Board to Ward

how to embed a culture of HCAI prevention in acute trusts

Department of Health

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Description	This is a guide to help trusts on a journey to reduce healthcare associated infection (HCAI) through creating and embedding a culture of improving patient safety and care throughout NHS acute trusts. In trusts that instill such a culture, infection prevention and control (IPC) an integral part of the everyday work of all trust staff, and individuals with the ability, motivation and tools they need to ensure that infections are avoided.
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Board to Ward

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Department of Health

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About board to ward and this guide

This is a guide to help trusts on their journey to reduce healthcare associated infections (HCAI) through creating and embedding a culture of improving patient safety and care throughout NHS acute trusts.

In trusts that instil such a culture, infection prevention and control (IPC) will be an integral part of the everyday work of all trust staff, and individuals will have the ability, motivation and tools they need to ensure that infections are avoided. Patients and visitors, too, will become part of this culture.

We, the healthcare community, should strive towards such a culture, as it is one of the building blocks to delivering clean and safe care. Reducing infections saves lives – it is a national priority and something on which the public will not accept anything less.

Although many trusts have made significant progress in reducing HCAI, sustaining this improvement over time is a challenge and requires a fundamental change in culture. This is a change beyond just implementing clinical procedures, cleaning routines, dress codes and hygiene policies as stand-alone actions. It is a change to a culture of a zero tolerance to HCAI throughout a trust to develop a resilient organisation – this is what we mean by a 'board to ward' culture.

This guide will help trusts understand the many aspects of a board to ward approach. It explains the steps that trusts can take to place infection prevention at the heart of their organisational culture – and the steps to take to sustain this. The case studies included in the guide, and other trust-based examples, show how some organisations have already succeeded in reducing HCAI through behavioural change and, more importantly, how they have embedded those changes within their culture.

Over the last few years, my team has worked with many trusts around the country. Drawing from these experiences, we have created a set of principles and developed tools and techniques that have a real impact in creating a culture to reduce HCAI and encourage improvement.

This guide distils and packages elements of the work that trusts are doing and forms the foundation for the development of a successful infection prevention and control strategy. Implementing all the components of good practice referred to in the guide will assist trusts not only in reaching a board to ward culture but also in becoming a resilient organisation.

Janice Stevens
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Department of Health

About the contributors

We assembled a team of expert contributors for this guide from among individuals working within and alongside the Department of Health's HCAI and cleanliness division's improvement team, including Michael Dickson (lead portfolio manager for the South), Mary Moore, Sharon Lamont and Pam Coen (portfolio managers).

We are also grateful to the following senior staff of trusts, with whom we have worked to help ensure that the information is relevant and useful.

Cheryl Etches is director of nursing and midwifery at Royal Wolverhampton Hospitals NHS Trust, which she joined in June 2005 after positions as deputy director of nursing and head of governance at the Heart of England Foundation Trust and Derby Hospitals NHS Foundation Trust. She took over the executive role for infection prevention in September 2005. Within 18 months, the trust had won four national and international awards for its achievements.

Erika Grobler has over 20 years' healthcare experience, having originally trained as a nurse in South Africa. She has worked in a variety of disciplines including intensive care, cardiac, liver and neurosciences in the UK and abroad. In 2003 she became matron for the liver unit at King's College Hospital, where she further developed her frontline experience of infection control. Since 2005, she has been clinical risk and governance co-ordinator for critical care and surgery services at King's, and in April 2007 she became the trust's implementation lead for the Department of Health's improvement team programme, with responsibility for governance issues.

Gill Heaton is the chief nurse and deputy chief executive at Central Manchester and Manchester Children's University Hospitals NHS Trust. She has the role of director of infection prevention and control in the organisation and has led the development and implementation of infection control procedures and practice across the trust.

Dr Alison Holmes is director of infection prevention and control and consultant in infectious diseases and reader in hospital epidemiology and infection control at Imperial College Healthcare NHS Trust. She holds specialist registration in infectious diseases and general internal medicine. She also completed an infectious diseases fellowship in Boston, Massachusetts, and a master's degree in public health at Harvard University.

Eileen Sills CBE is chief nurse and chief operating officer at Guy's and St Thomas' NHS Foundation Trust and a visiting professor at London South Bank University and King's College London. She was previously director of nursing, then acting chief executive at Whipps Cross University Hospital NHS Trust. She has a master's degree in health service management from the London School of Hygiene and Tropical Medicine.

Understanding the board to ward idea

Reducing healthcare associated infections (HCAI) remains a top priority for the NHS. Over the last few years the Department of Health has developed guidance and a range of tools to help trusts drive down infections across a variety of settings. Many trusts have shown performance improvement through the steps they have taken to reduce the incidence of meticillin-resistant *Staphylococcus aureus* (MRSA) and other infections.

Maintaining improvement in infection rates is a challenge, even when recommended procedures have been introduced. It has become clear that embedding tools and ensuring that the latest guidance is followed consistently means instilling an appropriate culture at all levels of NHS organisations.

This guide uses the metaphor of a journey to describe the cultural shift that is needed in a trust, from board level to ward. A journey is an apt metaphor, because it will take time and effort for any trust to get to the desired state described within this publication. There may be several starting points, and there will certainly be different routes that trusts can take. But to encourage this change all staff will have to change their mindset along the way.

Board to ward trusts place HCAI reduction at the heart of their activities. Trusts can reduce HCAI – and sustain this reduction – by seeing infection prevention and control (IPC) as integral to providing high levels of patient care and safety.

Trusts can drive such a change in mindset by taking action in six key areas. Trusts wanting to create and embed a board to ward culture will need to:

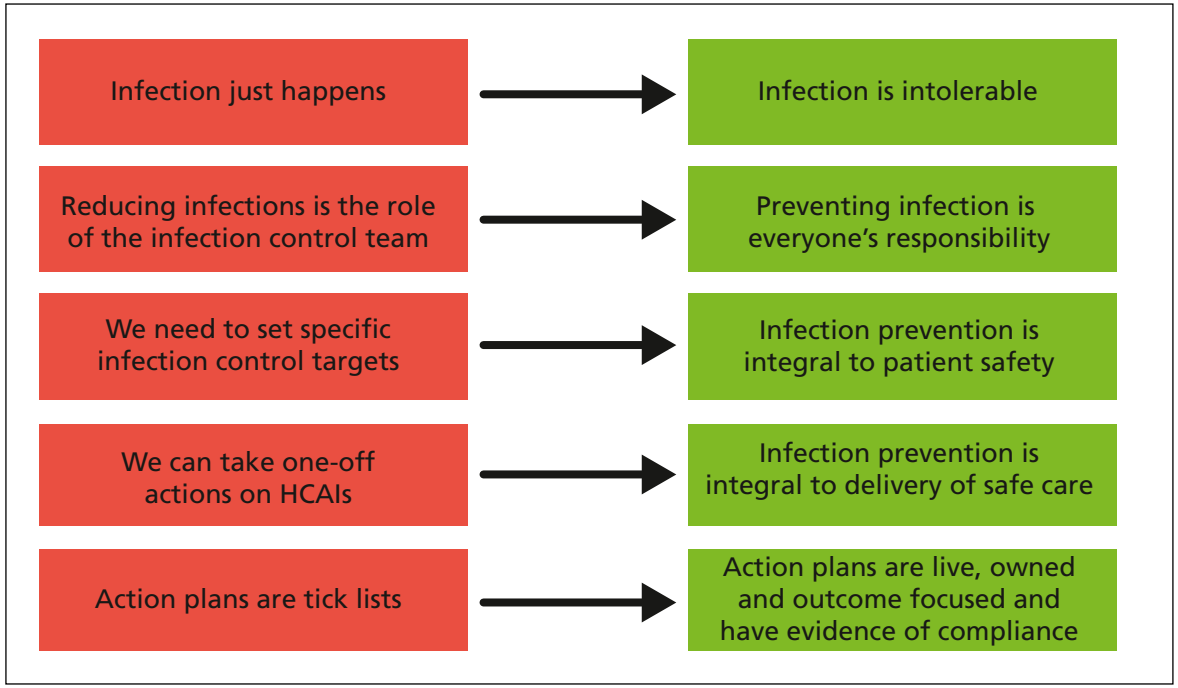
- establish a clear vision;
- provide effective leadership;
- ensure competence and measure compliance;
- communicate clear accountability (and escalation policies);
- put in place an assurance framework; and
- learn from others, both inside the organisation as well as outside it.

A clear vision

Creating a board to ward culture requires focus and attention. A trust on such a journey will be determined to achieve a culture of 'zero tolerance' to infection and will make realising this goal a priority. Improving quality and safety by embedding HCAI prevention policies will become part of the trust's strategy.

Effective leadership

Achieving behaviour change requires consistent leadership at every level of an organisation. Board members act as role models for the rest of the staff. Directors of infection prevention and control (DIPCs) have a critical role to play in supporting other leaders within a trust and in driving forward actions for improvement.



Sustainable change in the culture of a trust will occur only if its staff change their mindset

Competence

Training is the start of the journey, but organisations need to be sure not only that their staff understand what they need to do, but that this is translated into delivery of highly reliable clinical practice.

Accountability

Staff need to understand what is expected of them as individuals and for what they will be held to account. They will also need responsibility and authority to do what is being demanded of them, and understand that there is a clear escalation channel (and potentially that there are consequences) for non-delivery.

Assurance framework

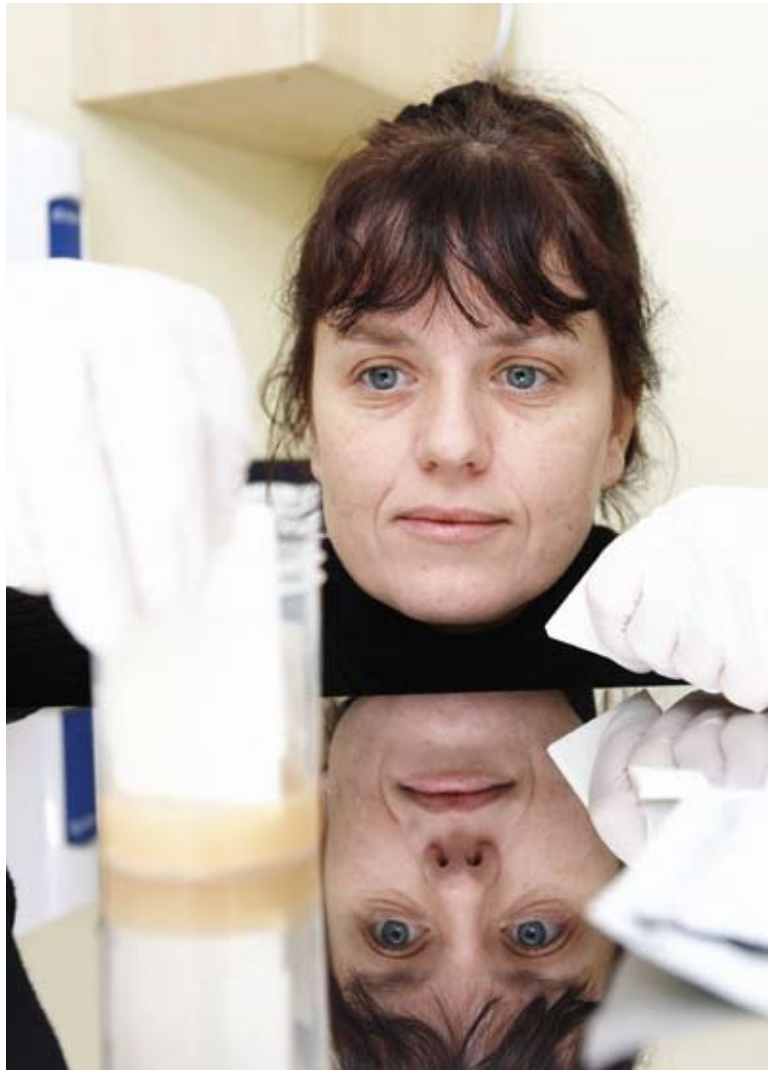
Trust boards need to be confident that the policies, systems and processes needed to prevent HCAI are implemented within the organisation and they have methods and measures to assure compliance. They need to be assured that they have clarified their HCAI goals, identified the key risks, and have taken actions to mitigate these.

Learning from others

Even with these first five steps taken, a board to ward trust will face challenges. Experience clearly shows that achieving a board to ward culture requires persistence and resilience. A trust will need to appeal to employees' professionalism and common sense, and be proactive in sharing good practice to overcome any inertia or potential resistance to change.

Each section of this guide is described in more detail. The case studies throughout this document offer practical examples of what trusts have already done, and further examples are located at **www.safe-clean-care.nhs.uk**

A clear vision



The start of the journey to embedding a culture of HCAI prevention involves establishing a clear vision and a desire to deliver clean, safe, high-quality care, thus encouraging the cultural shift to 'zero tolerance' towards infection. For such a shift to occur, HCAI prevention needs to be prioritised and integrated within the trust's overall strategy and objectives.

Fostering a culture of HCAI prevention will mean that staff are bound together by a common sense of purpose – with everyone wanting the best outcome for patients and recognising that prevention and control of HCAI is essential to achieving this fundamental goal. Staff will recognise that infection causes needless anxiety, pain and sometimes even death. Furthermore, beyond the obvious effects on patients, infections affect a trust's resources, through costs and length of stay, reputation and overall efficiency of the organisation.

Accountability, responsibility and authority for preventing and reducing HCAI should be clear at every level of the organisation from board to ward. Every staff member takes responsibility for the prevention of harm caused by infection. Prevention of infection is an integral part of the trust's wider strategy to improve the quality of its services and the safety of the people in its care. It also means that prevention of HCAI is clearly prioritised. This is what is meant by a 'deeply embedded culture'.

Even after it is established that the idea of HCAI is intolerable, there may still be 'spikes' in infection rates, and compliance with policies may weaken, but a clear focus on the organisation's vision, and setting and monitoring goals can help maintain the momentum.

The trust board and senior management play a major role in creating the vision and consequently the conditions in which a resilient organisational culture can thrive. In such a culture of 'zero tolerance towards infection', the trust board has IPC as a standing item on the agenda, and ensures that all the key staff and support structures are in place to enable the appropriate attitude to HCAI to be nurtured and instilled. The board and senior management also ensure that the vision is communicated to staff and that staff understand and adopt it in everyday practice.

Organisational change at Imperial College Healthcare NHS Trust

Spreading a culture of patient safety in which infection control is embedded requires a sea change in organisation, according to Alison Holmes, DIPC and consultant in infectious diseases at Imperial College Healthcare NHS Trust. She believes that the old model of small IPC teams is not effective in addressing the complex causes of HCAI, which extend beyond clinical, procedural and cleanliness issues.

The trust is made up of the former Hammersmith Hospitals and St Mary's NHS Trusts. Prior to the creation of the new trust, Alison implemented a widely publicised change to some of the structures of the former Hammersmith Hospitals NHS Trust that had a profound impact on the way that infection control was viewed and managed. The Hammersmith Organisational Model for Infection Prevention (HOMIP) model distributes IPC throughout the organisation as an intrinsic part of patient safety and quality of care that is relevant to clinical teams, directors and the trust board – all staff, in fact, from board to ward. Alison says:

'A few key conditions are required for successful organisational change. One that is particularly interesting in teaching hospitals is the requirement for credible role models. DIPCs need the respect of clinical leaders and managers – and they also need to identify from within those groups those that will take IPC leadership and responsibility in their own directorates and departments.'

Three key elements of the HOMIP approach are:

- directorate accountability;
- performance management;
- clinical incident reporting.

Establishing directorate accountability and clinical incident reporting takes considerable effort to get right. For instance, governance structures and reporting processes have to be set up in ways that do not result in a blame culture but instead support investigation, learning and action.

Providing effective leadership

Research into what features make organisational change happen has emphasised the importance of the involvement and active support of senior leaders. Leadership also features strongly in an organisation's ability to sustain improvement. All members of trust boards have a role to play in challenging risks to patient safety, including the trust's HCAI agenda.

Leadership, however, is not confined to the board. It is also required at every level within the organisation, as the significant change required cannot be led by a small number of people. In a board to ward trust, leadership is found at all levels of the organisation. For instance, at Guy's and St Thomas' NHS Foundation Trust all senior nurses regularly undertake formal walkabouts, observing and reinforcing good practice.

Board chairs and non-executive directors

The board chair and non-executive directors are accountable for the performance of the trust, and for assuring quality for the safety of their patients. Putting safety and IPC at the top of the trust's agenda – and inviting the public or press to attend relevant trust meetings – helps this. It is good practice for executive and non-executive staff to visit wards, to challenge directorate heads about infection rates and compliance with policy, and observe and monitor environmental risks and behavioural challenges, which can drive the vision of a board to ward trust.

Chief executives

Chief executives who lead 'from the front' with the goal of reducing HCAI send a powerful message through the organisation that HCAI is a priority. Chief executives can communicate this goal internally through the organisation and externally through communicating with patients, the public and other stakeholders. A trust's chief executive should work closely with the DIPC to achieve these goals.

The Royal Wolverhampton Hospitals NHS Trust replaced its infection control executive committee with an infection prevention board, chaired by the chief executive. The trust's director of nursing and midwifery, Cheryl Etches, says:

'I asked the chief executive that the trust board treat infection prevention in the same way as we treat the trust's finances and activity. He has done this, and his personal commitment at leading from the front has made a significant contribution to our success.'

Directors of infection prevention and control

The DIPC plays a crucial role in HCAI reduction. Effective leaders who are respected by peers and are highly visible, DIPCs are key leaders in enabling improvement. They provide assurance to the board that the trust complies with legislation and that the HCAI agenda is being enacted through the organisition.

The infection prevention team

All members of the infection prevention team individually and collectively provide leadership and specialist expertise in their organisation. A board to ward trust's infection prevention team is visible, respected and dynamic. Its members have technical expertise and are key enablers and drivers of HCAI prevention. They recognise that their own contribution is invaluable but that an important element of their role is to promote responsibility and action among other staff.

Directors of nursing and medical directors

Senior medical and nursing leadership is essential to achieving sustainable improvement in IPC. Credible, respected and influential medical and nursing directors who take personal responsibility and devote time to efforts to reduce infections are crucial. Respected by their peers, they influence others, consistently reinforce expectations, outline the actions required and evaluate progress made.

Finance directors

Finance directors can evaluate both the financial impact of infections in their organisation and their impact on overall productivity. They can track this information over time and can use the results to inform decisions to invest in initiatives to further prevent and reduce infections. HCAI results in significant financial costs for an organisation and has an impact on activity and capacity. 'Invest to save' strategies can be resource positive for trusts and focus on reducing HCAI.

Human resource directors

Human resource (HR) directors can ensure that their trust's HR processes support the strategic move to a 'zero tolerance towards infection'. This includes ensuring that responsibility for infection prevention features in all job descriptions, objectives and appraisals. HR systems should ensure that training programmes for all staff and contractors are in place and are undertaken, and should support efforts to maximise compliance with policies on such matters as hygiene, cleaning and dress codes.

Clinical directors

The journey towards a board to ward culture may require clinicians to change or adapt the way they work, as individuals or as teams. Medical leaders are important in gaining the support of their colleagues and championing the changes required. This role can include explaining the benefits of IPC to colleagues and describing the impact infection has on their clinical priorities, delivering good clinical outcomes, low mortality and morbidity rates, and shorter hospital stays.

Matrons

Matrons are responsible for the quality of care delivered in their area and have a specific responsibility to improve cleanliness and reduce infection. They lead by example, provide advice and ensure that guidance on reducing HCAI is implemented. They do this on a day-to-day basis by regularly being present in clinical areas and observing practice. They act on the findings of their observations with high-impact interventions, audit of policies and practice, or benchmarking with peers.

Domestic and facilities staff

Domestic and facilities staff are an important part of the infection prevention infrastructure. The Government's recent deep-clean programme in hospitals has reinforced the importance of cleanliness in restoring public confidence in the NHS. Domestic and facilities staff play a vital role in providing a clean hospital environment every day, especially in areas where HCAI can be a problem. They are integral to increasing patients' confidence in their local hospital.

Staff competence – critical to sustained improvement

All staff must have the appropriate knowledge and skills if they are to help a trust achieve and sustain reductions in HCAI and embed a culture of prevention. They need formal training and development opportunities, and their competence needs to be assured.

In a board to ward trust all staff are clear about which aspects of their clinical practice can influence progress on infection and consequently what knowledge and skills they need to provide clean, safe care. Clinical staff require the necessary training in IPC, both theoretical and practical. Trusts can also encourage a culture of self-reflection and audit, which should be underpinned by opportunities to seek further training and support if required. To enable this to happen, a board to ward trust will put in place supporting systems and structures, and should have processes to assure itself that training is being translated into consistent and effective clinical practice.

Training starts on day one

Board to ward trusts include training on IPC in all staff members' induction. This training is then reinforced through a programme of mandatory updates. Training is delivered in a variety of ways (for instance, e-learning) to suit people's learning styles.

Development opportunities can be created

Opportunities for in-house development takes two forms. First, members of the team will be given the support and development opportunities they need to enable them to maximise their impact in the trust (both as individuals and as a team). Second, staff will be given time and support to implement improvement activities in their own work areas.

A process of observation and reinforcement is important. The board to ward idea also values proven competence and practice. Eileen Sills at Guy's and St Thomas' NHS Foundation Trust says:

'We have trained the majority of our staff – to date, 8,200 over a seven-month period. This training focuses on general issues around infection control and the part they need to play. All staff on induction are trained, and from this year, all staff will receive six-monthly written updates. All our departments audit hand hygiene monthly and some more often, including daily if they are concerned about performance.'

CASE STUDY

Putting information to better use in Manchester

Information plays an important role in reducing HCAI, but it is often a challenge to ensure that the correct information is available in a timely fashion for it to be used effectively. Gill Heaton, DIPC and chief nurse at Central Manchester and Manchester Children's University Hospitals NHS Trust (CMMC), explains how her trust needed to address gaps in data:

'We were not collecting information on our performance properly, or using it effectively. For instance, we didn't have the data to be able to perform a root cause analysis on an MRSA bacteraemia – we didn't know the timings of the stages from alert, through treatment for colonisation, to bacteraemia.'

One of the most significant things that CMMC has done is to ensure that information on aspects of infection is distributed throughout the trust and made use of in practical ways. The diagram on page 17 shows in simplified form how specific types of information are collected, reported and used to help in efforts to reduce MRSA bacteraemias. It is important to note that the information systems work across HCAI: other information also flows in a similar way for *C. difficile* and glycopeptide-resistant enterococci (GRE) infection, and for many other aspects of patient care.

Using information to build staff competence

CMMC's approach to using information extends beyond monitoring of performance of HCAI indicators themselves. As Jo Rothwell, infection control lead nurse, explains:

'When we put in place the ANTT [aseptic non-touch technique] clinical guidelines, we made sure we were collecting the data we needed to roll the programme out quickly. For every procedure, starting with IV practice, we set targets for the rates at which all relevant staff would be trained and assessed. Ward managers had to provide details of progress against the targets to the DIPC every week until all the staff had been trained, and assessed as competent.'

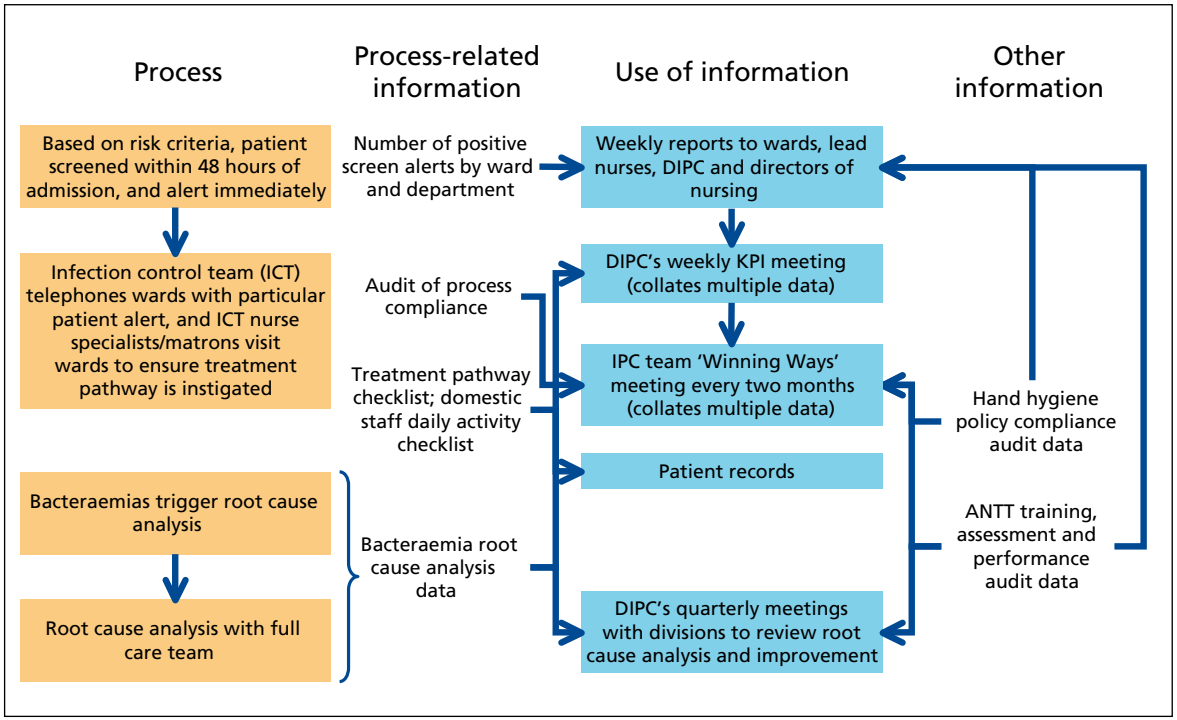
ANTT practice is observed and audited to ensure that performance is good enough – CMMC recognises that training alone is not sufficient to guarantee that the approach is working to reduce infection.

Effective use of data

One feature of the approach at CMMC is the thought that was given to setting the frequency with which different types of information are disseminated to different parts of the trust. Having regular meetings to address specific metrics and examine specific types of information lessens the chance that important data is missed or not acted on.

Although performance information is distributed, daily weekly, monthly and quarterly to relevant parts of the trust, one of the key uses of the data is at the DIPC's weekly KPI meeting. Gill Heaton says:

'I ask a lot of difficult questions at these meetings about the root causes of bacteraemias, and I expect the clinical team to have the answers ... and that includes being able to tell me what their hand hygiene compliance rates are, for example.'



Simplified and partial use of information for MRSA prevention and control at CMMC

Ensuring accountability for performance

Sustained improvements in preventing and controlling infection cannot be delivered by just a few people.

Previously, infection issues were seen primarily or even solely as the responsibility of a trust's infection control team. Although this team is crucial to a trust's strategy, and its contribution and expertise are essential, for progress to be made towards a board to ward culture the emphasis needs to be on making IPC everyone's responsibility. This might sound simple in principle, but the effort needed to make it a reality can be significant.

What does 'everyone's responsibility' really mean?

The expectation that everyone should be responsible for reducing infection is integral to the strategic direction of a board to ward trust and its goals to improve quality and reduce harm. Staff members in a board to ward trust believe that they have an important role to play in preventing infection. They clearly understand what is expected of them, know how they need to contribute, and have the required knowledge and skills to undertake their role.

Devolvement of responsibility requires staff to have the authority to make decisions and take appropriate action. Trusts can achieve this by:

- clearly describing individuals' responsibility for HCAI in all job descriptions;
- including actions to prevent HCAI in personal objectives;

- using the appraisal process and regular one-to-one sessions to monitor performance;
- clearly stating the consequences of poor performance and underpinning this with effective HR systems; and
- putting in place key performance indicators (KPIs) for each directorate that work towards reducing infection rates and that include measures of compliance with local and national standards.

Metrics at directorate level need to be agreed and monitored. Key to this is the presentation and use of this data by directorate managers and clinicians.

What else is required?

Clinical directorates were originally established to give teams ownership and responsibility for delivery of their services. Budgets, staffing, resource management and clinical activity have been devolved in many organisations for some time. This same degree of 'devolvement' of quality and performance measures is proving equally as important. This is explained in more detail in the section on Assurance (page 24).

CASE STUDY

Separating delivery from performance at King's College Hospital

In 2007 King's College Hospital NHS Foundation Trust invited a Department of Health inspection team to review its IPC processes. The visit highlighted the need to clarify roles and responsibilities for infection control at all levels of the organisation.

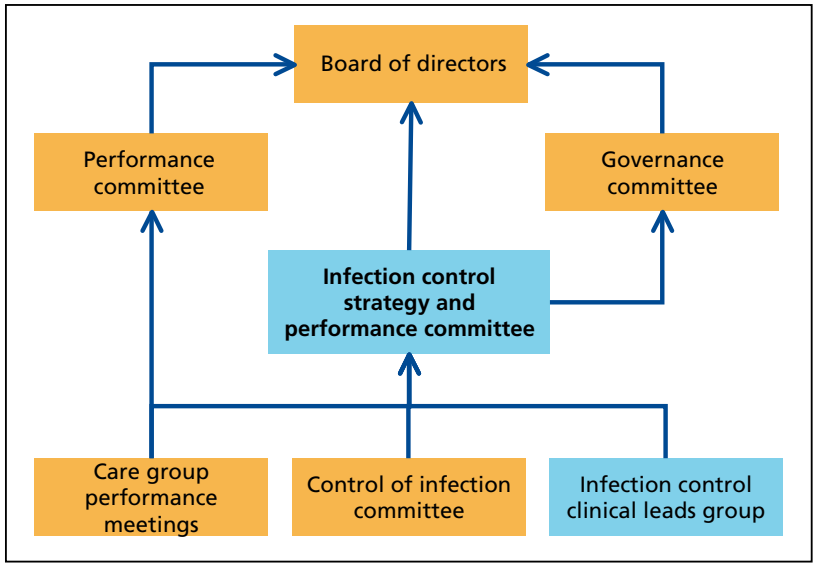
Responsibility for delivering infection control targets at King's is now shared by senior clinical and management staff within divisions, in recognition that these targets are just as important as other performance targets, such as '18 week' waits (a national target to ensure that a patient has to wait no more than 18 weeks between diagnosis and treatment). King's has strengthened its IPC structures. Providing more timely data, clear performance indicators and a more robust reporting structure has meant that the board receives information with which it can assure itself that genuine and lasting progress is being made.

Professor John Moxham, medical director and DIPC, is keen to involve the board in the monitoring, challenging and supporting of work designed to improve infection control in the trust. He says:

'One of the real successes of the last year has been the establishment of a process designed to share and publicise best practice across different divisions, ensuring a consistency of approach and cross-fertilisation of ideas between different teams.'

Clear reporting and accountability

In the new structure, the monthly infection control strategy and performance committee has clear terms of reference. These include reviewing HCAI performance data, holding divisions to account for their infection control performance, and ratifying infection control policies.



King's College Hospital has clear reporting lines for IPC, with the infection control strategy and performance committee at the heart of the structure

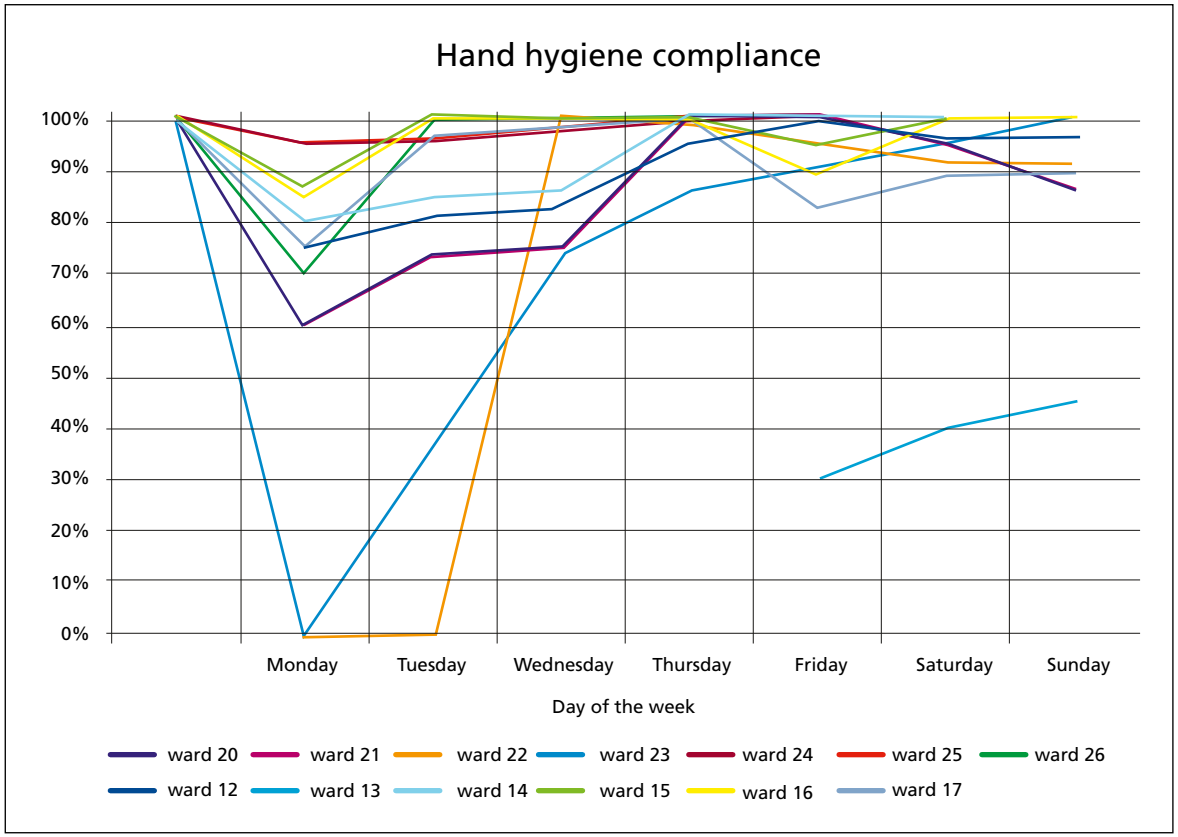
A programme management approach

Commenting on the work done at King's, Pam Coen, the Department of Health's portfolio manager, says:

'The fundamental review of infection control governance has resulted in a management approach that supports a programme of work in IPC, rather than hindering it. The previous role of the IPC team encompassed performance setting, delivery and monitoring – too much for one team, however dedicated. The new structure is much more effective at embedding IPC throughout the trust from board to ward.'

Monitoring of IPC performance

King's already had a well-established and effective performance monitoring process. Infection prevention KPIs are now included systematically within the trust's scorecards. Relevant committees review the data at appropriate intervals so that it can be analysed and acted on much more effectively. The responsibility for gathering data and populating the scorecards with HCAI KPIs lies with the infection control team and the hospital's business intelligence unit.



Scorecards can include additional infection control KPIs, including root cause analyses, hand hygiene audit results and training in infection control

Imperial College Healthcare NHS Trust

Great care is needed in scorecard design

Alison Holmes believes that IPC is not just about responding to current national challenges concerning HCAI. The trust's approach to the design of scorecards, she says, reflects a broader local approach and addresses local priorities:

'To be valuable, KPIs must reflect trusts' and individual directorates' particular situations. For instance, when MRSA bacteraemia was the only mandatory target, it was important that many trusts did not lose sight that C. difficile *may have been far more of a problem for their local patient population, or indeed that particular infection issues related to specific local patient groups were not addressed, at the expense of the external KPIs related to centrally driven targets.'*

Ideally, information underlying the scorecard will reflect processes and risks, and the data supporting the KPIs must be robust and credible in the organisation so that the causes of the 'red lights' can be quickly and reliably diagnosed, understood and acted upon as necessary.

Doing it all again

Alison faces similar challenges at the newly created Imperial College Healthcare NHS Trust:

'There are huge issues to address in the merger of hospital trusts – not just for infection prevention and control, but for every aspect of the trust's work. But one thing I am convinced of is an organisational approach is required that distributes and embeds IPC throughout the clinical programme groups that have been created and establishes it in the culture of a trust.'

The importance of embedding a cultural change in acute hospitals is recognised elsewhere in the new trust. Interviewed about HCAI by the BBC, Mark Enright, professor of molecular epidemiology at Imperial College, said:

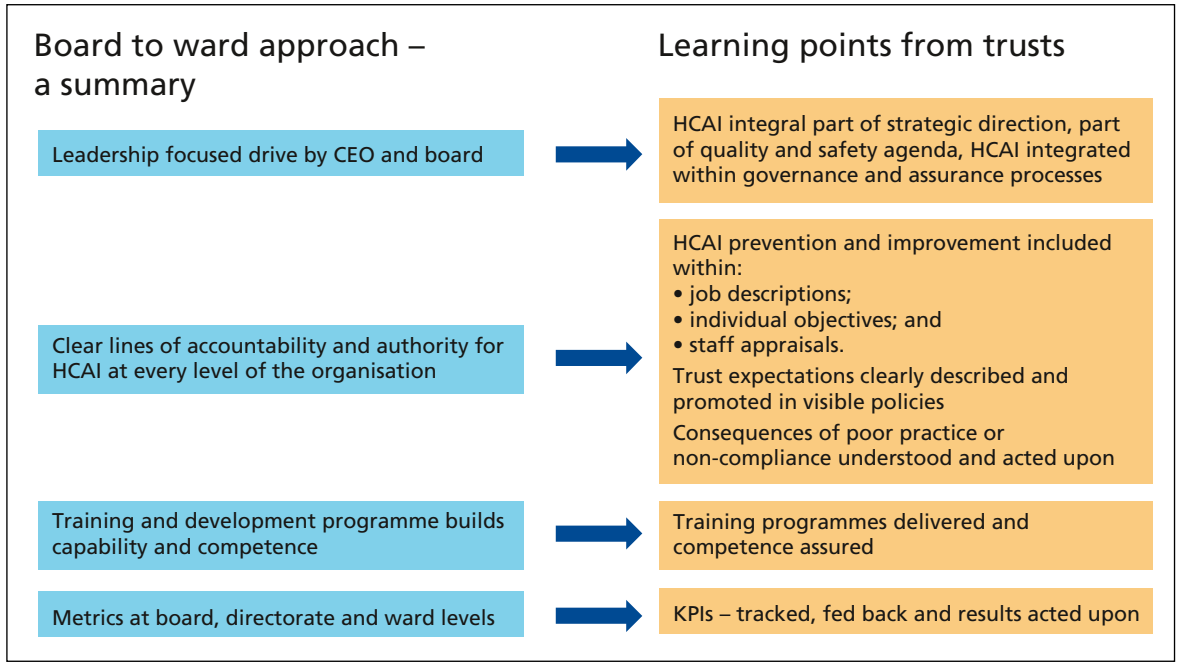
'[In some trusts] there is still an ethos that once you've met your target, you are "allowed" to have some infections each month. Trusts need to move to a different culture whereby they consider every infection avoidable.'

Delivery and best practice at King's College Hospital

A key part of the new structure at King's is the infection control clinical leads group, which is chaired by the DIPC and made up of infection control leads from each of the hospital's divisions and representatives of the infection control team and clinical effectiveness department.

Erika Grobler, clinical risk and governance co-ordinator and author of the new infection control governance policy at King's, says:

'This group is responsible for implementing all infection control strategies including the Saving Lives programme. It oversees all infection control initiatives, including root cause analyses, and the sharing of best practice across the organisation. Infection control leads act as clinical champions within their divisions.'



It is important that data help clinical teams interpret performance

Assurance frameworks – helping trusts to stay on track

A repeated theme identified in the Department of Health's HCAI improvement programme is what has been referred to as a 'board to ward disconnect'. Although in some trusts boards are committed to reducing and preventing HCAI and have ensured that good policies and procedures have been introduced, they have not necessarily achieved the improvement they expected. The missing element is often systems to assure compliance that these policies and procedures are in place and being adhered to by all staff, every day.

A board to ward trust will ensure that:

- it is in control of its HCAI agenda – infection prevention responsibilities are clearly outlined across the organisation and feed into corporate governance;
- it turns data and intelligence into action;
- HCAI prevention is incorporated within its management of risk and clinical governance – the infection control committee reports directly to the board;
- outcome-based action plans are created that focus on HCAI prevention; and
- it has confidence that its systems, policies and people are delivering to the trust's corporate objectives.

Establishing a robust assurance framework for HCAI is crucial. There needs to be a clear and concise structure for reporting key information on risks and measurements to trust boards so that they can see that policy is being translated into practice.

This will need supporting systems, processes and performance indicators. These will include:

- **KPIs**, to be used by everyone from the board to individual staff members to monitor progress and direct action;
- **compliance monitoring**, which is locally measured and measurable at a trust level;
- **root cause analysis**, which gives insight into the potential causes of HCAI and can be used to focus action that will prevent reoccurrence; and
- **clear understanding of performance**, and learning through connecting information, thus providing intelligence for action, such as linking HCAI and mortality.

Control of HCAI agenda with clear responsibilities

Some governance arrangements and organisational structures hinder the spread of an effective culture of IPC throughout a trust, because individual efforts can get lost in the system. Other structures support it, and also support greater ownership of the issue where it matters. Some trusts have seen organisational change make a big impact on rates of HCAI. Placing expertise in IPC in a specialist unit – even if its responsibilities are trust-wide – can sometimes work against the creation of a shared culture. It emphasises barriers and differences between teams and departments, and makes it more likely that staff will consider IPC to be 'someone else's problem' and not an individual responsibility – which it is.

King's College Hospital has given its management teams clear responsibility for meeting measurable performance targets while empowering clinical staff within divisions to drive change and implement new processes. Central to the process are monthly infection control scorecards, which identify where action needs to be taken quickly. Jacqueline Docherty, deputy chief executive and director of nursing and operations, says:

'King's has a strong culture of performance management. By ensuring infection control is a core component in this framework all staff can now clearly identify individual roles and responsibilities for infection control across the organisation and can understand their divisional and departmental KPIs.'

At Imperial College Healthcare NHS Trust, governance arrangements supported the creation of an IPC culture across the trust. General managers and all clinical directors have direct responsibility for infection control within their directorates, aligning the management of infection control with existing decision-making systems and funding streams. Relevant data is regularly reviewed at directorate meetings, at clinical governance meetings and by the trust executive.

Balanced scorecards with KPIs can be used to assess the trust's operational position, incorporating HCAI KPIs and other organisational metrics. They offer a performance overview that can be used to identify opportunities and risks at a glance, and should be measurable.

Alison Holmes at Imperial College advises care in creating KPIs and scorecards:

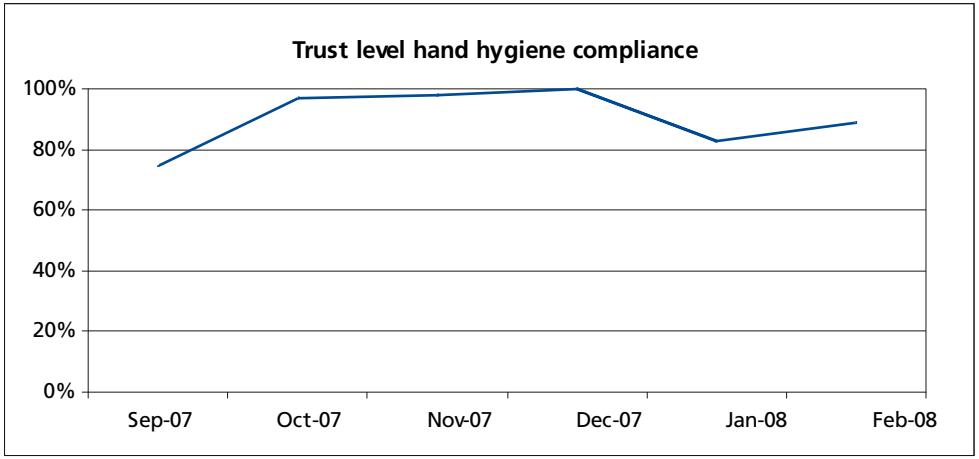
'Different parts of a trust need different types of information, in different forms and with different levels of detail, to be able to act. Thinking this through is an essential step in laying the foundation for an environment of sustainable HCAI reduction.'

Management of risk

For corporate objectives to be realised, potential sources of risk need to be identified and communicated and actions to mitigate risks put in place so that they do not become real, or are minimised.

For a board to be assured that it has control of its HCAI agenda, infection control committees should report directly to the board, so that risks and actions can be challenged, and to ensure that policies are put into practice.

Numbers	Acceptable level	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08
MRSA	as trajectory	5	2	2	1	0	1
Trajectory	12 p.a.	1	1	1	1	1	1
CDI	as trajectory	24	16	16	17	21	16
Trajectory	192 p.a.	16	18	20	25	20	20
HII compliance							
Central venous catheter	100%	60%	73%	75%	100%	100%	86%
Peripheral intravenous cannula	100%	100%	100%	96%	98%	100%	95%
Renal dialysis catheter	100%	0%	0%	100%	98%	96%	92%
Surgical site	100%	0%	32%	73%	86%	90%	100%
Ventilation	100%	100%	100%	100%	100%	100%	100%
Urinary catheter	100%	95%	96%	99%	100%	100%	100%
CDI	100%	70%	100%	100%	100%	95%	100%
Compliance							
MRSA screening	100%	75%	81%	83%	95%	100%	96%
Number of patients colonised	tbc						
Decolonisation	100%	80%	85%	86%	100%	100%	100%
Antimicrobial prescribing	100%		100%	100%	100%		100%
Isolation	100%	85%	100%	100%	100%	90%	100%
Hand hygiene	100%	75%	97%	98%	100%	83%	89%



Information should be presented in a format that can be readily understood across a trust

Outcome-based action delivery plans

In order to provide assurance, trusts need to have effective action plans and delivery systems in place. They should be directly linked to corporate objectives. Risks need to be identified and mitigating actions put in place.

It is recommended that action plans adhere to Specific Measurable Achievable Realistic Time Specific (SMART) principles and are owned by named individuals. To ensure that action plans are effective, regular monitoring is required at a senior level. Action plans should be dynamic tools: they should be regularly updated to reflect existing and new objectives and as additional risks are identified.

Understanding risks is a key component of the Healthcare Commission's code of practice, the aim of which is to promote tangible actions from best practice guidance.

Learning from others

In establishing a new culture of IPC, trusts are embarking on a journey to establish a set of values, beliefs and systems that may be different from those they have now. Change is inevitable if trusts are going to make significant improvements. Along the way difficulties will be experienced, the effort required will be relentless, and levels of enthusiasm will vary. It is important to recognise these challenges and to be prepared with strategies to drive and maintain the momentum.

Learning the lessons from other trusts that have made progress in the journey to a board to ward culture can help in identifying how to prepare for the journey. The experience of such trusts emphasises the need to:

- show persistence and resilience;
- demonstrate professionalism;
- celebrate success;
- share good practice;
- be visible in adhering to policies; and
- challenge where required.

Bravery and resilience

Creating an environment where reducing HCAI is central to patient care requires significant effort, and setbacks should not distract or deter trusts.

Gill Heaton at CMMC says:

'It's a long journey. It requires stamina and resilience, and constant enthusiasm. The national target for MRSA is of equal importance to those relating to emergency access, 18 weeks (time from referral to treatment), cancer etc. It is, however, one of the hardest to achieve; it requires every single member of staff to take accountability and responsibility for their clinical practice. Achieving success in this is one of the hardest but most rewarding things I have done. It really is making a difference to patients' experience and their safety.'

A powerful way to demonstrate persistence is to adopt a 'zero tolerance' towards non-compliance with key policies or procedures. Typically, these would cover those things the trust believes are crucial to the values and beliefs that the desired culture requires, such as dress codes and hand hygiene. A zero tolerance approach enables clear expectations of non-compliance to be understood and acted on.

Hand hygiene and dress codes can be a potential cause of friction in a trust – such as the requirement to be 'bare below the elbow' (as suggested in the Department of Health uniforms and workwear guidance to help trusts set policies which comply with the code of practice requirement that they should specifically support good hand hygiene).

In a trust that has established a board to ward culture, staff know that they will be backed up by their colleagues if they challenge other, perhaps more senior staff.

Where a strategic health authority has imposed a policy on uniforms across the authority area – such as in the East Midlands – it may be helpful in setting local expectation. In some hospitals, such as in Hull, providing polo shirts for junior doctors has proved effective in countering any individual resistance.

Some organisational changes are needed to establish effective structures for IPC right across a trust, from board to ward. As Alison Holmes's team found at Imperial College:

'Trusts cannot and should not rely on a few individuals' commitment, enthusiasm and short-lived campaigns. To achieve sustainable improvement, a systems and organisational-based approach is required that embeds best practice and drives cultural change.'

Policies into practice

Being able to assure that policies are being implemented on the ground, by all staff every day, is crucial in a board to ward trust.

Regularly measuring and acting on compliance translates into organisational and behavioural change. Frequent monitoring, together with setting acceptable compliance levels and communicating and measuring them is often key. Some trusts have embraced publishing of performance results in ward areas for all to see. Intelligence, when appropriately presented and regularly evaluated, is key to a resilient organisation. Examples of good use of intelligence and presentation of information include hand hygiene and uniforms and workwear.

CASE STUDY

Ensuring high compliance on hand hygiene can be a challenge. Hereford Hospitals NHS Trust identified a number of obstacles to its hand hygiene campaign, called 'Challenge'. It needed to:

- overcome traditional practices among certain groups of staff;
- boost the confidence of staff to challenge each other; and
- involve the public, for example by explaining the 'Challenge' campaign through educational road shows in supermarkets and schools and through press releases and public forums within the hospital.

Cultural change is more likely to occur when frequent observation, monitoring and feedback systems are in place to allow trusts to see where improvements have the most impact. For example, in some trusts, non-executive directors observe and audit hand hygiene practice at ward entry; in others, campaigns are publicised beyond the hospital doors.

It is clear that regular observation and documentation that checks against trust standards really make a difference. Trusts now recognise that weekly and daily

checking is needed to assure them that policy is being put into practice.

Eileen Sills at Guy's and St Thomas' NHS Foundation Trust says:

'We had been chipping away at the HCAI issue for a couple of years before we realised that improvements weren't going to continue without implementing a zero tolerance approach to our hand hygiene policy and dress code. It is backed up – improvement notices are sent out to departments breaching agreed acceptable standards, and disciplinary action will be taken – although we have not had to do this, as the campaign has been accepted by all staff.'

Appealing to professionalism – a powerful lever for change

All healthcare professionals operate within a code of practice or conduct. For example, the General Medical Council's *Good Medical Practice* (2006) states:

'You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.'

'Doctors must practise good standards of clinical care, practise within the limits of their competence, and make sure that patients are not put at unnecessary risk.'

Furthermore, nurses operate within the Nursing and Midwifery Council's *Code of Professional Conduct*, which states:

'You have a duty of care to your patients and clients, who are entitled to receive safe and competent care.'

These statements make it clear that healthcare professionals have a responsibility to protect patients from harm and a clear obligation to ensure that their practice does not contribute to such harm. Therefore, a way to engage clinical staff can be to appeal to their professionalism and make sure that they make the connection between what they need to do in their work and their professional commitment to protect patients from harm.

As Gill Heaton at CMMC points out:

'You train people and assess them as competent. They are professionals, and you must assume they will do their jobs responsibly and safely. If you find out – through root cause analysis, for instance – that they are not doing this, and that they have let down their patients, they must accept personal responsibility and accountability for their practice.'

Eileen Sills at Guy's and St Thomas' agrees:

'Creating the right culture to support a reduction in infection needs to be led from the top ... All staff need to understand that even if they don't like or agree with a policy, their contract with our trust sets expectations that they adhere to policies, and non-compliance has consequences.'

According to trusts that have gone through this process, clear job descriptions are required. At Guy's and St Thomas', payslips include updates on the current IPC requirements of all staff, and at King's College Hospital all job descriptions include a section relating to IPC.

In addition, some trusts have issued letters with return signature slips to ensure that staff members have read and understood what is expected of them in respect of their local HCAI agenda.

Celebrating success to reinforce professional behaviour

Linked to the idea of appealing to professionalism is the idea of celebrating success. Board to ward trusts look for opportunities to celebrate successes both internally and with the wider public. Examples of actions taken by specific trusts include:

- rewarding staff for compliance with the hand hygiene policy over three consecutive months;
- operating a trust-wide ward accreditation scheme using key compliance measures;
- making audit results widely available;
- rewarding the cleanest wards, thereby instilling a competitive aspect to the celebration of success.

Speeding progress by sharing good practice

Although trusts vary in size, complexity and case mix, the activities required to achieve sustainable improvement in IPC fundamentally remain the same. It makes sense, therefore, not to continually reinvent the wheel. Even if a key part of achieving improvement is assuring local ownership, it is possible to take other people's good practice, documentation or tools and adapt them for local use. This can save valuable time and effort.

How trusts have embedded a board to ward culture

The national team is often asked for examples of good practice, such as policies, job descriptions and balanced scorecards. This section looks at the Royal Wolverhampton Hospitals NHS Trust (RWHT), showing how it dealt with particular issues and the tools it used. These resources can be found on **www.clean-safe-care.nhs.uk**

Changing the culture and hitting targets in Wolverhampton

RWHT saved 212 lives, £6.8 million and 16,000 bed days in one year of concerted effort to reduce HCAI.

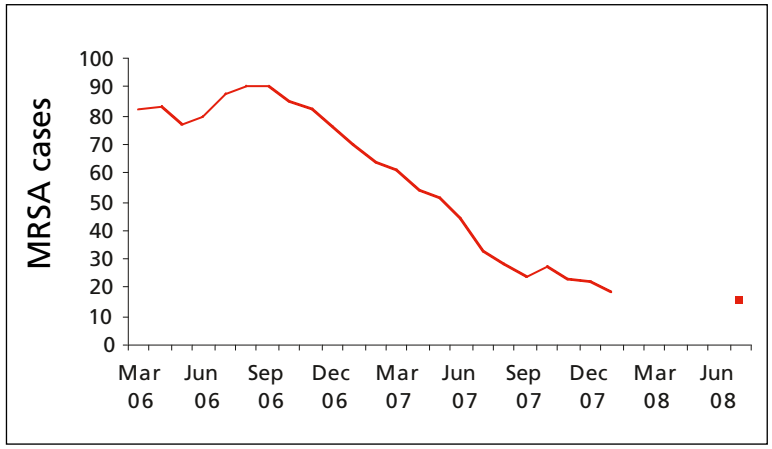
The RWHT won the *Health Service Journal* Patient Safety Award in 2007 and the Secretary of State's Award for Excellence in Healthcare Management for its efforts to reduce HCAI. The trust's director of nursing and midwifery, Cheryl Etches, believes that cultural change has helped:

'Even though there have been ups and downs, our board to ward approach means we know we can sustain improvements by changing the focus of our efforts as necessary – and wherever it is needed in the organisation.'

The changes implemented at the trust have included practical measures such as decluttering wards, equipping wards with new commodes, replacing mattresses and instituting new dress codes. They also include widespread organisational and process changes at all levels within the trust. Cheryl Etches sums up how the change has been achieved:

'Making infection prevention a high priority area, with leadership from the top, and using monitoring in an action-focused, outcome-oriented way has been important. Another factor has been to deal not just with MRSA, or other specific problems, but to consider all infections. These are the things that have helped us to reduce infection rates, length of stay and costs.'

Getting the active involvement of patients and visitors as well as staff has also contributed. Local press campaigns aimed at improving awareness of the importance of good hygiene in hospitals, replacing visitors' chairs with short benches, and using volunteers to monitor hand-gelling by visitors and staff at the doors are three examples.



The change in MRSA infection rates since the new regime was implemented in May 2006 is clear

What made a difference at Wolverhampton:

- active support from the chief executive officer;
- leading from the front;
- a consistent message;
- aligning structures and processes with outcomes;
- pre-empting knockbacks and keeping up staff morale;
- performance monitoring;
- being determined; and
- celebrating success openly.

Monitoring and objective setting

Programmes of continuous monitoring and assessment of performance have contributed to improvement at Wolverhampton. Matrons and ward managers are monitored monthly against a set of KPIs, and medical and surgical consultants' annual appraisals now include a number of objectives against which they are assessed. Performance against objectives is taken into account when each consultant's pay progression is considered.

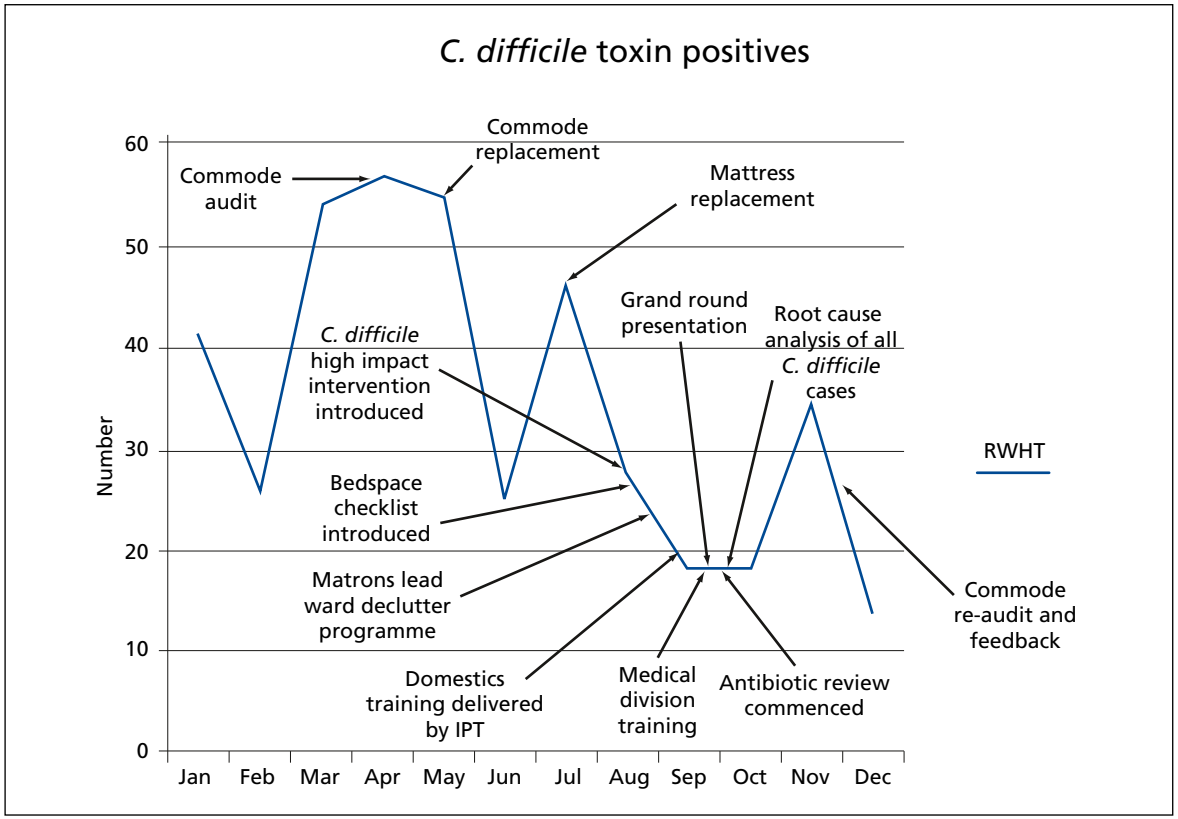
Showing persistence

One of the most significant aspects of the Wolverhampton experience is the trust's persistence in sustaining HCAI reduction. Not all changes can be implemented at once, but as there are many different ways of addressing HCAI issues, a continuous approach can be taken. The way in which different actions were phased in over the 12 months and the range of actions taken to embed the culture and sustain the improvement is illustrated here.

Achieving a change in culture

An illustration of the cultural change that the trust has achieved is that there have been instances of domestic staff challenging doctors for not gelling their hands. Cheryl Etches adds:

'We have ensured that staff are clear about what we expect of them. This is supported with policies, clinical practices and objectives. Where staff have blatantly refused to comply with trust policy, disciplinary action has been taken.'



A number of actions over a period of months has helped sustain improvement, for instance in rates of C. difficile infection

Further reading

More information and further case studies illustrating the successful approaches that trusts have taken to reduce HCAI can be found on the Clean, Safe Care site at **www.clean-safe-care.nhs.uk**

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