Infection, Prevention and Control

Final Internal Audit Report

2026/27

Cardiff & Vale University Health Board



Reasonable Assurance

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Executive Summary

Purpose

Our audit review of Infection Prevention and Control was completed in line with the 2026/27 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board'). The purpose was to review the controls in place for the management of key systems and risk areas in relation to infection prevention and control.

Infection Prevention and Control (IPC) is fundamental in ensuring the provision of a safe environment for staff and service users.

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

The Health Board's central IPC Team provides advice and support to all Health Board services, particularly clinical and front facing staff. IPC is however the responsibility of all Health Board staff, with Clinical Boards responsible for ensuring effective IPC management within their operational services.

Infection Control is reported as part of the Integrated Performance Report detailing the number of infection control cases within the Health Board.[1]

A recent Independent Assessment of the Health Board highlighted that 'staff had been found to be poorly compliant with Infection Prevention and Control Standards.' However, the scope of our IPC audit was focussing on the governance and processes in place across the Health Board. The review did not include an assessment of IPC practices at ward level.

Overview

We have concluded **reasonable assurance** on this area. Whilst improvements are required to strengthen the IPC control framework, we recognise that governance structures, committee oversight and performance reporting are generally operating effectively.

The matters requiring management attention include:

- IPC policies and procedures were not consistently available, up to date, or approved.
- There was no approved annual IPC Programme to direct and monitor IPC activities.
- Gaps were identified in the timeliness, completion, and monitoring of infection control incident reporting and investigations.
- IPC Group Terms of Reference (ToR) were in draft form and did not fully reflect current governance arrangements and accountabilities.
- IPC Group attendance, quorum compliance, and action-tracking arrangements require strengthening to support effective oversight and accountability.

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

[1] RFA - CAV-FTS-61017 - Provision of Travel and Transport Bookings (1).xlsx page 182

Scope & Assurance Summary

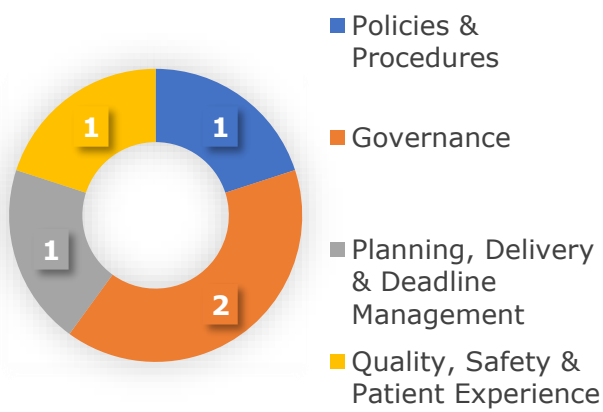
	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	The Health Board has appropriate, up to date infection prevention and control policies and procedures in place which provide clear direction and align with Welsh Government requirements and relevant legislation	1	**Reasonable**
2	An appropriate infection control framework and / or plan is produced and effectively communicated and implemented across the Health Board	2	**Limited**
3	Robust incident reporting and monitoring processes are in place across the Health Board to allow for accurate and timely identification and recording of all infection control related incidents to ensure appropriate actions are taken and lessons are learned	3	**Limited**
4	There is an Infection, Prevention and Control (IPC) group in place which is supported by a clearly defined and up to date Terms of Reference (ToR) which includes confirmation of appropriate and relevant membership	4	**Reasonable**
5	The IPC Group operates in accordance with its ToR, and members attend meetings regularly	5	**Reasonable**
6	There is regular reporting on IPC performance, and reports are submitted to appropriate management and Board level Groups for information and action		**Substantial**

Management Actions

2 High-Priority

3 Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: The Health Board has appropriate, up to date infection prevention and control policies and procedures in place which provide clear direction and align with Welsh Government requirements and relevant legislation	**Reasonable**

Overview / Summary of Observations

There are a range of IPC policies and procedures in place, and these are reviewed and updated by the IPC Group. The IPC policies and procedures were assessed for appropriate approval, version control, review dates, availability on SharePoint, and reference to relevant national guidance.

The review identified that most of the procedures were available on SharePoint, included version control information and, where documented, had been approved by the IPC Group.

Several documents had review dates that had expired, and some procedures contained inactive or broken links to national guidance. In addition, an outdated version of a procedure remained accessible on SharePoint alongside the current version, creating a risk of staff referring to superseded guidance. A small number of policies did not have a clear reference to the National Infection Prevention and Control Manual (NIPCM), however, they did make detailed reference to other national guidance relevant to the subject matter.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Review, update and accessibility of IP&C Policies** The Health Board has a range of IPC policies and procedures in place. However, the following issues were noted from review of all 12 IP&C procedures: • Two of the procedures were not observed. The viral gastroenteritis (Nora Virus) was not available on SharePoint. There was a link to the Ectoparasitic procedure on SharePoint, but the link was inactive. • The hand hygiene procedure did not detail the group that had approved it. • The needlestick injuries and sharps protocol was available on SharePoint; however, both the current version and an outdated version were accessible. • The hand hygiene procedure was approved at the March 2026 IPC meeting but was not provided and was not available on SharePoint. • An out-of-date version of Clostridium difficile is on SharePoint; however, it was ratified at the June 2026 IPC meeting. The	Outdated, incomplete, or inaccessible guidance. Non-compliance with Welsh Government requirements. Increased risk of infection control incidents across the Health Board.	**Agreed Action:** We will undertake a comprehensive review of IPC policies and procedures to ensure we: • Have appropriate documented approval by the relevant group. • Review and update within required timescales. • Upload all relevant IP&C procedures once reviewed and approved to SharePoint. • Remove or archive superseded versions from SharePoint. • Check that all contain working links to current national guidance and other references.

	approved version is yet to be uploaded on SharePoint, and the date of next review has not been entered within the procedure. • Five procedures were out of date including: ○ Varicella Zoster, MRSA, Blood-borne viruses, Infectious incidents and outbreaks and viral hepatitis. References to the national guidance were stated in the 10 procedures we viewed, however, there were a number of instances whereby the links within both the out of date and updated procedures were inactive.		**Expected Evidence of Implementation:** • All IP&C policies and procedures are up to date. • Copies of reviewed and approved procedures uploaded on SharePoint. • Outdated versions are removed from SharePoint. • Confirmation that procedures have active links within the documents. • Approval by the relevant governance group.
		Medium Priority	**Officer:** Natasha Goswell – Deputy Executive Nurse Director, Yvonne Hyde – Head of Nursing Infection Prevention & Control **Target Implementation Date:** March 2027
	Theme: Policies & Procedures	Control Design	

Objective 2: An appropriate infection control framework and / or plan is produced and effectively communicated and implemented across the Health Board	**Limited**

Overview / Summary of Observations

The Head of Nursing for IPC is required to prepare an annual IPC Programme. This sets out the IPC team's aims and objectives for the year and includes targets and also specifies a range of IPC audits to be carried out during the year. However, at the time of our audit there was no IPC programme available for 2026/27.

IPC audits continue to be undertaken including assessments of hand hygiene, ward environments, equipment and mattresses across wards at UHL and UHW; however, we were unable to confirm whether audits performed were aligned to a formally approved annual plan. Management acknowledged that there is currently no documented schedule of planned audits and no formal monitoring process to assess completion of expected audit activity. The Head of Nursing for IPC stated that staff shortages and competing clinical priorities have contributed to delays in developing and implementing the annual programme.

All IPC audits carried out are recorded on the Tendable system, and this enables reports to be prepared showing all IPC team audit activity, as well as the audits undertaken by wards / departments. The Tendable audit report is a standing agenda within the IPC Group meeting.

The annual IPC framework/ plan is expected to be communicated across the Health Board through the IP&C Group, where each Clinical Board Director of Nursing is represented and should have input into the plan. Information is then expected to be cascaded down through established governance routes.

There are draft MRSA and Clostridioides Difficile (C. diff) frameworks which have been developed but have not been finalised or approved by an appropriate governance group.

An IPC cell group was established in response to the covid-19 pandemic and has since evolved to consider a wider range of infection prevention and control matters, including ongoing incidents and outbreaks. The group meets weekly and is attended by the Digital communications representative who supports the disseminate of IPC related messages.

Key Findings		Risk & Impact	Agreed Management Action
2	**Absence of an Approved Annual IP& C** Our previous audit of IPC in 2023/24 identified that the IPC Annual Programme remained in draft form. The Health Board has not had a finalised annual programme in place during the intervening years and, at the time of this audit there was still no approved annual IPC strategy/programme in place for 2026/27. Consequently, there was no documented programme setting out clear objectives, responsibilities, planned audit activity, timescales or KPIs. Furthermore, the absence of an approved programme suggests that current Clinical Board input has not	IP&C activities are not formally planned, monitored or reported consistently. Reduced oversight of performance against objectives. Inability to demonstrate that key IP&C risks are	**Agreed Action:** We will develop, approve and implement an annual Infection Prevention and Control Programme that includes: • Clear objectives and priorities. • Defined responsibilities and ownership. • Specific MRSA and C. diff plans. • Planned proactive and reactive audit schedules. • KPIs and reporting arrangements. • Monitoring of planned versus completed audits.

	been incorporated into a plan, and the Clinical Boards have not developed their own IPC plans. While the types of pro-active audits to be undertaken were identified, no targets had been established for the number of audits of each type to be completed during the year. In addition, minutes of the IPC Group meetings held in September 2025, March 2026, and June 2026 evidenced that no Programme for 2026/2027 has been received or reviewed. In addition, draft MRSA and Clostridioides Difficile (C. diff) frameworks have been developed but have not been finalised or approved by an appropriate governance group.	being managed effectively.	The programme will be approved through the appropriate governance structure and monitored regularly throughout the year. **Expected Evidence of Implementation:** • Approved IPC Programme/Work Plan for 2026/27. • Staff awareness of plan/ framework. • Minutes of Infection Prevention and Control Group evidencing approval. • Documented audit schedule identifying planned audits. • Quarterly performance reports showing planned versus completed audits. • KPI monitoring reports presented to relevant governance groups.
		High Priority	**Officer:** Natasha Goswell – Deputy Executive Nurse Director, Yvonne Hyde – Head of Nursing Infection Prevention & Control
	Theme: Planning, Delivery & Deadline Management	Control Design	**Target Implementation Date:** Dec 2026

Objective 3: Robust incident reporting and monitoring processes are in place across the Health Board to allow for accurate and timely identification and recording of all infection control related incidents to ensure appropriate actions are taken and lessons are learned	**Limited**

Overview / Summary of Observations

The review of the Health Board's incident reporting arrangements identified that a documented Incident Reporting Policy is in place, which requires all incidents, hazards and near misses to be reported as soon as they are identified and investigated appropriately. The Head of Nursing for IPC confirmed that ward teams are expected to record infection-related incidents through Datix. In addition to Datix reporting, the IPC team operates a daily incident and outbreak monitoring process, with information circulated automatically to relevant stakeholders to support timely management of outbreaks and bed capacity issues.

A sample of five IPC incidents reported between January and June 2026 were reviewed to assess timeliness of reporting, completeness of records, investigation processes, lessons learnt and action tracking. All incidents evidenced immediate actions and management reviews undertaken using the Yorkshire Contributory Factors Framework (YCFF). The YCFF is a healthcare specific investigation framework used during management reviews to identify and categorise contributory factors to incidents. Completion of the YCFF section within the Datix review tab is a key requirement of the investigation process. Lessons learnt were documented in most cases where required.

Whilst incident reporting, investigation and governance arrangements are in place and supported by regular organisational monitoring of IPC trends through Quality Committee reporting (as noted under Objective 6 below), weaknesses were identified relating to timeliness of reporting and investigation, completion of records, evidence of action implementation and oversight processes.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Timeliness, Completion and Monitoring of IPC Incident Reporting** The Health Board has an established incident reporting process supported by the Incident Reporting Policy and Datix reporting system. Daily outbreak and incident monitoring arrangements are also in place, alongside regular reporting of IPC trends through governance committees. We selected five recorded incidents and identified several weaknesses in the operation of the process: • Two of the incidents were reported 13 and 55 days after the incident occurred. • The Management reviews for three incidents took 63, 178 and 412 days.	Delayed reporting and investigation of IPC incidents. Lessons learnt not being identified or acted upon promptly. Under-reporting and incomplete trend analysis.	**Agreed Action:** • We will reinforce IPC incident reporting requirements and timescales and monitor compliance with reporting and investigation deadlines. • We will strengthen oversight of Datix records to ensure incidents are fully completed and actions arising from investigations are tracked and evidenced. • We will introduce periodic assurance checks to confirm infection control incidents are recorded appropriately and managed in line with policy requirements. **Expected Evidence of Implementation:**

	• Two incidents had not been reviewed by the Corporate Patient Safety Team. • Three incidents did not evidence implementation of follow-up actions arising from lessons learnt, while one demonstrated only a partial implementation. • Four incidents had no progress notes completed. We were advised by the Head of Nursing for IPC that there is currently no robust process to confirm that infection control incidents identified locally are consistently recorded on Datix.		• Staff communications and compliance reports demonstrating adherence to incident reporting and investigation timescales. • Datix quality assurance reviews showing completion of required records, progress notes and action plans. • Assurance and action-tracking reports evidencing implementation of lessons learnt and reconciliation of identified IPC incidents against Datix records.
	Theme: Quality, Safety & Patient Experience	**High Priority** Control Operation	**Officer:** Natasha Goswell – Deputy Executive Nurse Director, Yvonne Hyde – Head of Nursing Infection Prevention & Control **Target Implementation Date:** March 2027

Objective 4: There is an Infection, Prevention and Control (IPC) group in place which is supported by a clearly defined and up to date Terms of Reference (ToR) which includes confirmation of appropriate and relevant membership	**Reasonable**

Overview / Summary of Observations

The Infection Prevention and Control Group (IPCG) has a Terms of Reference (ToR) which clearly sets out the Group's purpose, objectives and assurance role. It also explains how the IPCG supports the organisation by overseeing IPC arrangements and providing assurance through reporting to the Quality Committee and ultimately the Board.

The reporting and escalation arrangements are described, including the escalation of significant risks affecting patient care, service delivery or organisational reputation.

It was identified that the ToR should be reviewed on an annual basis, however, it remains in draft form and has not yet been formally approved. The document does not include an approval date, review date or version control information. We also identified several areas where the ToR does not fully reflect the current governance structure, including Committee naming, reporting arrangements, subgroup structures and links to Clinical Boards.

While an IPC governance framework is in place and the draft ToR provides a clear foundation for the Group's role and objectives, improvements are required to finalise, update and approve the ToR to ensure it accurately reflects current governance arrangements, membership and accountability requirements.

	Key Findings	Risk & Impact	Agreed Management Action
4	**IPC Group Draft ToR and Alignment to Current Governance Arrangements** We reviewed the IPC ToR and noted that it clearly defines the Group's purpose, objectives, reporting arrangements and quorum requirements, however, the following was identified: • The IPCG ToR remains in draft and has not been formally approved or subjected to annual review. • The document does not contain an approval date, review date or version number. • The ToR is not fully aligned with the current governance structure. Although a separate governance document outlines the current governance arrangements, including the Healthcare Environment Steering Group, this group is not reflected within the subgroup structure set out in the ToR.	Governance responsibilities, reporting arrangements and accountability for IPC activities are unclear. Ineffective oversight of IPC risks Inconsistent escalation of issues Limited assurance to the Quality Committee and Board.	**Agreed Action:** • We will review, update and formally approve the IPCG ToR to reflect the current governance structure, reporting arrangements and subgroup framework. • We will reiterate the importance of key subgroup leads providing periodic reports as stated in the ToR. • We will establish annual review arrangements, including version control, approval dates and review dates. **Expected Evidence of Implementation:** • Approved IPCG ToR with version control, approval date and review date.

	• Changes to Committee names and reporting arrangements are not reflected. • Clinical Board reporting links are not clearly defined. • Membership information within the ToR does not fully reflect current organisational roles or attendance arrangements. As part of the IPCG's responsibility, the ToR states that they should receive reports from the: ○ Decontamination Group. ○ Ventilation Group. ○ Antimicrobial Management Group. ○ Water Safety Group. ○ Capital, Estates and Facilities management. ○ Public Health. However, for the three meetings reviewed in September 2025, March 2026 and June 2026, we noted the following: • The subgroups provided their minutes of meeting and not reports. • The Ventilation Group did not provide any update in form of minutes or report.		• Updated membership list aligned to current organisational roles and governance structure. • Meeting records demonstrating compliance with attendance and quorum requirements. • Evidence of subcommittee and Clinical Board reporting, escalation routes and subgroup arrangements are reflected within the approved ToR.
	Theme: Governance	**Medium Priority** Control Operation	**Officer:** Natasha Goswell – Deputy Executive Nurse Director, Yvonne Hyde – Head of Nursing Infection Prevention & Control **Target Implementation Date:** Dec 2026

Objective 5: The IPC Group operates in accordance with its ToR, and members attend meetings regularly	**Reasonable**

Overview / Summary of Observations

The draft ToR requires a minimum of three meetings per year. Our review of the IPC Group meeting arrangements identified that meetings were held in September 2025, March 2026 and June 2026 and therefore were in line with the ToR.

The review of agendas and minutes confirmed that the group regularly considered a broad range of IPC matters, including healthcare-associated infections, outbreaks, surveillance data, audit results, antimicrobial stewardship, decontamination, estates risks and Clinical Board performance. There was also evidence of constructive challenge by members and follow-up discussions on key issues.

The IPCG is actively overseeing IPC matters and meetings are generally operating in line with the draft ToR. However, findings were identified in the attendance, quorum requirements (refer to objective 4), compliance and action tracking arrangements. In particular, action management was not consistently documented, making it a challenge sometimes to demonstrate that actions were appropriately monitored and completed.

Key Findings		Risk & Impact	Agreed Management Action
5	**Attendance, Quorum Compliance and Action Tracking** Our review of the IPCG meeting records confirmed that meetings are taking place and key infection prevention and control matters are routinely discussed. Agendas are standardised, minutes are maintained, and there is evidence of challenge and scrutiny by members. However, a number of observations were identified: • The September 2025 meeting was not quorate, as the quorate requirement was not met due to the absence of two key members. However, no decisions were made within this meeting. • Attendance by several key members was inconsistent, with six positions identified in the ToR not attending any of the three meetings reviewed. The March 2026 meeting recorded no apologies for absence, despite their being absence of some members. • Actions arising from meetings are not consistently recorded within a formal action log. Responsible officers and target completion dates for actions are not documented. • Action updates cannot always be traced between meetings, limiting the audit trail from action identification through to closure.	Reduction in the effectiveness of governance oversight and decision-making. Agreed improvements are not implemented where action notes are not tracked adequately. Ineffective monitoring, or escalation of risks	**Agreed Action:** • We will review IPCG membership and attendance arrangements to ensure appropriate representation from all key stakeholder groups. • We will strengthen compliance with quorum requirements and formally record attendance, absences and deputy representation. • We will introduce a standard action log with named owners, target dates and progress updates to monitor actions through to completion. • We will align meeting arrangements and frequency with the approved governance structure and updated ToR. • We will approve the IPC Education Plan. **Expected Evidence of Implementation:** • Updated IPCG membership list and attendance monitoring reports. • Meeting minutes demonstrating compliance with quorum requirements. • Standardised action log showing action owners, target dates and completion status.

	• The IPC Group ToR state that the Group is responsible for approving both the annual IPC Programme/Framework and the IPC Education Programme. Discussions with the Head of IPC confirmed that an IPC Education Programme is not currently in place, attributed to resource constraints within the team. However, evidence was available to demonstrate that a number of IPC education and training activities continue to be delivered.		• Approved ToR evidencing alignment with current governance requirements and meeting frequency. • Approved IPC Education Plan.
		Medium Priority	**Officer:** Natasha Goswell – Deputy Executive Nurse Director, Yvonne Hyde – Head of Nursing Infection Prevention & Control
	Theme: Governance	Control Operation	**Target Implementation Date:** Dec 2026

Objective 6: There is regular reporting on IPC performance, and reports are submitted to appropriate management and Board level Groups for information and action	**Substantial**

Overview / Summary of Observations

As part of the IPC group's reporting and assurance arrangement, the IPC Group ToR states:

'*The Group Chair shall report formally, regularly and on a timely basis to the Patient Safety and Quality Committee on the Group's activities. This includes verbal updates on activity, the submission of Group minutes and written reports throughout the year'.*

It was identified during our previous IPC audit that the IPC Group was not reporting to the Quality Committee as required. We reviewed the Quality Committee minutes covering the period from 20th January 2026 to 28th July 2026 and confirmed the minutes from the IPC Group meetings held in September 2025 and March 2026 were submitted to the Quality Committee.

In addition, we reviewed the Quality Committee minutes and supporting papers for the same period and noted that IPC information was included within the Quality Indicators Report. Furthermore, the Clinical Boards Quality, Safety and Patient Experience (QSPE) Groups report into the Quality Committee and provide updates on IPC matters.

IPC data including the cumulative position on infections was reported as part of the Integrated Performance Report which is submitted to the Board. The Integrated Performance Report has recently been revised and presented to the Board in July 2026. The report included IPC related information and highlighted several outbreaks during the past month involving C.diff, MRSA and Acinetobacter species.

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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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Cardiff and Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

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Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



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