Going further faster:
Implementing the Saving Lives delivery programme
Sustainable change for cleaner, safer care
## Document Purpose

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### Title

Going further faster: implementing the Saving Lives delivery programme

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PCT CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, PCT PEC Chairs, NHS Trust Board Chairs, Directors of HR, Directors of Finance

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### Description

Guidance to support delivery of the PSA target to halve MRSA bacteraemia by 2008 and the Saving Lives delivery programme

### Cross Ref:

- Saving Lives: a delivery programme to reduce HCAI
- Winning Ways: Working together to reduce HCAI in England

### Superseded Docs

N/A

### Action Required

N/A

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N/A

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### For Recipient's Use
Introduction

The purpose of this guidance is to enable Trusts to make significant progress towards achieving the MRSA target by going further faster and making year on year improvement.

This work is the outcome of close partnership between the Department of Health and a number of NHS Trusts. We have worked with Trusts that have made significant, sustained improvements towards the national target of a 50% reduction in MRSA bacteraemias. These improvements have been scrutinised and the findings and recommendations are laid out in this document to support wider improvements across the NHS.

Sharing good practice learnt from those ahead of the game is a practical way for us all to increase the focus on reducing healthcare-associated infections (HCAIs) and move further towards our common goal of a clean and safe NHS with no avoidable HCAIs.

The focus of this guidance is on the actions that will impact on MRSA but it recognises that the activities, if implemented will support system-wide improvement in HCAI.
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Why reducing HCAI is important
Consider the impact on Trust business and the bigger picture.
- Quality patient care
- Productivity and efficiency
- Financial implications
- Patient choice
- Public confidence
- Statutory duty

Where to focus
Use your data to inform your action plan.
- Comply with data requirements in CMO/CNO letter
- Analyse and use MES* data
- Use data to drive improvement
- Audit performance and be ambitious

How to focus
Focus action around high-risk and priority areas.
- Use Trust MES* data to focus on hotspots (specialty and source)
- Drive, demonstrate and audit high level compliance with key High Impact Interventions
- Have clear strategy for high-risk groups: screen and/or decontaminate
- Reinforce ‘clean your hands’

Sustaining improvements
Whole-system engagement is crucial.
- Board-level commitment
- Authority, accountability and responsibility at directorate level
- Appoint senior clinical leads to champion and engage colleagues
- Integrate into Trust performance management process
- Embed in risk management and clinical governance framework
- Patient and public involvement should be central to your plans

*Mandatory Enhanced Surveillance
Why reducing HCAI is important

HCAI impacts on your Trust’s ability to deliver. HCAI costs the health service around £1billion per year. Patients who get an HCAI are subjected to increased anxiety, pain and suffering.

NHS leaders need to see HCAI in the context of service delivery. Trusts traditionally have looked to infection control teams to reduce HCAI. To realise system-wide change and sustainable improvement, all managers and clinicians need to understand the impact that HCAI has on their services and work together with infection control teams to make this everyone’s responsibility.
Reducing HCAI benefits all aspects of quality and efficiency

Productivity and performance

- Reduce length of stay
- Reduce lost bed days
- Reduce costs including pharmacy costs
- Reduce pressure in augmented care
- Improved clinical governance procedures
- Utilise beds more flexibly
- Impacts on other targets

Service efficiency benefits

Workforce benefits
- Staff are clear about the contributions they can make
- Staff are clear about where they need to focus effort
- Greater insights developed between staff about roles and responsibility
- Staff able to use resources more flexibly

Quality of service

Patient experience
- Reduce fear and anxiety
- Increase patient confidence
- Patients not subjected to unnecessary discomfort and pain
- Patients will not have extended stay in hospital due to infection
- Reduce complaints and litigation
- Reduce complications caused by infection

Clinical outcomes
- Improve mortality and morbidity rates
- Optimise recovery times
- Fewer adverse incidents
- Appropriate use of antibiotics

Each HCAI costs between £4,000 and £10,000
Understanding the local impact of HCAI on Trust productivity

In order to assist Trusts in understanding and identifying the benefits of reducing MRSA and other HCAIs, a tool has been developed. The table below is an example of how your Trust can see the impact on business activity locally. The tool is available online at www.clean-safe-care.nhs.uk with full instructions.

The tool demonstrates specific local benefits for Trust decision makers and will help provide a business case for direct improvement. (see example below)

<table>
<thead>
<tr>
<th>Trust example: Target reduction by 2008 - 60%</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>2004/05</td>
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<tr>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>MRSA bacteraemia</td>
</tr>
<tr>
<td>Excess cost - MRSA</td>
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<tr>
<td>Additional bed days - MRSA</td>
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<tr>
<td>Potential saving - MRSA</td>
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<tr>
<td>Potential bed day saving - MRSA</td>
</tr>
<tr>
<td>% of total bed days saved - MRSA</td>
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<tr>
<td>All HCAIs (estimated)</td>
</tr>
<tr>
<td>Excess cost - all HCAI</td>
</tr>
<tr>
<td>Additional bed days - all HCAI</td>
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<tr>
<td>Potential saving - all HCAI</td>
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<tr>
<td>Potential bed day saving - all HCAI</td>
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<tr>
<td>% of total bed days saved - all HCAI</td>
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</tbody>
</table>
Commissioning a patient-led NHS expects clean, safe, reliable healthcare.

**Patient Choice** means that Trusts will be judged by their ability to provide high-quality, reliable and safe care. Patients rightfully expect healthcare to be delivered in an environment where risks are proactively reduced.

Patients will have less confidence in providers that are rated poorly or who show little sign of improvement.

**Payment by Results (PBR)**
HCAI impacts on a Trust’s financial position. Under Payment by Results, procedures will attract a defined tariff which will not take account of additional costs incurred by treatment of HCAI.

For example, if a Trust has 40 cases of MRSA bacteraemia (below the average figure) per year, it will incur additional costs of between £160,000 and £400,000 in excess of tariff income. This does not take account of other HCAIs, which could increase this figure tenfold.

**What price safety?**
The National Audit Office (2000) estimated the cost of a bloodstream infection to be around £6,209. An American study estimated that a ventilator-associated pneumonia infection would cost around $11,897 per patient.

These costs do not reflect the pain, suffering and discomfort caused to the patients and their families.
'Costs associated with the reduction of infection rates [included] savings of approximately 4000 bed days and £1.4 million in hospital costs, the prevention of 100 MRSA bacteraemias and 360 surgical site infections.'

*From a case study of improvements made at Guy’s and St. Thomas’ NHS Foundation Trust (see p25)*
Where to focus

Experience from Trusts shows that focussing effort at specialties with high infection rates can yield significant gains. The case studies in this guidance illustrate the benefits of these strategies.
1. Enter data using MES

Trust should use their Mandatory Enhanced Surveillance (MES) data to determine where the high priority areas are in their Trust ("the hotspots").

Analysis of this data will determine areas and specialties with higher rates such as augmented care. Focussing on these areas first can yield significant gains.

Trusts should also look for areas with higher numbers (eg general surgery), determine the source of bacteraemias and focus effort there.

Source data can be collected using the additional voluntary MES fields.

2. Analyse data to inform action

Trust example of enhanced data
Diagnosed after 48 hours: specialty patients admitted to

- General medicine 22%
- Geriatric medicine 14%
- General surgery 22%
- Renal 14%
- Trauma and orthopaedics 7%
- Cardiology 7%
- Other 14%
- Other 14%
How to focus

• Using High Impact Interventions (HIIs)
• Screening and/or decolonising high-risk patient groups

The Saving Lives High Impact Interventions are simple evidence based tools which increase reliability of key procedures. They allow Trusts to monitor compliance using simple audit tools and run charts. They provide rapid feedback to teams to drive improvement. Screening and/or decolonising high-risk patient groups will support a Trusts strategy to reduce the risk to patients.

The EPIC guidelines (Pratt et al 2001) suggests certain specialties where screening should take place. Trust’s that have rigorously introduced protocols to screen and/or decolonise high-risk groups (as part of their package of measures) have seen significant reductions and improvements in these areas (see Guy’s and St. Thomas’ and Leeds case studies later).
High Impact Interventions (HIIs)
Research into hand hygiene compliance amongst healthcare staff has shown that compliance is inconsistent. Observation of practice regularly reveals a mismatch between what staff say they are doing and what they actually do.

Staff that are unsure will not always feel confident that they can check their practice as ‘they feel they should know this already’.

It is important to have the right systems and processes in place to support good infection prevention and control. However sustained improvements will only be achieved when all staff undertake key clinical procedures right every time.

Real improvement requires a fundamental change in behaviour - HIIs can be the tool to facilitate that change if implemented effectively.

Why HIIs?
We need a systematic method of measuring and improving compliance for specific clinical procedures. HIIs are a sensitive and valid assessment of quality (Hayward BMJ 1996). Winning Ways (Department of Health, 2003) referred to the use of HACCP principles to improve practice - HIIs use the same philosophy. For each clinical procedure there are a number of evidence based element that need to be performed correctly ie critical control points.

Observation of practice in a number of hospitals nationally and internationally revealed that whilst a number of the critical elements were performed in a procedure, rarely were all of them performed consistently. Reducing HCAI requires all elements to be performed all of the time.
The HIls provide the tools to observe practice, measure compliance and feed back results quickly.

‘I am absolutely convinced that if clinical leaders take time to observe practice they will see the value of improving the reliability of key procedures like line insertion and wound care. Clinical staff that have championed this work have seen real reductions in their infections.’

Janice Stevens, Director, MRSA/Cleaner Hospitals Programme, Department of Health

<table>
<thead>
<tr>
<th>Observation</th>
<th>Catheter type</th>
<th>Insertion site</th>
<th>Alcoholic chlorhexidine</th>
<th>Microbial contamination prevention (HII 1)</th>
<th>All elements performed?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
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<td>Total</td>
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<tr>
<td>% Compliance</td>
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</table>
The Saving Lives High Impact Interventions

- The risk of microbial contamination
- Central venous catheter and peripheral line care
- Preventing surgical site infection
- Care of ventilated patients (or tracheotomy)
- Urinary catheter care
- *Clostridium difficile*
Performance management should underpin the Trust’s strategy to reduce HCAI, drive improvement and make infection prevention and control everyone’s responsibility. This requires a Trust-wide approach across all staff.
System-wide action

Sustainable improvement in HCAI requires Trusts to have an organisation-wide action plan which embeds infection prevention and control across the entire organisation.

The plan should incorporate national guidance and good practice, engage staff and make this everyone’s business.

Saving Lives Nine key challenges and key actions to reduce MRSA

<table>
<thead>
<tr>
<th>Organisational focus</th>
<th>Key challenge</th>
<th>Specific Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage senior management</td>
<td>Challenge 1</td>
<td>Engage the board and use performance management at every level</td>
</tr>
<tr>
<td>Appoint infection control leaders at every level</td>
<td>Challenge 2</td>
<td>Ensure clinical ownership across organisation</td>
</tr>
<tr>
<td>Implement a local surveillance programme</td>
<td>Challenge 3</td>
<td>Screen and/or decontaminate according to risk assessment</td>
</tr>
<tr>
<td>Adopt national evidence-based guidance</td>
<td>Challenge 4</td>
<td>Use HIs to monitor and increase compliance</td>
</tr>
<tr>
<td>Ensure the effective auditing of practices</td>
<td>Challenge 5</td>
<td>Integrate with risk and clinical governance framework</td>
</tr>
<tr>
<td>Ensure that Trust employees have infection control training</td>
<td>Challenge 6</td>
<td>Ensure infection control is part of induction and ongoing training</td>
</tr>
<tr>
<td>Review patient journey for A&amp;E and planned patients</td>
<td>Challenge 7</td>
<td>Effectively coordinate bed management with infection control input</td>
</tr>
<tr>
<td>Review the status of the built environment</td>
<td>Challenge 8</td>
<td>Clean and decontaminate</td>
</tr>
<tr>
<td>Implement robust Trust-wide policies</td>
<td>Challenge 9</td>
<td>Proactively manage your reputation, engage all staff and local community</td>
</tr>
</tbody>
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Performance management at individual level

**Principles:**
Individuals know the contribution they can make and how to achieve this, applying good infection prevention and control to their everyday work. Translate this into personal and professional development plans and objectives.

**Indicators (for individuals):**
- Clinical outcomes
- Length of stay
- Mortality rates
- Morbidity rates

**Clinical drivers:**
- Application of best practice guidelines
- Compliance with key procedures across teams
- Reputation – the impact of Patient Choice
- Performance review and appraisal features infection control as a core requirement

**Actions:**
- Include infection control in job descriptions
- Ensure key staff have as an objective in appraisals
- Include in job plans and appraisals for consultants
- Measure performance through performance review
- Identify development needs and include in personal development plans

Performance management at organisational level

**Principles:**
Clear accountability, responsibilities and objectives at directorate and Trust level.

Trust boards and directorates need comprehensive reports on HCAI, including MRSA data.

**Balanced Scorecards:**
Saving Lives assessment challenges
Data - examples could include:
- MRSA/MSSA numbers and rates
- Compliance data for HIIs
- Other mandatory reported infections
- Antibiotic costs and usage
- Relevant complaints and litigation
- PEAT Scores
- Length of stay and lost bed days
- Outbreak information
- Root cause analysis
- Training information

**National drivers:**
**CNST** - Infection control sections align with Saving Lives, HR section links to mandatory training
- Compliance to standards will meet CNST requirements and could therefore help to reduce premiums.

**Standards for Better Health** - Close links with the Healthcare Commission ensures that the Saving Lives Nine key challenges underpin the Standards for Better Health domains.

**Code of Practice** - Trusts will have a statutory duty to comply, using Saving Lives will help demonstrate compliance with much of the Code.
‘Infection control is being integrated into consultant appraisals and into leadership training for managers.’

From a case study of improvements made at Hammersmith Hospitals NHS Trust (see p26)
Putting vision into action

‘The Trust has undergone a period of organisational change at each level to provide a structure that brings managers and clinical healthcare professionals together to ensure that patient experience is improved.’

*From a case study of improvements made at Bolton Hospitals NHS Trust (see p22)*
Chief Executives and Boards must engage staff at every level of their organisation to lead this cultural and behavioural change.

**Culture in a Trust where infections are accepted or seen as the norm**
- The Trust looks to infection control team to reduce HCAI
- Some staff might be unclear about whose responsibility infection control is and whether they can contribute
- Varied compliance to essential clinical procedures
- Patient confidence is low with regular adverse media coverage
- HCAI is not part of Trust risk and governance framework
- Lack of clinical leadership across organisations to HCAI
- Patients choose care elsewhere
- Lack of board engagement
- Infection control is managed in ‘silos’

**Culture in a Trust that is striving for no avoidable HCAI**
- Infection control is owned by individual directorates supported by infection control teams
- All staff understand their role, responsibility and contribution
- High reliability to key clinical procedures and risks are reduced
- Patient and public confidence has improved or is high and there are good news stories about the Trust.
- HCAI is integrated into risk management and governance framework
- Real clinical engagement embedded in HCAI
- Patients choose your hospital
- Real board engagement and endorsement
- Managers and professionals take collaborative approach to improvement

Making cultural and behavioural change a reality
Improvement in practice

Case studies

Sharing good practice allows us to share learning across the NHS.

The following case studies illustrate that there are far fewer barriers to change than we think. Achieving our target is going to be challenging but there is scope for going further faster towards our common goal of clean, safe, reliable healthcare.

Implementing the changes and driving improvement (as demonstrated in this guidance) will enable all Trusts to make sustained change towards 'no avoidable HCAI' and provide quality patient care, while still performing in a productive and efficient way.
Case studies include:
- Bolton Hospitals NHS Trust
- Guy’s and St. Thomas’ NHS Foundation Trust
- Hammersmith Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust

Special thanks to all of these Trusts for their support and help in preparing this guidance.
Case study

Bolton Hospitals NHS Trust
‘A quiet revolution’

Key outcomes:
- Impact of HCAI on Trust business recognised by board
- Quality at the centre of Trust plans
- Senior ownership and leadership for infection control agenda

Bolton Hospitals NHS Trust is working towards a five-year strategy for quality improvement. They are clear about the purpose, which is to provide:
- the best possible care for their patients
- improved health for their community
- joy and pride in work for their staff

A fundamental driver for this is the vision to be a leader in safety and put quality at the centre of the strategy.

Putting vision into action
The Trust has undergone a period of organisational change at each level to provide a structure that brings managers and clinical healthcare professionals together to ensure that patient experience is improved.

Quality has equal place on all agendas along with other operational objectives such as patient access and financial stability. The Trust has been taking forward ‘Winning Ways’ proactively by the joint leadership of the Medical and Nursing Directors since 2003/04. The Winning Ways Group is a subgroup of the Infection Control Committee, which reports directly to the Governance Committee.

In autumn 2004, a new Chief Executive joined the Trust and reaffirmed a key objective for the organisation to reduce hospital-acquired infections, linked closely to the reducing mortality programme within the Trust led by the Medical Director.
The reorganisation of the management structure brought the operational leadership of the Trust to the Nursing Director who, with the Medical Director, provides senior ownership and leadership for the infection control agenda.

The Trust signed up to the Saving Lives delivery programme at its instigation and amalgamated this with the previous Winning Ways action plans. The group was reviewed and is chaired by the Medical Director with a membership that includes:
- the Director of Nursing and Performance Improvement
- the clinical divisions
- Associate Medical Directors
- Divisional Nurses
- The Infection Control Team

All of the above have specific objectives for collaborative reduction in HCAI.

**Taking forward improvement - the action plan**
- Built upon the previous Winning Ways work and incorporated this with Saving Lives, Towards Cleaner Hospitals, with best possible care delivered through lean thinking
- Ownership and leadership at ward and departmental level supported by specialists directly linking with Trust staff, and patient and public involvement
- Instigated performance management and accountability
- Integration of initiatives and strategy into coherent Trust policy
- Implicit personal accountability for improving HCAI from Chief Executive to front line

The Trust found there were few barriers to this common agenda and there was integral commitment throughout the Trust to quality improvement. Our latest initiative, led by the **Medical Director** is ‘naked below the elbows’.

**Sustaining improvement**
The impact of this work is plain to see. The Trust has made significant reductions to its MRSA bacteraemias (see chart below) and is an SHA benchmark.

**The benefits**
The overarching benefit to this strategy is the common agenda of improvement in patient outcomes. Bolton Hospitals NHS Trust has a challenging hospital mortality rate but it does not have a change programme in isolation, reducing HCAI is integral to the SHMR programme.

Delivering best possible care through lean thinking approaches to quality improvement and patient-centred provision is just the start of our ‘quiet revolution’.
Case study

Guy’s and St. Thomas’ NHS Foundation Trust
Reducing MRSA - increasing the focus

Overview
Guy’s & St. Thomas’ is one of England’s largest NHS Foundation Trusts. It is a major tertiary referral centre, providing a full range of highly specialised services, including:
• The UK’s largest intensive care unit;
• Specialist cardiac and renal services;
• Specialist haematology and oncology services.

The Trust admits many sick patients from other hospitals, some of whom already have MRSA infection when they arrive. Many patients in these specialist units are highly vulnerable to infection because of their general medical condition.

Infection control working group
The Trust set up a multi-disciplinary infection control working group in October 2003. The group was established by the Chief Executive. It is chaired by the Medical Director and the Chief Nurse and reports to the Trust Board. Each clinical division takes ownership of and responsibility for MRSA infections in their wards and clinics. Results of practice audits and MRSA surveillance are fed back at each meeting.

Actions to reduce HCAI
The Trust updated its infection control policies, ensured they were disseminated to all staff and monitored compliance through audit, feedback and performance management.

A series of high-impact interventions was introduced, including:
• Education and communications programmes for all staff;
• Hand hygiene campaigns, including implementing the NPSA’s national cleanyourhands campaign, a separate Trust-wide hand hygiene campaign and information roadshows aimed at staff and visitors.
• Introducing an MRSA care pathway, including screening of patients in high-risk areas for MRSA;
• An enhanced programme of intravascular device management based on national guidelines – Trust investigations found that around 50% of MRSA bacteraemias were associated with lines;
• A major programme of environmental cleaning and refurbishment.
Other initiatives included providing feedback to clinicians on individual MRSA cases and targeted work programmes in intensive care and renal medicine. The programme initially targeted high-risk areas. It was then rolled out to other areas in the Trust. The programme was successful because:
- It was a clear Trust-wide priority
- It had strong leadership and support at a senior level
- There was engagement and support from staff at all levels

**MRSA infection rates at the Trust**
The programme’s effectiveness was monitored through surveillance of MRSA infection rates. Since the introduction of the programme in October 2003, MRSA bacteraemia rates have fallen steadily. The Trust has moved from having one of the worst MRSA bacteraemia rates for specialist Trusts to one of the best. Comparing figures between the second quarter of 2003 and the first quarter of 2006:
- MRSA bacteraemia rates have more than halved from 0.48 per 1,000 bed days to 0.15;
- Actual numbers of MRSA bacteraemias have fallen from 41 to 13;
- The number of patients acquiring MRSA at the Trust has more than halved, falling from 192 to 79;
- The number of patients giving positive MRSA results from wound swabs has fallen from 187 to 90.

In addition, the number of patients admitted to the Trust with MRSA has risen from around 40% in 2003 to around 70% in 2005.

**Costs associated with the reduction in infection rates**
- By extrapolating the reduction in MRSA infections from 2003 to 2006 and using published UK data for costs, we estimate that the programme has helped to make the following annual savings:
  - The prevention of 100 MRSA bacteraemias and 360 surgical site infections;
  - Savings of approximately 4000 bed days and £1.4million in hospital costs

**Conclusions**
- Introducing a high-level plan to reduce rates of MRSA infection has had a sustained and positive approach across the Trust. Improvements can be made, however, and work is now ongoing to achieve further reductions.
Case study

The Hammersmith Organisational Model for Infection Prevention (HOMIP)

The Hammersmith Organisational Model for Infection Prevention (HOMIP) was developed to ensure infection and public health expertise was used effectively and strategically in the acute Trust setting. By embedding infection prevention within the framework and shared values of a large, complex NHS Trust, it aims to change the behaviour and culture across the organisation. It represents a successful partnership between infection control and organisational development.

Key outcomes:
- 35% reduction in MRSA bacteraemias and significant reductions in other HCAIs
- Directorate responsibility for infection control
- Shared goals for senior managers and clinicians

After a year, HOMIP is producing some impressive results. The Trust has seen a 35% reduction in MRSA bacteraemia, and significant reductions in other HCAIs. There are three key elements:

**Directorate accountability**
The general managers and clinical directors of each hospital directorate have direct responsibility for infection prevention within their directorate. This arrangement aligns the management of infection prevention with the existing decision-making systems and funding streams, and reinforces ownership across the workforce. It also allows directorates to target activity and develop specific action plans, advised by the Infection Control Service. It ensures that senior managers and clinicians have shared goals, and a shared understanding of balancing risk. It also provides a practical framework on which models of best practice can rapidly be adopted and assimilated into directorate activity.
Performance management

Infection prevention targets were agreed with the Director of Infection Prevention and Control. These were integrated into the balanced scorecard already used by directorates to measure performance at the Trust. They include outcomes (such as MRSA bacteraemia, and rates of all MRSA infections and \textit{Clostridium difficile} cases) and processes (such as hand hygiene and antibiotic prescribing). As well as these core measures, directorates receive individual case details and risk information.

Datasets are reviewed in directorate meetings, at the Trust Executive and monthly at the Trust Clinical Governance Committee meetings. Additional targets are included to address specific risks in different directorates, eg the Cardiac Directorate is required to encompass sternal wound surveillance within the integrated care pathway for cardiothoracic patients; the Renal Directorate is required to monitor dialysis-associated bacteraemia and optimise provision of vascular access; in the Women’s and Children’s Directorate, the Neonatal Unit needs to embed neonatal bacteraemia surveillance in the day-to-day activity of the unit. The system has worked well; it also effectively integrates antibiotic control and infection control.

Clinical incident reporting

A key step in HOMIP has been the use of clinical incident reporting as a means of countering complacency, raising awareness and generating directorate-based investigation and action, in a blame-free environment. Reporting fosters a collective view that the occurrence of an HCAI is unacceptable at this Trust. For example, each MRSA bacteraemia generates a clinical incident report and immediate standardised investigations, which informs directorate-led action. The process contributes to a learning culture. Reports are encouraged and clinical governance training is regularly well attended. In the Surgical Directorate, attendance at the clinical governance session on infection prevention was included in the consultants’ appraisals.

Where next?

Further information on risks will be integrated into the feedback; including staffing levels, environmental scores, training attendance and even the number of bed movements per patient.

Performance management will soon be extended to the non-clinical directorates such as IT, human resources, pathology services and estates and facilities, with appropriate frameworks designed for each. Infection prevention is being integrated into consultant appraisals and into leadership training for managers.

HOMIP works. Infection prevention has become a high-profile issue on shared management and clinical agendas, and the data analysis and feedback has fuelled much directorate-based action and success. At Trust level, in the past year, cases of MRSA bacteraemias have fallen significantly, the decrease is still sustained and this year it had the second biggest reduction in MRSA of all specialist Trusts in the country.

Behaviour change at an individual or single-profession level is not good enough. Neither is reliance on individual enthusiasm and short-lived campaigns. Sustainable improvement needs a systems-based approach which embeds best practice and drives cultural change. HOMIP is a long-term project an evolving, step-by-step, strategic approach, which is just beginning.
Case study
Leeds Teaching Hospitals NHS Trust
Engaging and involving Trust Directors in infection control

Key outcomes:
- Targeted decolonisation of high-risk patients
- 20% reduction in MRSA bacteraemia in one year and reductions in other HCAIs, eg Clostridium difficile
- Trust-wide ownership of infection control clinical and managerial engagement

Written feedback on progress with objectives was provided by the Director for Infection Prevention and Control to the Trust Headquarters Management Group.

Also, ‘attainment of the objectives was part of the performance review of individual directors, carried out by the Chief Executive’.

At the same time, each Trust clinical directorate (clinical management team) was required to commit to a plan to address infection control issues, via the clinical management team performance management framework. Specific projects included the cleanyourhands campaign, placing hand hygiene signs (in the most common languages) at the entrances to all hospitals and wards, peri-operative mupirocin-based prophylaxis against MRSA and MRSA risk factor analysis in targeted clinical areas (ITUs, renal units, elderly medicine, gut surgery) with high incidence of MRSA bacteraemia.
Recent awareness-raising work included a campaign week in which senior Trust clinicians and managers took a personal role in demonstrating the Trust’s commitment and the operational priority being given to proper use of hand gel.

**Barriers and outcomes to change**
Directors’ objectives were chosen that required considerable organisational input and Trust-wide implementation. Previous experience has shown that it is these types of changes that are most difficult for the Infection Control Team alone to implement.

Business plans that were developed from the objectives were perceived to have a greater chance of success given the level of director involvement.

**Roles and responsibilities**
It was made clear that, although each objective was supported by a named member of the Infection Control Team, the prime responsibility for this lay with each executive director. The programme was overseen by the Director for Infection Prevention and Control and a Consultant Nurse, both of whom are infection control trained.

**Sustaining the changes you have made**
Focus on MRSA bacteraemia alone is unlikely to yield major improvements in infection rates as the control mechanisms for HCAI are clearly many and varied, and include organisational, protocol-driven and human behaviour factors. Continuous focus and feedback are required to maintain the impetus gained from the increased resource given to infection control issues. A new set of directors’ objectives has since been set.

**What are the benefits to organisation and roles, and to patients?**
MRSA bacteraemia cases have fallen by 20% (2005/06 compared with 2003/04 as baseline); reports of *Clostridium difficile* and ward closures due to viral gastroenteritis have also decreased.

Most importantly, the increased emphasis on infection control, clearly supported and actioned by the Chief Executive and directors, has enabled organisation change within a complex health environment.
Further reading and references


Improving patient care by reducing the risk of hospital-acquired infection: A progress report, July 2004, National Audit Office


‘Save 100 000 Lives’: Institute of Healthcare Improvement; available at http://www.ihi.org/IHI/Programs/Campaign/ (accessed 26 April 2006)

Saving Lives: delivery programme to reduce healthcare-associated infection (HCAI) including MRSA, June 2005, Department of Health

Ten reliability changes for service improvement and delivery: a guide for NHS Leaders, NHS Modernisation Agency, Leicester 2004

Towards cleaner hospitals and lower rates of infection: A summary of action, November 2004, Department of Health


Winning Ways: Working together to reduce healthcare-associated infections in England, December 2003, Department of Health