

Turning Strategic Intent into Practical Action

Adapting strategic management principles for
infection prevention practice

Suzie Hammouche

We are busy, but are we strategic?

Most IPC programmes are operationally driven - the day consumes the plan.

What fills the day

- Outbreak and exposure response
- Audits inherited from previous years
- Accreditation evidence gathering
- Committee papers and policy review
- Dealing with queries and BAU

What moves the programme

- Deciding what we will NOT do
- Anchoring IPC to organisational goals
- Measuring things that can actually change
- Building the coalition before the launch
- Costing the ask, and naming the trade-off

The left column is urgent. The right column is important. Only one of them gets protected time.

Four areas, borrowed from business

Not new theory - established management practice, applied to an IPC programme.

1

Shape the service

Business planning. Ask the organisation what matters, cost your programme, and make the trade-off theirs.

2

Measure what matters

Impact versus effort. Stop the rituals. Spend your hours where the evidence and the variance are.

3

Influence, don't instruct

Stakeholder analysis. Find the blockers, understand them, and convert them.

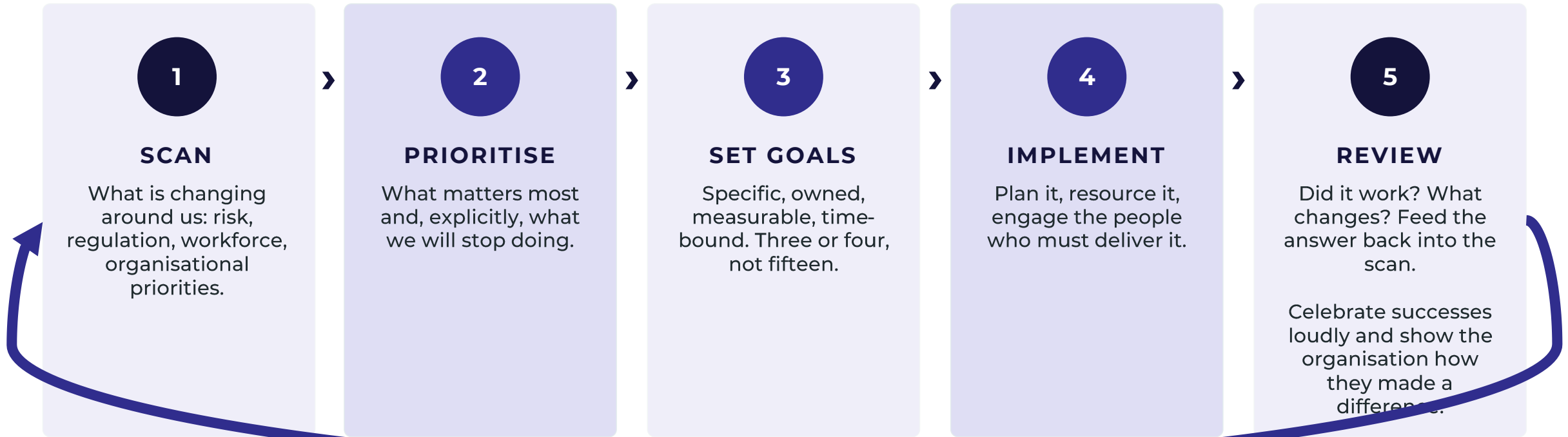
4

Make it stick

Implementation planning and a review cadence that surfaces failure early enough to fix it.

What setting a strategy actually involves

Five stages. Most IPC programmes live permanently in stage four and rarely visit the others.



Stages 1 to 3 are an annual conversation. Stages 4 and 5 run continuously - and stage 5 is the one almost everyone drops.

1. **Stop trying to do everything**

Shaping the service

Start by asking, not assuming

Environmental scanning begins inside your own organisation.

- 1 What are the organisation's top three priorities this year - in their words, not ours?
- 2 Where does IPC already appear in the strategic plan? Where should it?
- 3 Which board-level risks do we own a share of - and who currently owns them?
- 4 What is the executive being held to account for that we could help deliver?

If your improvement priorities cannot be traced back to a line in the organisational priorities or material clinical risk, they will struggle for executive attention.

Cost the programme in hours

A worked example: every activity priced, and mapped to something the organisation already cares about.

IPC activity	Hrs/week	FTE	Aligned organisational priority
Surveillance, data and reporting	22	0.58	Board risk register / accreditation
Hand hygiene audit programme	14	0.37	NSQHS Standard 3 compliance
Environmental & equipment cleaning audit	6	0.16	HAI reduction / bed flow
Outbreak response (annualised average)	10	0.26	Business continuity
Education and competency	8	0.21	Workforce capability
Policy, committees, accreditation	12	0.32	Clinical governance
Improvement and project work	12	0.32	Strategic plan delivery
TOTAL REQUIRED	84	2.2	Funded establishment: 1.6 FTE

Gap: 0.6 FTE - roughly 23 hours a week of work with no one funded to do it.

“

The programme requires 2.2 FTE.

We are funded for 1.6 FTE.

**Which activities should we
deprioritise, and what residual
risk is the organisation prepared
to accept?**

”

This does not make you difficult. It moves an IPC resourcing problem to where the accountability actually sits - and it puts the decision, and the residual risk, in the minutes.

From cost centre to investment

Same programme. Different language. Very different conversation.

Cost centre language

- “We need another FTE”
- “The standard requires it”
- Reports activity: audits done, sessions delivered

Investment language

- “This returns X bed days and Y dollars”
- “Here is the return on three hours a day”
- Reports outcomes: infections avoided, cost avoided

Investment vs Costs – CLEEN

1 in 10

Patients will
acquire an HAI

7.8 days

Increased
length of stay

\$2.6k

Per bed day

500 bed hospital

14.3k

Extra bed days

\$37M

Additional costs

Assumptions: Average stay of 5.7 days. 86% occupancy rate. 33% of patients stay <48 hours

Intervention

\$530k

Additional
cleaners

\$47k

Auditor labour
costs

\$59k

Additional spend
for consumables

10% reduction in infections

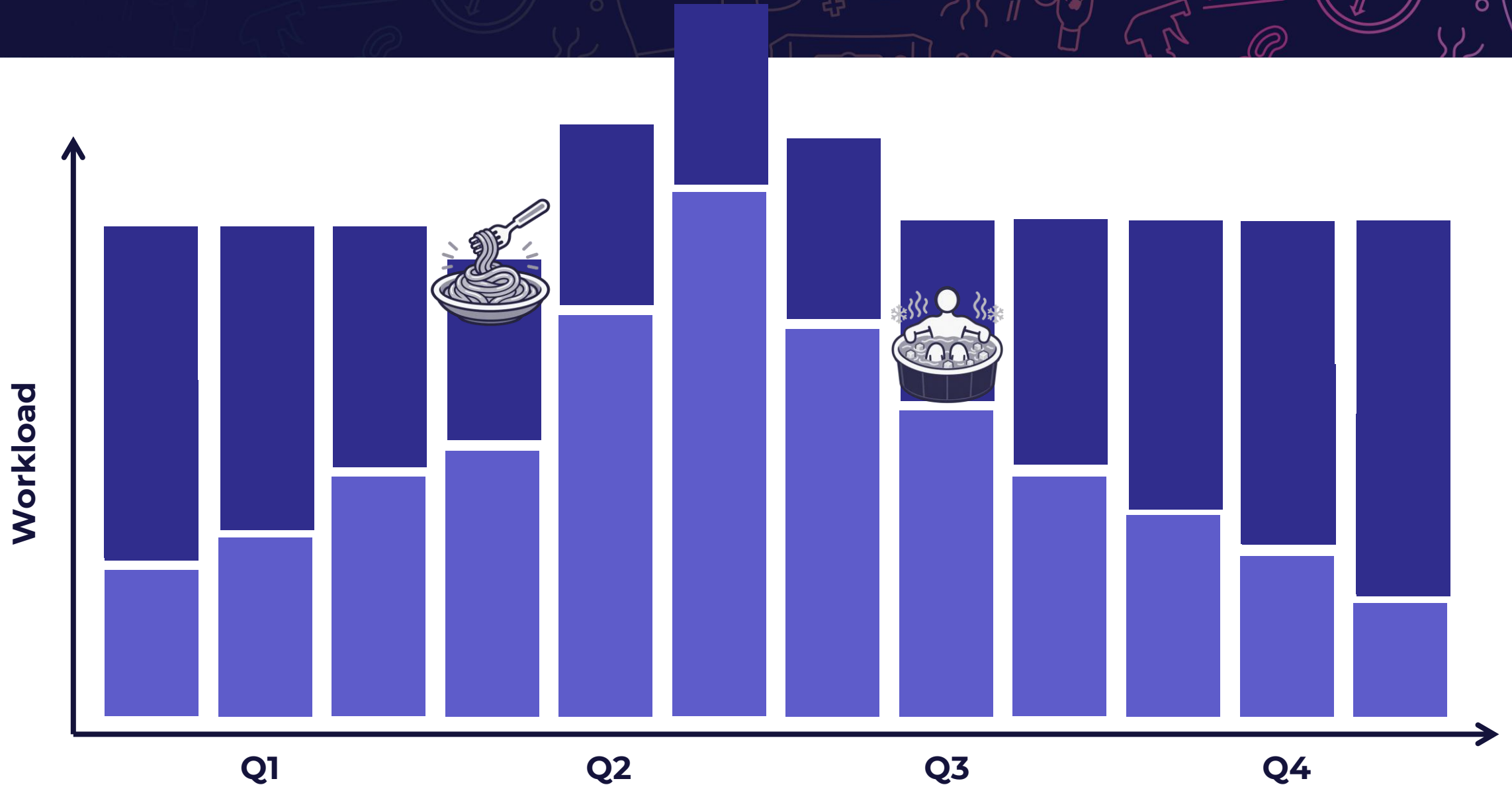
1,439

Bed days saved

\$3.1M

Saved

Managing the Workload



2. Measure what matters

Impact versus effort: the biggest
bang for the buck

Plot every activity before you protect it

Impact on patient harm, against the effort it consumes. Do this with your team, out loud.

IMPACT ON HARM	HIGH	DO NOW • Shared equipment cleaning + feedback • Clear escalation pathway • Targeted line-care bundle	PLAN AND RESOURCE • Surveillance system rebuild • AMS integration • Ventilation / build programme
	LOW	FILL-IN • Signage refresh • Ad hoc ward education	QUESTION IT • 100-moment HH audits sitting at 98% for three years • Annual policy re-formatting • Routine environmental swabbing with no action rule
		LOW EFFORT	HIGH EFFORT

The inherited audit vs. the audit that acts

Audits are often performed ritually - because we have always done them - rather than because they act.

Direct observation, ritually performed

- Observer effect inflates the result
- Compliance parked at 95-99% - no variance left to act on
- Large, recurring labour cost
- Feedback loop rarely changes anything

Quantitative, evidence-linked auditing

- Objective marker: fluorescent gel, ATP, direct measurement
- Real baseline - thoroughness often starts far lower
- Audit-and-feedback with randomised evidence of infection reduction
- Every result has an action attached

**Ask of every audit: if this comes back good, what will we do differently?
If the answer is “nothing” - why are we spending the hours?**

Four tests for any measure you keep

Apply these to every audit, dashboard and KPI in your programme.

1

Does it vary?

A metric with no variance carries no information.

2

Can we act on it?

Is there a named owner and a defined action for a bad result?

3

Does it link to harm?

Can you draw the line from this number to a patient outcome?

4

Would you defend the hours?

If asked to justify the labour cost at exec, could you?

Anything that fails two or more of these (without a regulatory or assurance rationale) is a candidate to stop – and the freed hours are your improvement budget.

3. Influence, don't instruct

Stakeholder engagement and
change management

IPC has almost no authority over the people whose behaviour determines infection rates.

So we borrow authority - from the policy, from the standard, from the executive. It has never reliably worked. Influence is not a soft skill in IPC; it is the delivery mechanism.

“The policy says” has never changed a ward.

Map who will back you - and who will block you

Do this on paper for your next initiative. It takes twenty minutes and it changes the plan.

POWER / INFLUENCE

KEEP SATISFIED

High power, low interest

- CFO / finance
- Operations and site managers
- Procurement

Your blockers usually live here

PARTNER CLOSELY

High power, high interest

- Director of Nursing
- Quality & safety executive
- Clinical governance lead

Co-own the plan with them

MONITOR

Low power, low interest

- Peripheral services
- External suppliers

Minimal effort

MOBILISE

Low power, high interest

- Ward IPC champions
- Environmental services staff
- New graduates

Your delivery engine

LOW INTEREST IN IPC

HIGH INTEREST IN IPC

Work the blockers - they are rarely opponents

Usually the cost of your request is visible to them and the benefit is not.

1

Name them

Be specific. "The execs" is not a stakeholder.

2

Find their metric

What are they personally measured on this year?

3

Translate

Restate your ask in the currency of that metric.

4

Share the win

Share the result publicly.

In practice

The blocker: an operations manager resisting dedicated equipment cleaning time. **Their metric:** bed turnaround and throughput. **The translation:** this is not extra work - it is bed-day protection, because every HAI costs you days you cannot recover. Then you ask for the resource to do it, jointly, in their name.

4. Make it stick

Implementation planning and the
discipline of review

Put the whole plan on one page

If your IPC strategy runs to thirty pages, nobody on a ward will ever read it. Six columns is enough.

Objective	Why the organisation cares	Owner	Measure	Milestone	Resource
Reduce HAP by 25%	Board risk register; mortality	IPC lead + ward NUM	HAP per 10,000 bed days	Baseline wk 4, review wk 12	0.2 FTE + consumables
Shared equipment cleaning to 90% thoroughness	HAI reduction; bed flow	Environmental services manager	Fluorescent marker audit	Wards 1-2 by Q1, all by Q3	3 hrs per weekday
Named IPC link on every ward	Engagement; escalation speed	Director of Nursing	% wards with a named link	All wards by end Q2	Nil - reallocation

Two rules. Every line has one accountable owner at the level where delivery can actually be controlled - and that should not automatically be IPC. If you own everything, nothing is owned.

Every objective carries a resource, or an explicit note that something else stops to pay for it.

Cadence helps us manage the pace

Implementation fails quietly. Cadence is what makes the failure visible while it can still be fixed.

Rhythm	Who is in the room	What is reviewed	The decision made
Weekly - 15 min	IPC team only	Milestones on track? What is blocked this week?	Unblock it, or escalate it today
Monthly - 30 min	IPC + ward and service owners	Measure trend by ward, named feedback to each owner	Adjust the approach; re-target effort
Quarterly - 60 min	IPC + executive sponsor	Progress against plan, hours actually used, emerging risks	Continue, stop, or re-resource
Annually	Executive / board quality committee	Whole programme against the organisational strategy	Re-scan, re-prioritise, re-cost

The quarterly review is where the costed plan comes back out. It is not a one-off document you wrote to get funding - it is the agenda.

Four signs the implementation is failing

Spot these at a review and act. They rarely resolve on their own.

1

The measure has not moved by the second review

And nobody has changed the approach - we are simply doing the same thing harder.
Should the measure be a leading indicator?

2

The owner has changed twice, or the owner is still you

Ownership that keeps moving was never really accepted in the first place.

3

Reporting has drifted from outcome back to activity

When the outcome is not moving, teams start reporting effort. Watch for it.

4

The people doing the work cannot say why

If a ward cannot explain the purpose in one sentence, it will stop the moment you look away.

Any of these at a quarterly review is a trigger to stop and rethink - not a reason to try harder.

What can be learned the hard way

Lessons from implementations that worked - and several that did not.

What fails

- Launched trust-wide at once, with no ward-level owner
- Relied on email, policy and the intranet
- Measured process, then had nothing to show at six months
- Added work without removing any
- Went for the enthusiasts and ignored the blockers

What works

- One named owner per ward, before go-live
- Started where the data was worst - easiest win to see
- Paired every ask with a resource or a removal
- Fed results back within four weeks, by name, to the ward
- Converted one blocker before scaling

The difference was almost never the intervention. It was the implementation.

Thank you