, leading to high incidence of HCAI resulting in harm to patients and	**Agreed Action:** The IPT workplan has now been refreshed with all actions now allocated a responsible officer and completion dates updated where appropriate. Risks stated on the Workplan have been amended to reflect current risks. The 26/27 Workplan is currently being drafted.

		increased service pressure.	**Expected Evidence of Implementation:** Updated IPT Workplan
		Medium Priority	**Officer:** Rebecca Richards, Head of Infection Prevention **Target Implementation Date:** Completed April 2026
	Theme: Planning, Delivery & Deadline Management	Control Design	

Objective 4: There is regular reporting of IPC performance with clear oversight arrangements to support escalation of risks and issues within the Clinical Care/Service Groups	**Limited**

Clinical Care Group Integrated Governance Groups

IPC is a standing agenda item for the CCG IGG (Quality Health & Safety) meetings. Review of IGG meetings for Community & Integrated Medicine and Planned & Specialist Care CCGs confirmed that IPC update reports are regularly presented, and there was evidence of Clinical Service Groups also reporting up to CCGs on IPC matters. CCGs escalate to IQFPD via AAA reporting – this has been reviewed as part of the recent Operational Governance Arrangements audit.

Hospital Assurance HCAI Scrutiny Panel

The primary purpose of these hospital site panels is to provide independent scrutiny of healthcare-acquired infection investigations; however, several meetings across all sites have been stood down due to the unavailability of key staff, which can result in delays in case reviews. Terms of reference for the Scrutiny Panels incorrectly identify them as subgroups of the IPSSG. We did however identify reporting to the County IPGs. **[Finding 4]**

County Infection Prevention Group (IPG)

Terms of reference identify County IPGs as responsible for monitoring infection rates and reporting performance and improvement plans to the IPSSG. However, the IPGs report to CCGs and are not subgroups of the IPSSG. **[Finding 4]**

Infection Prevention Strategic Steering Group (IPSSG)

The IPSSG is a group of the Quality & Safety Intelligence Group responsible for providing advice and assurance on all matters relating to infection prevention, including setting the strategic direction, ensuring improvement and assurance arrangements are in place to promote best practice and drive improvement. Terms of reference identify three subgroups which should be reporting bi-monthly to the IPSSG, although there is limited evidence of reporting by these groups since June 2025. **[Finding 4]**

In line with the Group workplan Clinical Care Groups (CCGs) should be reporting bi-monthly on standards of environmental hygiene, learning from spot checks, hand hygiene, antimicrobial resistance, IPC risks and mandatory training compliance. However, only one CCG has reported in line with the work plan, and there was no evidence of reporting during the period reviewed (August – November 2025) from MH&LD, Allied Health Professions & Health Sciences, Primary Care or Public Health. Attendance by members identified in the terms of reference is also generally poor. **[Finding 4]**

IPSSG reports to the QSIG via the triple A exception reporting, with QSIG feeding into the Integrated Quality, Finance, Performance & Delivery (IQFPD) Group. QSIG reports to QSEC and IPC matters such as challenges in meeting targets for reducing hospital-onset infections are highlighted via the Targeted

intervention progress report. IPC matters including HCAI rates and training compliance are also reported twice yearly to QSEC via the Quality Assurance Report.

Key Findings		Risk & Impact	Agreed Management Action
4	**IPC Governance Arrangements** Terms of reference for the Hospital Assurance HCAI Scrutiny Panels and County IPGs show that they are groups of and report to IPSSG however this is incorrect – they report via CCGs. There is also poor attendance at Scrutiny Panel meetings with some meetings stood down. Terms of reference for the IPSSG identify three subgroups – the Decontamination Group; Antimicrobial Stewardship Group and C Difficile Improvement Group. However, there is limited evidence of reporting to IPSSG. The Decontamination Group and Antimicrobial Stewardship Group were due to report to the January 2026 IPSSG meeting but this was stood down. We were subsequently advised that the Decontamination Group reported to the March 2026 IPSSG (after conclusion of audit fieldwork). There was no evidence of reporting by the C.Difficile Improvement Group, although a general update on work in relation to C.Difficile was provided at the November 2025 meeting. The IPSSG work programme requires bi-monthly reporting from CCGs however only one CCG (Estates & Facilities) has reported in line with the work plan, there was evidence of reporting from CIM and Planned & Specialist Care (although not at the required frequency) and no evidence of reporting from MHLD, AHP&HS, Primary Care or Public Health. Attendance at IPSSG meetings is not in line with terms of reference, with poor representation from CCGs.	Inadequate oversight and assurance arrangements undermines delivery of IPC improvements, increasing HCAI risk and potential harm to patients, staff and service delivery.	**Agreed Action:** IPC governance and reporting arrangements will be reviewed and streamlined where appropriate. Terms of reference will be updated to reflect actual reporting arrangements. Membership of the IPSSG will be reviewed to ensure appropriateness. The IPSSG Chair will write to members to reinforce the importance of regular attendance and participation. **Expected Evidence of Implementation:** Revised terms of reference approved by QSIG Letter to all members reinforcing importance of regular attendance and participation.
		High Priority	**Officer:** Executive Director of Nursing, Quality and Patient Experience **Target Implementation Date:** 30 June 2026
	Theme: Governance	Control Design	

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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