	Objective	Action	Operational lead/involved individuals	Executive lead	Date of delivery/ review timescales	Risk	Measure of success	Progress and escalation	Feb 15	Mar 15	Apr 15	May 15	June 15	Q2
Criterion 1 – Systems														
1.1	IPC team have increased visibility on wards and clinical areas.	Initiate IPN daily diary recording to demonstrate clinical activity.	Matron IP	DIPC	Feb-15	Risk of increased patient harm due to HCAI if IP Team are not available for advice and support to staff.	IPNs completeing diary updatse and demonstrating >50% clinical based working.	Activity recorded and shows 25% average IPN clinical visits.						
		IPN electronic hand held device to access systems while out of office	Matron IP	DIPC	May-15	Risk of insufficient data available for IPNs to provide robust advice when working clinically.	Portble devices in use which allow access to all systems.	Devices ordered May 20th						
		Implement IPN 7 day working	Matron IP	DoN	Jun-15	Increased risk of staff failing to manage HCAI effectively at weekends and bank holidays.	IPNs working 7 days per week.							
	Visibility and strong role-modelling behaviour to ensure compliance with good IPC practice in clinical areas	Development programme for IP Team members which promotes team-working and which embeds changes in practice and approach to IP service delivery	GM/Matron IP/Head of Ed and Training	Dir HR	Jun-15	IPNs revert to traditional working practices	Confident and visible team of IPNs able to challenge practice. Team development startegy to be completed.	Leadership and development course identified for IP Matron. Team development programme to be agreed.						
	Improved compliance with IPC practice in clinical areas particular PPE	Undertaking of IPS Standard precautions audit when visiting clinical areas and targeted approach to education and training for PPE and any other concerns identified	IPNs/Matrons	DIPC	May-15	IPNs and ward managers revert to traditional working practices	Good compliance with few IPC issues identified	IPS audits completed (schedule of outstanding areas in place). PPE promotional package roll out May 18th						
	Improve compliance with Norovirus management	Training presentations to be provided to all staff on immediate "lessons learned" and required changes to practice	IPNs	DIPC	Feb-15	IPNs and ward managers revert to traditional working practices	Compliance with IPC issues identified	COMPLETE Onging monitoring via IPS audits and additions made to mandatory training for all staff.						
		Outbreak training day. Pre winter briefing and preparedness on use of orms and data collection.	DIPC/ IP Matron	DIPC	Sep-15									
	Embedded infection prevention as part of the ward accreditation framework	IPT to become part of ward accreditation rounds	Matron IP/Lead matrons	DoN	May-15	Ward staff revert to traditional working practices	IPT take part in ward accreditation rounds							
	Implement cleanliness assurance audits	Cleanliness audits to be undertaken by Trust-employed staff once recruited	PFI compliance manager	Dir Estates and Facilities	Apr-15	Lack of "Trust" owned data to challenge data provided by Interserve	Data to measure compliance versus agreed KPIs	COMPLETE						
	Improve cleaning provision in A&E due to exceptional turn over and throughput of patient activity	Cleaning of clinical equipment by "band 2" staff in A&E once recruited	A&E dept manager	CEO	Apr-15	Non-ownership of cleaning of individual; pieces of medical equipment	Staff in post and cleaning undertaken in line with requirements	COMPLETE X2 Band 2 generic workers employed in A&E						
	Reduce the risk Norovirus transmission using doors on open bays	Doors on ward bays to be piloted and introduced following approval of the business case by EMT	PFI compliance manager/GM HMC	Dir Estates and Facilities/DoF	Jun-15	No means of closing bays during outbreaks. Bays open on wards	Successful pilot and plans to widen the scope of the project	Funding agreed for pilot, lead staff identified but the pilot has not commenced						
	Improve executive ownership of infection prevention related issues.	Monthly executive walk-rounds of clinical areas with IPNs	Matron IP	CEO	Apr-15	Lack of awareness of IPC issues by exec/non-exec directors	Plan in place and walk-rounds commenced	COMPLETE & Schedule in place						
1.2	Reinvigorate the "board to ward" approach	A date for training to the Trust Board to be arranged. Short presentation to board.	Matron IP/DIPC	DIPC	May-15	Meaningful decisions cannot be reached without an understanding of the	Training session undertaken	Presentation provided to CPG but a more focussed session is required to the Board						
1.3	Ensure that medical devices are appropriately decontaminated	Develop mandatory training and evidence for medical device cleaning.	Senior IP Nurse/Ed and Training lead	Director of Estates and Facilities / DIPC	Apr-15	Ownership of decontamination falling between two departments. Protocols need to be made more robust.	Rolling programme of staff trained.	COMPLETE. Decontamination of equipment aded to IPC Mandatory training workbook						
		Opportunities for switch to single use items need to be identified, business and clinical cases to be built.	H&S Manager / OH / IPN	DIPC	Jul-15	Single use items as gold standard in decontamination practice	Minimising use of reusable devices							
1.4	Ensure that safety devices are used as standard.	Establishment of working group and evidence of progress reported at IPCC.	H&S Manager	Medical Director / DIPC	Jun-15	Potential harm to staff and patients if non safe devices used.	Establishment of group and report to IPCC	Group establised. Safety cannula in place. Other devices to be reviewed.						
1.5	Ensure that urinary catheters are changed safely.	Policies and procedures with associated training and audit programs need to be reviewed.	Urology Specialist Nurses / IPC Team / Surgery matron	Medical Director / DIPC	Jun-15	Avoidable urinary catheter related infections harming patients	Minimising catheter related UTI. Policies and procedures in place	Group has been established, but work stalled						
1.6	Antibiotic Stewardship	Antibiotic ward rounds on admission units (high risk patients)	Consultant Microbiologists	DIPC	May-15	Inappropriate antibiotics at the point of admission	daily antibiotic ward rounds in place	COMPLETE						
		System for Identification of patients prescribed restricted antibiotic agents	Lead Pharmacist	DIPC	Jun-15	Use of inappropriate antibiotics	robust system for flagging use of restricted antibiotics							
		Antibiotic review bundle to assist with antibiotic auditing	Lead Pharmacist	DIPC	Jul-15	Unable to comlpete all aspects of antibiotic auditing and no measure of compliance with prescribing	Antibiotic review bundle established & antibiotic audits completed monthly for all wards.	Antibiotic audits in place but not all wards audited each month. Pilot of review bundle commenced on Maple A.						
1.7	Effective IP Committee with attendance from BU medical leads and lead matrons	Identify a medical lead for each BU	DIPC	Med Director	Mar-15	IPC issues become a "nursing issue" with poor medical engagement	Named nursing and medical lead for each BU	Lead matrons atend and compile BU reports. Clinical Leads identified for wach BU.						
Criterion 2 – Environment														
		New Cleaning Strategy and Cleaning Plan to be developed and iplemented outlining KPIs, monitoring & escalation framework framework, aligned to the BSI standard PAS5748:2014	Estates & Facilities Manager VG/ PFI compliance manager/GM	Director of Estates and Facilities / DIPC	Jun-15	*Ad hoc* and inconsistent cleaning methodology will result in increased risk of infection transmission	Full delivery of cleaning standards across both hospital sites	VG developing cleaning strategy and cleaning plan intended for presenataion at IPCC June 2015						

2.1	Ensure that environmental risks from infection are minimised with effective robust cleaning standards in place	Assessment of capacity and capability of domestic team to be undertaken	GM Interserve/PFI compliance manager	Director of Facilities and Estates	Apr-15	Inconsistency of approach, best practice not followed	Consistent approach to a measurable standard	External review commissioned by GM HMC to review cleaning standards, report awaited. Additional cleaning "hours" approved with bank/agency staff on site for an additional 1099 hours during March. Substantive recruitment fro additional 15 staff underway.
		Linen and waste collection to be increased with call-off collections prioritised for high risk affected wards	GM Interserve/PFI compliance manager	Director of Facilities and Estates	Apr-15	Cluttered environment and inability to segregate waste effectively	All waste to be appropriately stored and segregated	Waste strategy to be defined and implemented
		Review of standards of reactive cleaning provided by Interserve				Poor standard of terminal and deep cleans will result in contaminated environment and transmission of microorganisms	Sign off sheets for all terminal cleans. Review of sign off sheets regularly to demonstrate standards being met.	Sign off sheets in place.
2.2	New cleaning audit to be launched.	Audit staff to be appointed and system rolled out.	Estates and Facilities Manager	Director of Facilities and Estates / DIPC	Apr-15	Scores currently produced but not reliable or used effectively	Regular audits and all staff aware of scores in their own areas, and can use them to challenge poor practice.	Staff appointed but audits not commenced yet.
2.3	Ensure that low cleaning scores, IPS audit non compliance and low spray and glowscores are noted and acted upon.	Records of action taken, part of BU reports and environment reports to IPCC.	Lead Matrons/E&FM Manager	Director of Facilities and Estates / DIPC	May-15	If not acted upon, clinical areas remain insufficiently cleaned	Low scores lead to immediate action.	IPS audit exceptions to be incorporated within business unit reports to IPCC.To be confirmed by May 15. Exception reports to IPCC
2.4	Standardise cleaning products and methods across the Trust, with particular reference to wipes and floor cleaning.	Review current practice and decide which products to standardise.	Matron IP/DIPC/ E&FM manager/ PFI Compliance Manager/HMC	Director of Facilities and Estates / DIPC	Apr-15	Inconsistency of approach, best practice not followed	Consistent approach across the Trust in line with best practice.	External review commissioned by GM HMC to review cleaning products, report awaited
2.5	Treatment rooms are fit for purpose	Undertake review and risk analysis on both hospital sites	Interserve FM Mnager/Estates and Fcailities Manager	Director of Facilities and Estates / DIPC	Jun-15	No current assurance that invasive procedures/treatments are performed wihtin suitably ventilated, fit for purpose rooms	Comprehensive report to demonstrate survy undertaken and risks mitigated.	WCH review complete. CIC to be completed next.
2.6	Improved storage in dirty utility rooms	Fit all dirty utility rooms with cupboards for exposed clean kit	HMC/Interserve FM/ E&FM Manager	Director of E&F	Sep-15	Exposed clean kit such as pulp is exposed when cleaning and waste disposal taks place. Risk of contamination.	All dirty Utility rooms fitted out and refurbished	Pilot commenced. Elm A and Willow C complete.
2.7	Waste segregation solutionsfor CIC required to improve build up of waste within dirty utility rooms	Waste options appriaseal and implementation preferred option	PFI compliance manager/GM Interserve	Director of Estates and Facilities	Q2 (July 15)	Non compliance with HTM regulations	Waste segregation at the earliest opportunity. No waste stored on dirty utility floors.	Waste options proposal drafted for IPCC May. For EMT May.
Criterion 3-Pateint Information								
3.1	Ensure that the Trust website is attractive and informative	Revise external website.	IPC Team / DIPC	DIPC	Feb-15	Missinformation of patients and relatives about the procedures in place	Website needs to be updated and made more accessible from an IPC perspective	Completed (regular updates must be maintained)
	Review ward and departmental data presentation format for patients and carers.	Alternative formats of data presentation for IPC issues to be explored.	IP Matron	DIPC	Jun-15	Misinformation of patients and relatives about the procedures in place	User friendly data available to external viewers	Data presented within Wadr Performance dashboard however needs agreement how best to display on wards.
3.2	Patient and carer information is suitable	Review patient information leaflets.	IPC Team	DIPC	Q2 (July 15)	Misinformation of patients and relatives about the procedures in place	Updated patient information available wherever needed.	Cannula leaflet approved and at printers. CVC leafit draft being developed.
	Encourage hand hygiene before meals and after toileting / commode use, providing wipes where appropriate	Encourage hand hygiene, including opening wipes for those who struggle due to poor dexterity or cognition.	Matron	DIPC / Lead Matrons	Apr-15	Risk of C difficile and other enteric infections	All patients should be enabled to decontaminate hands when needed. Monitored via IPS and ward accreditation	All matrons have provided assuranse that wards are offering hand wipes to all patients who cannot access HH independantly.
3.3	NICE compliance with patient information leaflets	Develop leaflets for cannula, CVC and urinary catheter	IPNs/ IP Matron	DIPC	May-15	Patients lack of understanding may lead to alck of confidence in organisation	Leaflets devised and issued.	Cannula leaflet produced. Oters outstanding.
Criterion 4-Staff information								
4.1	Ensure that the intranet site is informative	For revision and re-launch of IP pages of the intranet	IP Matron/IP Team /Informatics Support	DIPC	Feb-15	Staff cannot locate information readily	Staff can locate information more easily	Completed. Access direct from home page of intranet.
4.2	Review data presentation format for IPC issues	Provide wards with meaningful data	IP Matron / IP Team	DIPC	Jun-15	Information does not lead to positive action	Information made available which facilitates improvement in practice	Data presented within Ward Performance dashboard however needs agreement how best to display on wards.
4.3	Ensure that the IPCT continues to be easily accessible	Review working practices and increase ward based activity	GM CSCS/ Matron IP	DIPC	Apr-15	Staff experience a delay in gaining information	Immediate availability of information with telephone support where needed	Complete. Continual review by IP Matron.
Criterion 5- Surveillance								
5.1	IP Team have robust data which is available and useful (information for action)	Hand held devices provided for all IPNs	Matron IP	DIPC	Apr-15	Time to provide specialist support lost through inefficiency.	IPT have portable access to data;	Hand held devices for IPT ordered.
		Ward monitoring data collection during outbreaks are complated	Matrons	DIPC	Jun-15		ward ownership of IP data collection in relation to Norovirus;	Ward Monitoring forms for Norovirus established with further training planned on 25th June 2015.
5.2	Ensure that mandatory SSI surveillance is in place	SSI Group must report rates of SSI to IPCC via surgical BU report.	Lead Orthopaedic Surgeon/ Surveillance Lead Nurse	Medical Director / DIPC	Apr-15	Surveillance is not robust, inaccurate figures submitted to national system. Risk of missing important patterns of root causes.	Robust data reported to IPCC monthly / quarterly	Complete. First report received April 2015
5.3	Reduce harm from MRSA	Improve indwelling device management.	Matron IP / DIPC	DIPC	Jun-15	Poor device management will result in missed opportunities to reduce harm	0 MRSA Bacteraemia. Improved submission of cannula audits and urinary catheter audits.	May. Cannula audit submission improved from March to April. Urinary Catheter audits to be added to ward performance dash board. No MRSA bacteraemia
5.4	Continue zero tolerance to MRSA bacteraemia risks	Improve MRSA screening compliance	Matron IP / IP Team	DIPC	Jun-15	MRSA bacteraemia and consequent harm to patients	0 MRSA bacteraemia to date 2015/16. Audit of MRSA screening shows improvement required	Complete, ongoing review of screening by IPCT
5.5	Continue universal selective MSSA screening) and decolonisation	Maintain *status quo* , challenge any areas of poor performance	Surveillance Team/IPCT	DIPC	Apr-15	MRSA causing harm	Ongoing low MRSA colonisation levels, lack of cross infection	Complete, ongoing review
5.6	Reduce harm from CPE	Re-launch CPE policy.	Matron IP/IP Team	DIPC	May-15	CPE becomes endemic	Staff complate selective CPE screening by following local policy.	Policy will be launched in May 15

5.8	Reduce harm from Clostridium difficile	Develop *C difficile* 2015/16 plan	DIPC/IPCT	DIPC	Jun-15	Clostridium difficile cases increase causing avoidable harm to patients	CDI Plan produced. Reduced CDI cases and target met for 2015/16	Target of 2.08 cases per month met for April.
		Review RCA process to streamline and create meaningful action plans	Matron IP	DIPC	Feb-15	Current RCA is not effective and has lost impact	Rollout new RCA tool that has been developed regionally. Discuss attributable cases each month with CCG.	Complete.
Criterion 6-Staff engagement								
6.1	Optimise staff engagement by re-launching the link practitioner network	Dedicated timeout for link practitioner.	Lead Matrons	DIPC	Apr-15	Lack of policy knowledge at ward level.	Formalised structures including protected time to undertake the IPC-related tasks	Complete, meets quarterly
6.2	Dedicated pink scrubs for theatre staff	Roll out new scrubs along with dedicated coms and staff engangement	HON Surgery	DoN	May-15	Risk of transmission of micro organisms from outside the theatre environment	Pink Scrubs in place.	Coms to be promoted throughout April/May ahead of scrub issue to staff.
6.3	Noroviurs awareness for all staff	Norovirus updates to me mandatory	Matron IPC	DIPC	May-15	Staff not engaged with processes and avoidable Norovirus transmission occurs	All staff updated	Complete. Norovirus sessions delivered to all wards during Feb and March. Norovirus added to IP mandatory training.
6.4	One day Event	Hold one day event to train and update staff on current pertinant IP risks and issues	Matron /IPCT	CEO	Jun-15	Staff not engaged with processes or IP ownership and avoidable infection transmission occurs	Hold event and cascade learning	Date set for 25th June 2016 Speakers confirmed and promotion underway.
6.5	Ward Audits	Audits for implementation this year are New urinary catheter audit and IPS standard precautions audit.	Matron IP / IP Team	DIPC	Q2 (July 15)	Lack of data to support and inform changes in practise wher patient harm could be reduced	Robust meaningful audit data which staff can understand and act upon	Existing urinary catheter auditneeds updated. IPS standard precautions audits commenced by IPCT April 2015
Criterion 7-Isolation								
7.1	Provide information on isolation in relation to Cdif cases	Include isolation timing within all CDI case review	IPCT	DIPC	May-15	Patients not isolated appropriately will increase risk of spread to others	All cdif patients must be isolated at symptom onset	Isolation included in all PIR. Exceptions discussed weekly HCAI meeting
		Annual audit of isolation for CDI cases	IPCT	DIPC	Mar-16	GAPS in practise may be missed leading to potential increased risk of transmission	Audit completed and findingd=s acted upon.	
Criterion 8-Laboratory								
8.1	Maintain regular formal contact between microbiologists, the DIPC and the rest of the IPC team	Weekly team meetings and site based clincal meetings with IPNs and Microbiologist	Matron IP/DIPC/Microbiologists	DIPC	Feb-15	Poor communication and misunderstandings	Regular formalised contact to enable good communicatio, effective team working and effective patient assessments	Complete
8.2	Environmental testing no longer possible at NCUH lab	To do tesing elsewhere	DIPC				Environmental water testing completed at alternative accredited lab.	
8.3	Horizon scan for new technologies particularly rapid diagnostics which may improve IPC practice	Review the methodology for norovirus testing currently in use, identifying options for improving the turnaround time	Infection Science operational manager	DIPC	Jun-15	Slow and unresponsive turnaround times	Business case completion and evaluations commenced.	The business case is non-viable for the introduction of Cepheiid - need to identify other methodologies by June 15
Criterion 9-Policies								
9.1	Ensure that the IPC guidance and policy is up to date and available on the Intranet	Update documents in order of priority	DIPC / Matron IP	DIPC	Apr-15	Staff referring to outdated policies	Updated policy for staff to follow	Policy list issued and being worked towards
		Aseptic Policy	IP Matron /DIPC	DIPC	May-15	Staff referring to outdated policies	Policy approved and published	Policy for TPG May 2015
		TB Policy	IP Matron/DIPC	DIPC	May-15	Staff referring to outdated policies	Policy approved and published	Reuqest this policy to postpone review until Dec 2015 due to national guidanece due out in October
		Patient Transfer Policy	IP Matron /DIPC	DIPC	May-15	Staff referring to outdated policies	Policy approved and published	Policy updated and for IPCC & TPG May 2015
		Pertussis Policy	IP Matron/ DIPC	DIPC	Jun-15	Staff referring to outdated policies	Policy approved and published	Draft prioritised for IPCC June 2015
		Hand Hygiene Policy	IP Matron/DIPC	DIPC	Jun-15	Staff referring to outdated policies	Policy approved and published	Current version due to expire June 2015
		Group A Strep Policy	IP Matron/DIPC	DIPC	Jun-15	Staff referring to outdated policies	Policy approved and published	Draft prioritised for IPCC June 2015
		CJD Policy	Cons Microbiologist	DIPC	Jun-15	Staff referring to outdated policies	Policy approved and published	Draft prioritised for IPCC June 2015
		Outbreak Policy	DIPC	DIPC	May-15	Staff referring to outdated policies	Policy approved and published	Draft completed for IPCC May 2015
		Norovirus Policy	DIPC	DIPC	May-15	Staff referring to outdated policies	Policy approved and published	Draft completed for May IPCC
Criterion 10-Staff health and training								
10.1	Ensure that new staff are trained in IPC at induction	Review training program annually.	DIPC / Senior IPNs	DIPC / Director of Human Resources	ongoing	Poor attendance could result in non-compliance	100% of all new staff to attend.	COMPLETE
	Continue IPC mandatory training for all staff.	Review training program annually.	DIPC / Senior IPNs	DIPC / Director of Human Resources	ongoing	Poor attendance could result in non-compliance	95% staff trained.	COMPLETE
	Continue separate training for doctors in addition to mandatory workbook.	Review training program and target medical staff	DIPC / Senior Nurse IPNs	DIPC	ongoing	Poor attendance and engagement	100% attendance for doctors whose clinical commitments may restrict opportunities for attendance	Approach being agreed by May 15
	Continue monitoring attendance and completion of mandatory IP training	Training dept. to provide data and feed back to managers	Training Department	Director of Human Resources	ongoing	Undertrained workforce, risk of HCAI to patients	Improving attendance rates monitored by education and training department	COMPLETE
	Consider formal competency assessment in ANNT	Develop or adapt competency assessments, including junior doctors logbooks	Training Department	Medical Director / DIPC	Apr-15	Undertrained workforce, risk of HCAI to patients	Formal competency assessment prior to undertaking procedures for all clinical staff.	Need to contact training dept. and agree an approach
	Ensure that all staff have IPC training reviewed as part of appraisal	Ensure that IPC is built into all appraisal and job planning documentation	Human Resources Dept.	Medical Director / DIPC	ongoing	Undertrained workforce, risk of HCAI to patients	All staff competent to undertake tasks	Medical director to confirm position
10.2	Ensure that OH policies and procedures are up to date and in line with national guidelines	Publication of updated policies on intranet	Occupational Health Manager	Director of Human Resources	ongoing	Inaccessible information may lead to patient of staff harm	Policies published and in use	Completed
10.3	Ensure that staff are protected from healthcare associated infection	Identify areas of weakness during IPC audit, and challenge non-conformance	IPC Team / Matrons / Procurement	DIPC	ongoing	Staff poorly protected	PPE suitable and available and use by staff appropriately; staff immunisation strategy robust; safety with devices is assured;	PPE COMPLETE Staff Immunisation COMPLETE outstanding assurance required for safety devices.