Transcript: Joint RCPath / HIS webinar - Communication in IPC: Spreading the message rather than infection! | 12 OCTOBER 2022

Watch the webinar

During this webinar our audience submitted their questions to our expert panel:

- Cariad Evans, Sheffield Teaching Hospitals NHS Trust
- Martin Kiernan, University of West London
- Sara Mumford, Maidstone and Tunbridge Wells NHS Trust

Chairs:

- Natasha Ratnaraja, University Hospitals Coventry and Warwickshire NHS Trust
- Gayti Morris, Sheffield Teaching Hospitals NHS Trust

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Gayti Morris 00:04

So, hi everybody. I think we'll make a start. Really warm welcome to everyone who's joining us this evening. It's my pleasure to co-chair alongside Natasha, the very first joint RCPath and HIS webinar on *Communication in IPC spreading the message rather than infection*. My name is Gayti Morris, I'm a consultant microbiologist and Infection Control Doctor based at Sheffield Teaching Hospital. I'm also a member of the HIS Council and sit on the RCPath Medical Microbiology and Medical Virology Speciality Advisory Committee.

And so the format of today's webinar will take six audience led questions which will be answered and discussed by our expert panellists. We'll also have the opportunity to ask questions and make comments in the question and answer box, the chat however is off. And with no further ado, I'm really excited today to introduce our panel who have a real breadth and depth of IPC knowledge, including and this is key, experience of how to communicate effectively.

So first of all, Dr Cariad Evans, do you want to give us a wave? Cariad is working as a clinical consultant biologist in Sheffield covering South Yorkshire North Derbyshire regional hospitals. She's also a member of NERVTAG and joined in November before the pandemic. I'm sure not expecting what was to come. She has contributed to numerous groups during the pandemic as well advising the Department of Health and UKHSA on evidence around face coverings and AGP'S. She's also part of a local clinical expert group advising the trust through the pandemic on IPC, testing and other matters and is the Sheffield Hospital HCID for virology and also a national HCID research group member.

And then next to her we have Martin Kiernan who's worked in the NHS as an infection prevention control nurse for 30 years and ended up deputy infection prevention control director. He's also had lots of experience ARHAI in England as well 10 years which finished 6 years ago, and was an ex president of the Infection Prevention Society and has contributed as the HIS scientific secretary to many of our meetings. He retired from the NHS six years ago but now works for the University of West London and Newcastle and Avon Dale universities but they're not where you might expect them to be. They're in Australia in New South Wales, he is currently a clinical consultant to Gamma Health Care and also has first hand experience of working in the NHS London Nightingale during pandemic.

And last but not least, we have Dr. Sarah Mumford, who is the director of infection prevention control and consultant microbiologist at Maidstone and Tunbridge Wells hospitals. She has a particular interest in infection prevention, infectious diseases, patient safety and medical management. And there she's really led a turnaround in infection control across the trust including addressing *C. diff* and MRSA infections. And in 2014, their infection prevention control team were placed second overall and then the best acute trust in the IPS cited team awards that year and during COVID 19 extra experience in being seconded to another trust to lead successful turnaround there of IPC.

Gayti Morris 03:59

And Dr. Mumford also led a number of other management roles including clinical director of diagnostics and Deputy medical director. So now I'll pass you on to Natasha to give you a little bit of background.

Natasha Ratnaraja 04:16

My name is Natasha Ratnaraja and I'm a consultant in infection at the University Hospitals Coventry and Warwickshire in the West Midlands, and I'm also the chair of specialist Advisory Committee for medical microbiology and medical virology at RCPath. If we could just have some slides. Thank you.

Natasha Ratnaraja 04:36

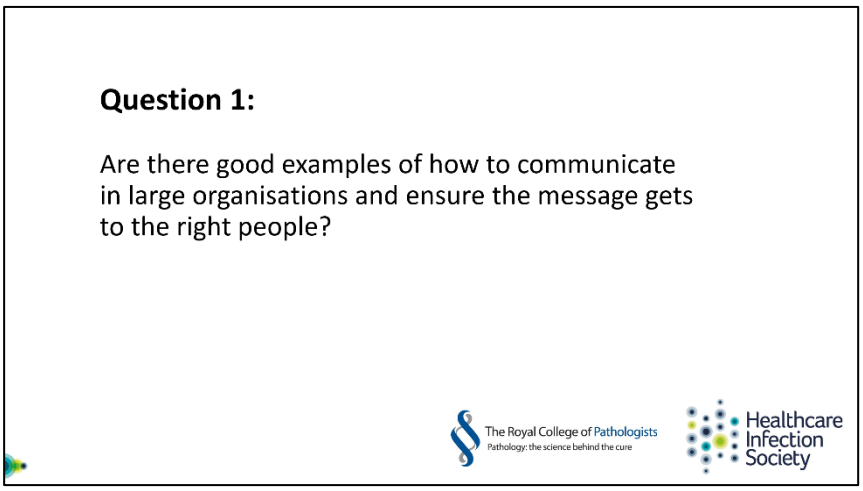
So just to give you a bit of a background why we chose this topic, infection control is such a broad subject. But what the recent pandemic has brought out is that it's really important to get that communication about communicable infections out in an appropriate manner so that we can have safe management and we actually see this all the time in infection prevention and control. And we'll undoubtedly see something this winter where we have to manage and communicable infection and as you all know, it requires a multidisciplinary approach. It isn't just the remit of the infection specialist and infection prevention and control specialists.

We have to involve really a board to ward approach as well as liaison with our colleagues in the community. And that's there to protect patients. But also staff and visitors. And as we all know, from the recent pandemic and even the swine flu pandemic management algorithms may not be there or may need to be changed at short notice, and they might be at odds with what you feel is the appropriate path to take. And often they can be conflicting views with other organizations and your own view. Next slide please. And then there's plenty of challenges. Think the flu pandemic of 1918 didn't have social media so it was slightly easier, one would argue, to contain but as well as the negative aspects of social media there are also some positive aspects of social media, and it's how we harness those that's the challenge.

We need to make people feel involved, bring them with us and not having them feel that they are being forced to do something. And that was seen in the early stages of the pandemic, but then the fatigue sets in as it can do amongst healthcare professionals, we can get Infection Prevention and Control fatigue and everybody has their personal limits about what is what they can tolerate, as we've seen with lockdown fatigue. Even outside of a pandemic, people can become blind to communications. We all walk past all the posters that we ourselves put up infection prevention and control just because we were so used to seeing them and when things are going bad if one gets involved, but what happens when things are going well, people might become apathetic because we're doing a good job. And that's when actually the danger might be that things could go wrong so good communication is essential. And this webinar is hopefully going to open up the discussion, what experiences our expert panellists have that can help us to meet these challenges. Thanks. So, the format, as Gayti said, would be six questions that have been sent in by participants, thank you to everybody that submitted a question and each question will be led by a panellist but all three panellists will contribute.

There is an eight minute time limit per question but you can post comments and questions in the Q&A box. And then if you wish to upvote comments and questions, please feel free to do so. If we did have time in that eight minutes slot, we can then mention your comments or ask additional questions. So I'll hand you over to Gayti.

Gayti Morris 08:03



Thanks Natasha. So if we can have the first question, please. So this is a really good one, I think.

And Sarah, I think you might have some thoughts on this one.

Sarah Mumford 08:24

Yes, thank you. I don't think there's a right answer to this. I mean, there isn't a single thing that you can do that you can guarantee that that's the way the message should be conveyed. You have to take a really wide approach and use absolutely everything and every approach in order to get communications across because it's not actually so much about the communication and the message it's more about the recipient and some people receive the information in a very different way to other people. So I think you have to do an approach which includes all sorts of different routes of getting to people and there is obviously the email approach. The newsletter, the daily, during COVID we did a daily news thing that went out to everybody. If 20% of our staff read it that was a real success. And we sent a separate one out also to managers just to say these are the messages we want to cascade but again they were very limited in the number of people who would actually read it. I think there is nothing to replace that personal touch so whether you do it by going out and speaking to somebody who can then cascade it, so use the ward rounds. Use the team huddles, use handovers, if you've got a really simple succinct message that's where you can really have an impact and get your message across really quickly. But there's also something about how we message upwards and how we get our executive and board members bought into what the message that we need to get out is.

And so you need to message up to them again. Email is better for them because they're all in their offices or at home reading their emails all the time. So that's an easier route. But actually, teams has been amazing in the pandemic, for doing this so that you can get those messages over and if there is a single person who is absolutely crucial to what you need to do, what you need to address, then I'd go and see that person and just sit down and talk to them. Because if you can get that single person who might be in charge of the whole operational structure or something like that, then those are the people that you need to get your message to implement it and start that cascade downwards.

But I know nothing about social media. So I know it's used and you have to make friends with your comms team Because they will have all of the tools of the trade at their fingertips, it's that multi directional approach which is the way to go.

Gayti Morris 11:57

Do you have anything to add to that maybe specific things that you found useful in your organizations? Yes, Martin.

Martin Kiernan 12:04

Serious point about getting the message over to different groups is interesting. But what I think we don't always do is ask people how they would like to receive information. So if you're trying to get at the hotel services staff environmental service workers, they may not even have an email address your average staff nurse may not be able to access it or work and you know, people access their information in a lot of different ways these days and I think doing a bit of work with different staff groups saying okay, how would you like us to deliver information to you that's relevant and what would be the most effective way of you getting it? And may be a WhatsApp Group, you know, it could be anything really that we don't really always know how people would like to get the information and I think that's something well worth exploring, something I've never seen studied. But we're trying to put out one piece of information which goes to management, right the way down through the organization, and they all access it in a completely different way. And they don't access their information in traditional ways anymore. So it's thinking outside the box.

Sarah Mumford 13:05

I absolutely agree with you Martin and doctors particularly love WhatsApp. Groups, and it's a really good way of getting messages out to them. We did actually ask our staff how they would like to be communicated with they didn’t know.

Cariad Evans 13:26

Yeah, we found that as well. We tried to say, you know, what are the best modality and they didn't know, it was all information overload, I think that was quite difficult. But I think I think it's a really valid point is how you how you identify it's not just about how you communicate with those different groups and how they want to receive that information. It's about that information being relevant to them as well. So we might frame it in a certain way that we think it's important, but actually for individual staff groups, it has different relevance and different applicability. So it's also trying to understand that as well. So then it's more powerful and more informative, if you understand how it's relevant to their particular working and their contribution to the organization. Thank you.

Gayti Morris 14:23

I guess any of our panellists, did you do anything that you did specific, a specific strategy that you used? Maybe either during the pandemic or other, you know, other issues that have been addressed. For example, you know, *C. diff* infections, MRSA or influenza that was particularly effective.

Martin Kiernan 14:44

And I can give you an example from Nightingale, which I actually thought was one of the best communicating organisations going at the London Nightingale because there was a daily clinical meeting. Anybody could bring a problem and when I say clinical meeting it was every department turned up, it was run by the medical director, a department would turn up and say I'm sorry, I've got a problem and it would be fixed because three or four other people stand up so I can sort something out. But actually the for the clinical staff, what they would do is when they came out of the shift, and looking at 12 and a half hour shift, there was a big board where you wrote a problem and when they got back for the next shift the solution was written in the next column. So it's a very much a you said we did and it was so it was looked at constantly and there's several people identify the same problem. And in that 12 hours, because it was staffed obviously all the time people would work on Here's is the potential solution. So it showed people it was actually worth identifying a problem because there was a chance that it was going to get a solution, if not immediately that it would be definitely picked up and worked on. So I thought that was a very good example of two way communication. So you could you didn't have to hang around or tell anyone about it. You just wrote it on a board and then you went and the answer was there when you came back the next day. So I quite like that.

Gayti Morris 16:02

Thanks, Cariad. Did you have your hand up briefly then as well?

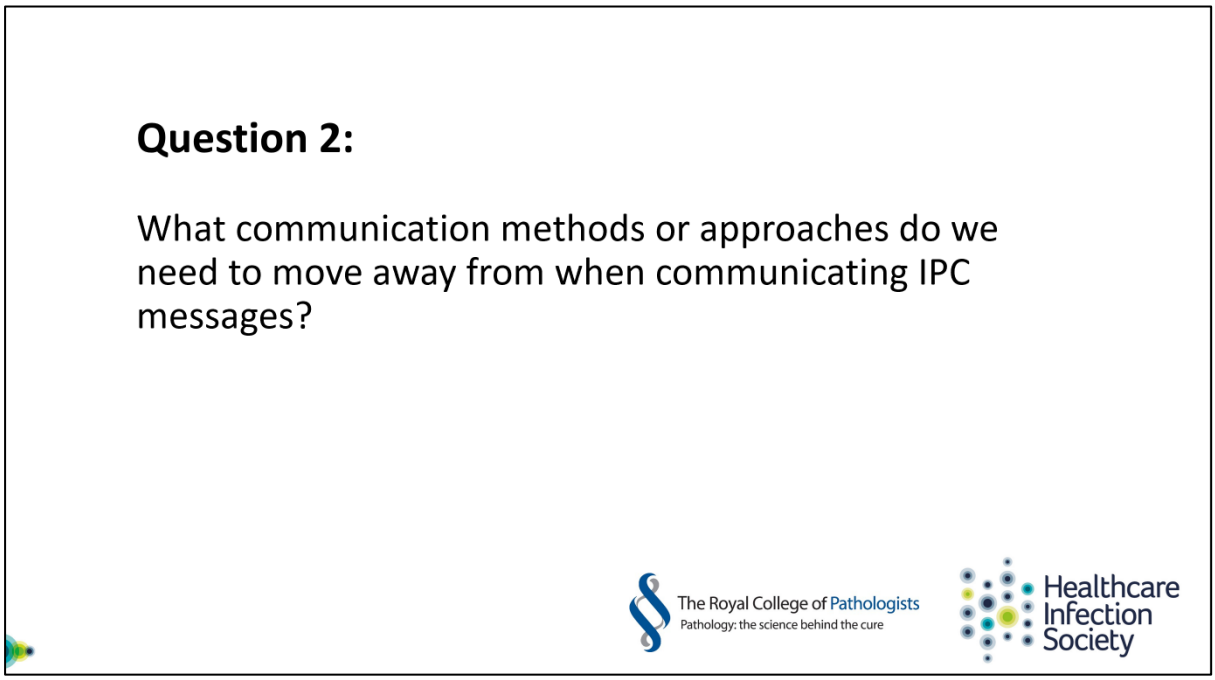
Cariad Evans 16:05

Yeah, I've got host of ideas I was gonna do a bit more in question four.

Natasha Ratnaraja 16:22

If we could have the next question.

Question 2



And Martin, I think you're going to lead on this.

Martin Kiernan 16:34

Yeah, I'm gonna have a stab at it, to me firstly, I think it depends on the sort of information you're trying to deliver. Is this new information? Is this a guideline update? Is this audit results? Is it outbreak reports or something like that? And I was gonna say, we don't ask people how they want to receive these sorts of messages, you know, is a local TikTok group or something like that useful but I think the Infographics are useful but just writing reports isn't very useful. I don't think people find a report very helpful at all unless they actually have to have it and I got to be honest I once had to write a report for the local health group, external report had to be produced every week, they may not have it if it turned up late, one of my last ones I actually used Google Translate to translate it into Welsh just to see if they ever read it. And I've sent it off to them, and they're either all fluent Welsh speakers, or they never read it. So it's actually do they actually really want this information anyway. But what I think we need to move away from is being careful with the language. So you know, we talked about compliance a lot and I hate the word compliance because it sort of infers subservience, infers you're being told what you do. So I think we have to move to a bit more a positive way of talking about things. I think we have to be definitely non punitive about it. Otherwise, what happens is when you communicate the message, if it's punitive at all or critical at all, people go straight into the five stages of grief and you get all the denial, the bargaining and why wouldn't you know, it wasn't me and I wasn't on duty and well, that's a while ago. I think we have to move away from periodic reports say audit reports that come out three months later, because things have moved on. And that was different then. So that timely information I think, is always extremely useful. So six monthly reports are no good at all. And neither I don't think our organization wide reports our C Diff rate is x per 10,000 bed days or whatever for the whole organization.

Martin Kiernan 18:37

Actually, we should be able to tease out a bit more local information that might make people a little bit more interested. You know, why is that ward actually got a higher rate over the last two years than some other wards and what happens is it actually can put out a report and a non punitive way and just state these are the facts, rather than ward X is much higher than the others it's five times higher. You just put the numbers in and people then start to read the numbers, and then they start to get maybe we got a bit of a problem here because I always found that if I told someone they've got a problem, and you need to sort it out, they never own the problem. They don't realize they've got a problem. So that's really not going to get people on board. Whereas if you say we've got a problem, how will you sort it out, that's not great. If we say we've got a problem how do we fix it? That's even better. But actually if people start to think for themselves, actually, we think we might have an issue here. So how do we fix it? Then you become the firefighter. Now they realize they have a fire and you're the person that goes in to help them put the fire out. So I think the way we phrase our information is really quite useful. So definitely non punitive definitely has to be timely. If we can make our reports customizable because often it's just a bland report, but if we were able to share our information with people so they're actually able to customize it and look at it themselves. That's really great. I also have to think, you know, I have to say we have to look at the direction in which our information goes in the organization as well. So I'll give you an example of cleaning audit. Might be done and it goes up the organization. And if it's not great, by the time it gets to the top, it becomes a bad report.

Martin Kiernan 20:14

And then the person at the top starts kicking everybody all the way down until they get to the poor person at the bottom and the poor person at the bottom. May actually have been trying to do extremely their best. But I actually had no feedback on what their performance was like. And though because they didn't know what their individual performance was like they weren't able to use any of their own data to say to their supervisor, well actually, look what's happening here. This is all the time I've got you know you've changed the format of this ward, for example, from being a ward where people's average length of stay is two weeks toit's a day case Ward and you haven't increased the number of cleaning hours therefore, how on earth am I supposed to do this? So that's why I'm failing cleaning scores but it doesn't. It doesn't go in that way. So it goes up as bad news and comes down as worst news to the poor person at the bottom. And so I don't think we are brilliant at doing that either. And I also think one thing I think we should try and stop it unless we absolutely have to is I try not to involve director of nursing or the chief exec in a campaign unless I'm absolutely certain, that they are really, really behind it. They often say oh yeah, we really support this. But they do it in such a lukewarm way. Everybody knows they're really not that bothered. I can remember going on a C. diff visit with the DoH back in the day to an organization that had a high rate. And the chief exec sat down at the meeting and said, Yes, we'd really you know, we realize we've got a problem. You know, we really want to be average.

So that killed everything immediately because his messaging to his organization was my aspiration for this organization is just to be average and so everyone knew he wasn't really that bothered. And the problem for him was of course if he stayed average, and everybody else got better, he was still going

to be worse. So I think we have to be careful about where we send our messaging to, and only include people who are really absolutely behind it and I'd rather let people think the chief exec or the director of nursing was 100% behind it than actually get the feeling that really, really they weren't so you know, I think we have to move away from negative messaging and try and put it in positive ways. There are opportunities for improvement. I've done UV audits in the past and instead of doing UV audit myself and going around marking rooms, and saying, Okay, well you missed four out of the 10 you actually give it to the two domestic things, and they do each other's rooms, and then they talk to each other about what they missed, and I realized that I hadn't really done that. And that's a better way of communicating the fact that maybe there's things that they can improve on. So opportunities for improvement. You know, we're doing great and I understand your problem but you know, there are maybe other things we can help you with, and then using those to tease out what the barriers are. So that's what I'm thinking. So any other contributions from colleagues?

Cariad Evans 23:03

The only other thing I have noted is, there was quite a lot through the pandemic of guidance and documents that would have changes, nuances, isolation periods reduced down and things like that, that we were quite guilty of sending long proses with small detail changes that weren't clear, weren't highlighted and therefore required individuals to read the entirety of it to even pick up on what the new take home messages were. So I think that came from top down as well. It was huge documents that we were sending you were just looking through them just going what's new, what's the update, what have they changed, and that's extremely difficult to sort of penetrate and then take on board. I think therefore, I completely agree with what you're saying Martin and all those large documents than those pieces of guidance are not helpful for communication and on the ground you just need bullet points, highlights, updates.

Sarah Mumford 24:10

That's important, isn't it? Because it's beholden on us as the people giving out the messages to not just give a message not just do this, do that but actually say this is the reason that actually distil out the simplest way of describing what the reason is because all the way through the pandemic there was why are we doing this now? we were doing that yesterday and now you want to do the opposite. So why are we doing that? You absolutely have to give them a very clear explanation why the change is taking place, even if we make it up a little bit because actually the guidance wasn't that clear either

Natasha Ratnaraja 24:53

One of the other questions because we are almost out of time. But there is a question in the Q&A box for Martin, which is “What word would you use to replace compliance?”

Martin Kiernan 25:03

Oh, that's a really difficult one.

But we talked to a language expert about this earlier last year. There's a lot of very cold words we use and trying to find a warm word. I haven't found one yet. Really. I wondered about concordance or I'm really I'm still struggling to be honest to find a word but it's all it's all about optimizing the opportunities to do the right thing rather than complying. So if you haven't complied with hand hygiene, that's not great. But maybe we're talking about some sort of safety index rather than hand hygiene compliance.

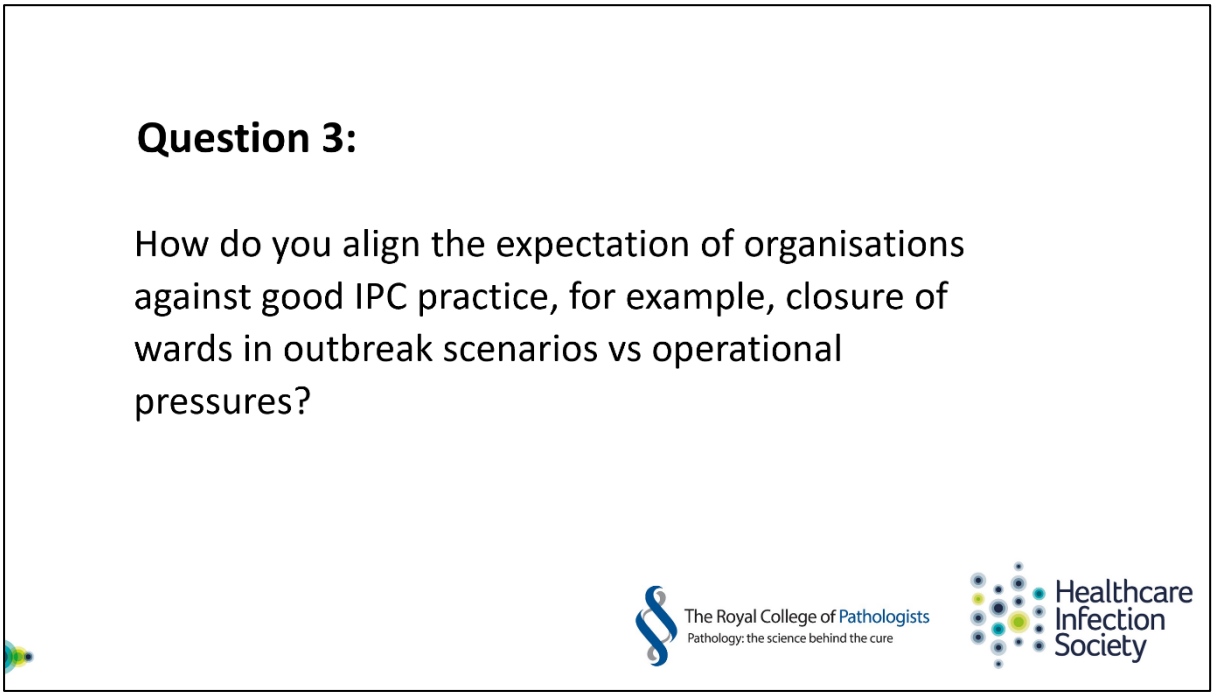
Not that make a difference because it's all 100%, anyway, according to most reports.

Natasha Ratnaraja 25:45

I think it's a difficult one and one if anybody else would like to post in the chat their ideas. I'd love to hear it. And I'm going to hand it back to Gayti. So thank you all for that question.

Gayti Morris 26:02

Thank you if you move on to question three



Needing to keep that ward open, and I think, Sarah you have some thoughts about how you might approach this question.

Sarah Mumford 26:26

So this is this is still a really live issue, isn't it? You know, we're all our hospitals are full and we've got patients backed up in A&E, we need beds, we've got covid outbreaks on the wards, I've got 2 hospitals with over 100 COVID patients in them between the two. And if we have an unexpected positive in a bay and we want to quarantine those patients, even though we are not supposed to be doing that

anymore it goes against everything in our Infection Control souls to disregard that and to take a chance. And so this was described to me yesterday by our chief operating officer who said yes but what's the chance of dying of Covid and what's the chance of dying in A&E if you've been there for 12 hours you can't get into a bed and you're not being cared for as well as you would be in a bed and there's an absolute point there and I think this is all about having a really pragmatic view of infection control.

Sarah Mumford 27:40

Little bit, being a little bit less risk averse than maybe feels comfortable and really weighing up doing the risk assessment in your head, weighing up, what you can do. So what is possible what can you do to reduce the risks? How can we find beds that don't really exist? How can we keep as many of our patients safe as possible? And how can we manage that COVID and now flu, we've now got flu coming into hospitals as well, which is a totally complicating factor and making space for them as well. Personally, I find it's good conversations with our operational colleagues. We have to have to work really closely with them. We have to get away from dogma. So we can't say well, no, you can't do that because it's infection control. So absolutely no you can't do it. We have to find workarounds. We have to be thinking outside the box. And we have to be taking risks where maybe under normal circumstances it doesn't feel right to do that. We have to be brave and then make firm decisions which everybody can clearly understand what the decision is and then move on wait till the next crisis strikes.

Cariad Evans 29:22

Yes, I think that's brilliantly summarized there, I think working closely with the ops team that handles the operational huddles every day and those communications are really, really important. I think the only thing I'd like to add is just is what you're describing is having a bit more of a pragmatic view now in the advent of you know, vaccinated patients, and a reduction in mortality from COVID. And we've seen that in the hospital acquired COVID as well. That means that our, our conversations that we had early on in the pandemic and when we had that had huge support for isolation, identifying exposed patients, cohorting exposed separate from everyone else, you know, all of those patients flows that we could operationalize and we did have support for and they listened to us and they were exemplary in my experience of operationalizing a really complex challenge to the NHS to keep COVID patients, exposed patients and non COVID patients apart, to where we are now with no beds, everyone together. The thing that we found useful just sharing experience is we have the kind of principles of patient placement documents that we find quite useful for our flow matrons and our ops teams so obviously the ops folks aren't, you know, clinically trained many of them so it was quite helpful, I flew into that as well. So it's three o'clock in the morning. I've only got a certain number of beds. I've got the queuing our of A&E, where's my biggest risk? If I just think about these patients and where is safe to kind of try and put them if I can? That's helped a little bit in these situations because we found we have been phoned a lot in these crisis situations for advice, which becomes really difficult, doesn't it in our in our positions when there is only a few of us to be responding in that way.

Sarah Mumford 31:34

It does feel like all the precautions we had in place have just been nibbled away just gradually so, can we board patients, yes you can board patients but can we board patients in a ward where there's a

quarantine bay or Yes, you can do that but the patient mustn't be infectious and they mustn't be..... and you start putting conditions on to things to make it work and I had can COVID contacts go into discharge lounge and my infection control nurses were going oh no, only after day five, if they are still negative after day five then they can go to the discharge lounge and I said no, day one is probably the safest time to get them in the discharge lounge so let's put them all in masks if they are asymptomatic put them in a mask and move them out. That's the safest thing you can do. So it's a real learning curve. If we push it too far, I guess it's gonna go wrong. And we're gonna have ward based outbreaks and there's going to be problems but I think we are probably at this as you said with the vaccinated population that we're going to get away with it.

Martin Kiernan 32:52

And being pragmatic and showing willingness to listen to the other sides arguments and discussion. I've always been uncomfortable about putting people on the wrong ward. You know, if you're a cardiac case and you end up in orthopaedics, chances are you're not going to do very well. And if you're an orthopaedic patient and you end up on cardiology, you're probably not going to do brilliantly either. So it's not the days of medicine and surgery and long gone it's all very specialized. Now you don't get the best medical care, you don't get the best nursing care. So it's bringing those sort of aspects into it as well and showing that we're willing to enter into discussions but you know, sometimes you do have to put conditions on and sometimes you maybe have to lay down that, well, okay, I understand what you want to do, so here are the three things that are most likely to happen, you know, what could happen if you do that, and we might get away with it. This might not go very well, or it might go disastrously wrong. So that's what we have to decide and on a balance of probabilities. It's more likely to be you'll get away with it. So I could live with it with you, but we'll have to do a joint risk assessment together and being part of a team, I think is really important.

Cariad Evans 34:06

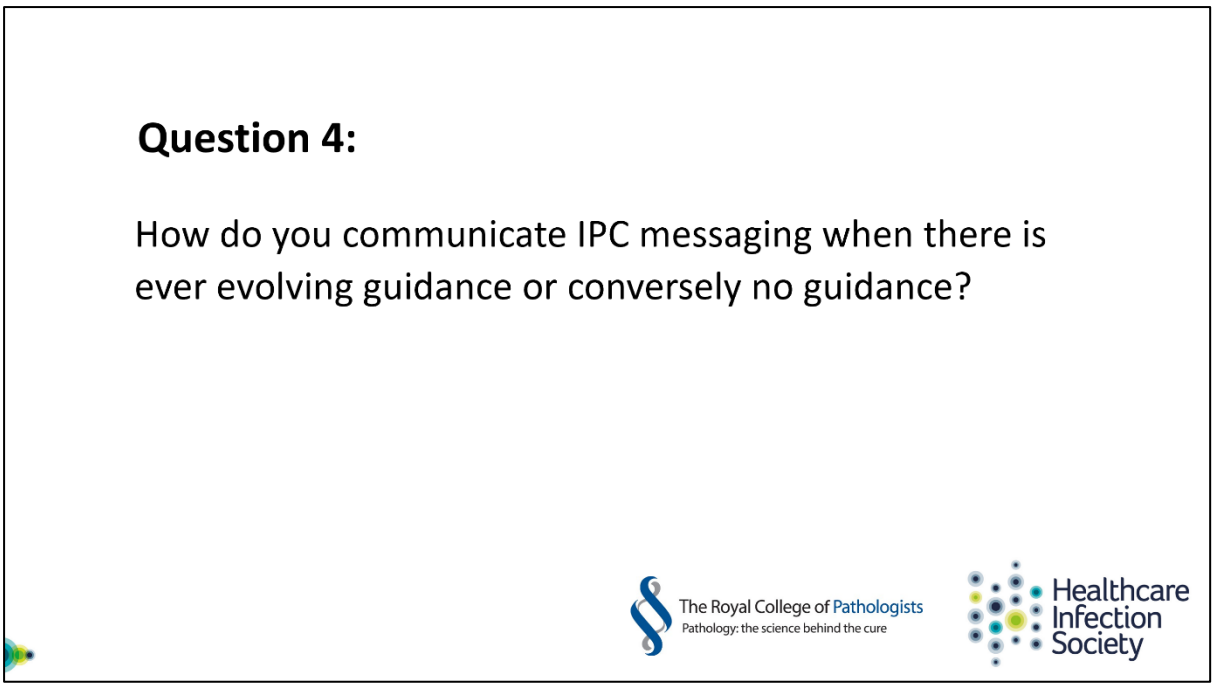
Great. Just to add on Martin I think building on all those other specialties starting to manage COVID patients was a big piece of work into this kind of phase of the pandemic that was really important because we went from COVID cohort and COVID care and very specialized, specific teams delivering that to COVID being you know, in all patients in all specialties, as you say they had to remain under their specialties and that came for those specialty reasons not for COVID reasons and engaging with all of those specialties that many of us have in previous walks of IPC worlds engaged with many of them before I had to then and help enable them to look after COVID patients

Gayti Morris 34:56

Really great discussion questions.

Natasha Ratnaraja 35:03

Question four



which I'm sure we've all come across recently. This one is for Cariad.

Cariad Evans 35:27

So I suppose I'd like to pick up on Sarah's one of Sarah's key points about communication, which was that personal communication I felt quite strongly that personal relationships with staff, specialties, areas within your organization and building on those facilitated all forms of IPC communication. And obviously, one person can't do that so how big a team can you get with your IPC team and with your IPC team to all have dedicated links to all departments, directorates, areas, that they then have their responsibilities to then communicate to those areas, with something that really facilitated that evolving, changing messaging and explanation of the logic for whatever it was that we have decided based not on guidance, but on expert opinion.

So some key things I wanted to share with everybody that we found brilliant, maybe lots of others, hopefully have used as well, but we have a team of PPE champions so every directorate from specialty has nurse, medic PP champions and we had a PP champions meeting, very frequent at the beginning and then went to weekly, then bi-weekly and what have you, on a Teams chat, so we talked about the usefulness of Teams. So you've got your PPE champs, they can get their messages out to their areas, they can field queries and calls in that area, and then they can chat on Teams chat back into the expert group and if they've got any queries or things that they were unsure of so that was great. We then kind of move towards the kind of staff welfare team. And they were, again, you know, IPC there is a focus, but much more holistic and going to all of the wards across the whole organization and we have them on the ground for months and months. And they were really fantastic about having conversations with people on the ground, challenging practice, thoughts, beliefs, interpretations of guidance and things like that. But in a really thoughtful, provocative and well being type way. We also had our matrons and our flow matrons, so, particularly at nights going out because it's quite difficult, a lot of night teams we find that they favour doing nights, so they will miss out potentially on communications and what's going on during the day. So then the matrons and the flow matrons would

go round in the evenings to go onto the wards and see what practice was going on. And again, just have some time with the individuals on the ground about what they understood as the current guidance and the current messaging.

And then, I suppose I'm a bit of a fan of an infographic and a flow diagram as many of my colleagues will laugh at me for, but me they are the bane of my life as well as being quite useful.

So I think having lots of visual aids, lots of posters, so when it's changing, you can highlight those changes. You can make it you know, you can quickly update those posters and get them out there. It's just simple, quick messages around what's needed.

I think the only final thing really to add is the evolving guidance. For me, I think the hardest things was having specialty bodies, have different guidance to UKHSA or NHSI I you know, those bodies. I found that extremely difficult to have those conversations with them those health specialties to try and align to different sets of guidance that were conflicting, both from very reputable sources, and both with their own intelligence, analysis, interpretation, and what have you, around that? And that's really hard when that's not your specialty and maybe is at odds with you know, with the mainstream guidance, and I found that quite difficult to engage with colleagues who have greater specialist knowledge in their area that were challenging some of the advice that we were trying to give that was at odds with their professional organizations. And again, I just think that it came down to sort of personal relationships and working out who's worked with those people for a long time, who knows them well, who can engage with them well, and ask your friends and colleagues just to take on those pieces of work streams for you to kind of help resolve those differences. Those are my thoughts.

Martin Kiernan 40:43

Cariad, how did you resolve the differences then because you've got one group who their professional body is saying one thing and from our point of view, NHSE/I is saying something completely different or something different. So actually, how did you get the resolution and which way did it go because you know, negotiation is always the art of not losing face, isn't it? And this often very entrenched view. So, I just wondered how you actually got to a resolution and what it was in that example?

Cariad Evans 41:14

Yeah, so that's a good question. So some examples I'd say were the actual individual lead for that specialty, had quite a fixed view. So when you actually brought in the rest of, for example, the consultant team and said, Can we have a team's meet? Can we all chat about this and see what the general consensus is across your specialty? Because this is an extremely difficult area and I do find it hard to advise, so let's see what everyone else says. And then you actually got lots of different views and it felt it was less like conflict between two individuals or two organizations. And then he came to quite a nice pragmatic decision. So sometimes then we would just have a hybrid of that specialist guidance and whatever other guidance for just our Trust or our locality based on expert opinion from those specialists, so I did that a few times to help resolve that.

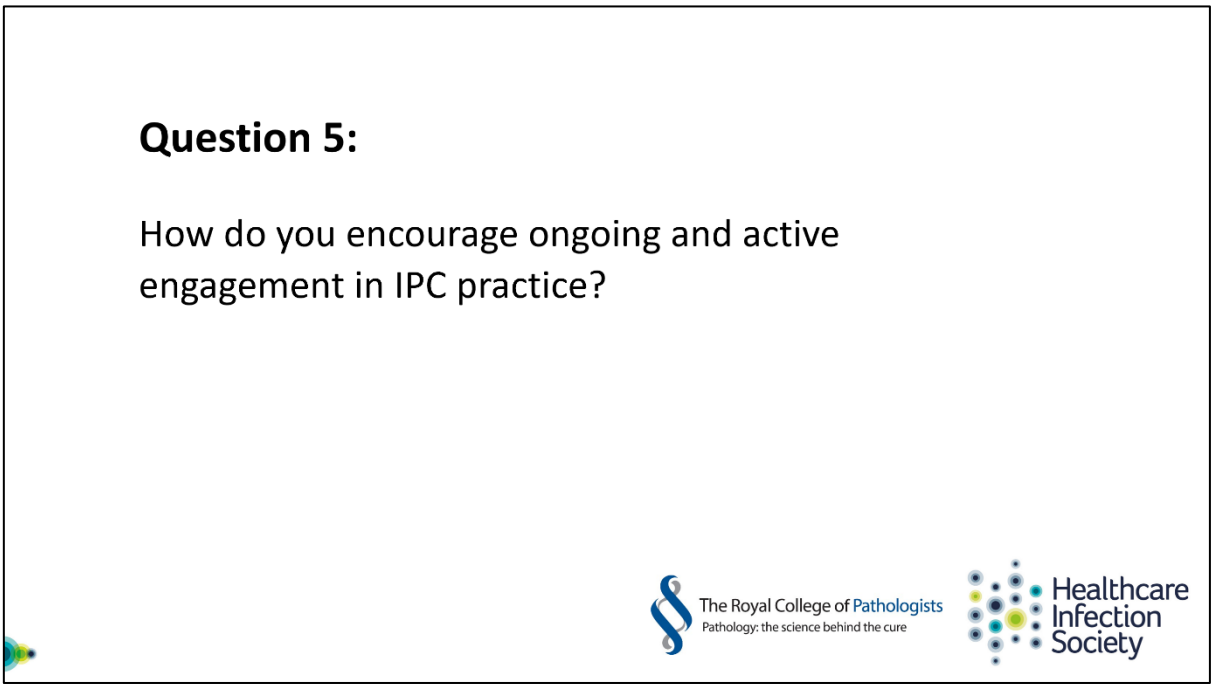
Sarah Mumford 42:16

So my take on that was pick your fights. So, like the resus counsel advice, for which everybody you know, all the resus teams desperate to support that wanted to wear FFP3 masks. It wasn't a fight worth having. I had consultants say to me, yeah, but if someone collapses in front of me, there's no way I'm going to walk away and go and get an FFFP3, I'm just going to get on my chest, you know, forget it. I'm not doing that. So we came up with a compromise, which was, this is what we're doing. We're following the resus counsel guidance, but for senior clinicians, if you choose to risk assess that for yourself and take that risk, that's absolutely fine. But please don't encourage your F1's to do it too. F1's must be wearing FFP3, so you can take that personal decision, but you don't take it to somebody else. And the other one was things like neonatal guidelines. It's not a fight worth having. It's just if that guidance is in the ballpark of the national guidance and you personally feel comfortable with what they're doing then I was, yeah, you carry on that seems fine, seems sensible, you do that. It's only where there was, things completely at odds and completely over the top that that we kind of got into further discussions about it. Like FFP3 masks for some for doing an echo for instance.

Sarah Mumford 42:46

And I think it's about common sense prevailing really isn't that everything else. I'll hand back to Gayti for the next question?

Gayti Morris 44:20



Thank you. Question Five

Martin Kiernan 44:33

Yes, well, if I'd have cracked that I think I'd patent it and sell it. When, I started 30 odd years ago, there was myself and a microbiologist and no data, and I was doing mandatory training, but I had no

information really to give them apart from spiels usual stuff. So as the team got bigger and bigger, I tried to provide more and more data and try and personalize the data to people so that they could see and eventually every ward ended up with a monthly report showing the number of hospital acquired bacteraemia they were having for whatever cause and with what we felt at the time was the cause, the *C. diff* rates their MRSA bacteraemia rate. The commode cleaning rates are just trying to provide them with a barrage of information that actually some people in the team will actually think that's quite interesting and why is that? So we will go around and count devices for example, and give them the device utilization ratio, and we were a merged organization, so we had two district generals on two sites, which eventually sort of came together ish.

But with orthopaedic ward on one side, everyone was catheterized for a fractured neck of femur and on the other side, nobody was catheterized and when they saw the stark differences, they started to talk to each other and actually ended up doing a piece of work on it and they just believe that people would be in pain if you put a catheter in and the other ward had cracked that. And so they weren't catheterizing anybody and the C Diff rate on the ward that we're actually catheterizing everybody was much higher than the other one. So then you start piecing things together, I think telling stories and making it real for people is useful. So realistic local data in mandatory training is important instead of just coming out with the same sort of messages, this is what's happening. If you've got anecdote that's really helpful. If you've got anecdote about a recent say C Diff root cause analysis where you might think, okay, give an example somebody's had C diff, okay, well, they had it. They had a uterine tract infection. They had sepsis, they had to have antibiotics. Okay, fine. Nothing much we could have done, but actually why did they have that, well they had the catheter in, okay well why did they have the catheter in, Oh, actually, they were constipated.

You actually tease it back to the fact that somebody wasn't eating and drinking and they became constipated. They end up with a Catheter in and people sort of get the story then. So I think storytelling is really important to engage people. I think finding friends is so important finding, you know, enthusiasts and link workers can work really well as long as they're people who have volunteered to be the link worker, rather than be, as many hospitals have linked worker schemes for various different things, and you're told you're the link worker, well, you can tell these people when they when they come along, they're not that bothered. They were just told they've got to go. So actually, I'd rather have nobody than somebody who's you know, then have somebody who's really quite enthusiastic about it as well. And then what you also then find out is there people who actually don't want to do it at all? And actually, you've got to find out what the problem is because you might think they're just not engaged at all with infection prevention, but actually they may have barriers that are stopping them, that you don't know about. So finding out what the real problem is and going to say to people, instead of saying why aren't you doing it, turning up and saying, I know you want to do this because it's good for patient care, and it's good for you. So what is stopping you and how can I help that?

So then finding out what the blockers are? And then sometimes you have to use a technique to find out the real problem because they'll say I can't do it because of such and such. So you start to use a technique called "if I could, would you" so okay, if I could show you that this would happen if you did that, would it help you? And would it make you I'm not convinced by the evidence or if I could show you some good quality randomized controlled trials in good peer reviewed journals, would you consider it? Because you obviously are an evidence based practitioner, so if I could, would you is also a very useful method of finding out to try and get to tease what the real problem is. Oh, I can't possibly buy that car because it's Green. If I could get your red one. Would you do it? Yeah. But it's a bit expensive and I could do something on the price could you do something about it? You can see where my background was back in the past many years ago down in Chislehurst, I think work with anybody

who shows an interest so you can go on to a ward and everybody scuttles off but there's actually often somebody around who wants to talk to you. So actually go and talk to them. That's quite useful. I think if you've got a problem area, try and find out who the key opinion leader is, is also very useful. And it may not be the ward manager or the senior staff nurse. It actually could be one of the healthcare assistants who's got such a strong personality that unless you get them on board, nothing's going to work in that area.

So actually, I know, Professor Saito in Hong Kong did a piece of work on that a years ago with his brother who was a psychologist and they actually did some scoring of people who do you actually trust and who do you get your information from on the ward, and they were often very surprised to actually who it was. He was the thought leader on the ward and what they found when they engage those people in Board activities, they actually took it on a lot better. I think showing people that you're not just the team who turned up to do mandatory training and tell people off and shove out a policy is useful as well. So I think if you're doing any local initiatives, and you're doing a lab poster abstract for IPs, or HIS, or whatever the conference is, if it's based in the clinical area, involve the clinical team in that and the nursing team, if it's a nurse like paper, get their name on the poster. And why not if when you've done those posters, start displaying them on the hospital corridor, or the post grad Medical Centre, or wherever people go or in the house in the hospital canteen because so many of us do a poster, and then you know, we think it's very interesting and our colleagues find it interesting, but actually, in your own organization showing that you're a team that's actually trying to advance the science and trying to find out things, you know, people might find that interesting. So you then start to change the perception of the team.

I think that's, that's really quite useful. And then I think what we have to do is also make information accessible. I'm really interested in the idea of using QR codes on posters on the wall, for like isolation facilities, if you're a patient or visitor, use a QR code because people use do use them now. And then up could come a sheet with the latest information, and actually that way, you'd be able to see how many people were actually getting, accessing that sort of information. So you could actually see if it's actually being used rather than people just ignoring a poster. And also it's like a lot cheaper than changing a load of posters because you just changed the link from the QR code. So those are some of my ideas anyway.

Gayti Morris 51:09

Well, thank you. Cariad and Sarah, we've probably got about a minute or so do either of you have anything you'd like to add to that? Lots of interesting ideas there from Martin.

Sarah Mumford 51:17

I think this is one of those things. It's easy in a crisis. It's really difficult day to day. And it's, it's about I do, I think Martin is absolutely right about the storytelling, make it real, make it you know, this is the story of this patient and this is where it went wrong. And this is what we could have done and this is how we could have intervened. And I do this a lot with the doctors especially around *C. diff* and sepsis, you know, this is what we could have done to make this this journey through the hospital different and this this is what may have prevented this patient becoming more unwell and getting that healthcare associated infection. So that's really important one but it is just that constant explaining to people why we're doing it and it's so difficult just at the moment because people everyone on the

world seems to have forgotten what IPC was like before COVID. They just fixated on what we do now and gloves become skin and so it is a real at the moment but just constant talking to people making them understand why we're doing what we're doing. You can't just tell them to follow standard infection control precautions. It just doesn't work.

Gayti Morris 52:39

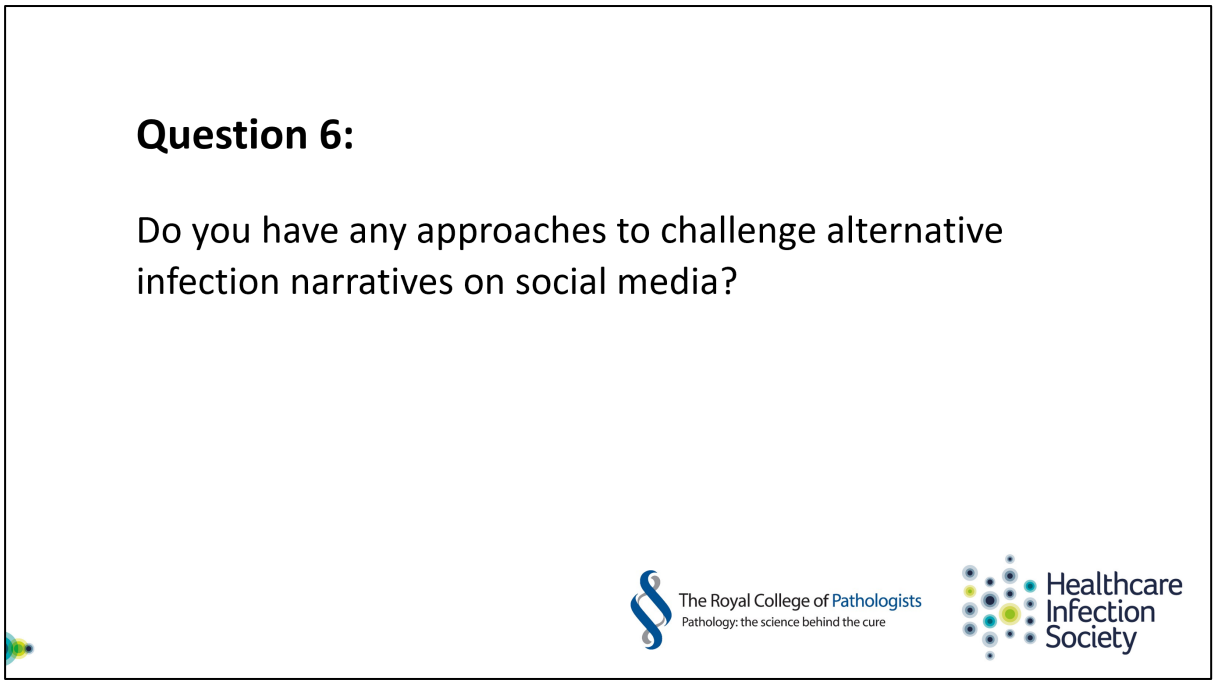
Thank you. Really interesting. I think we're just going to move on to our final question.

Natasha Ratnaraja 52:50

Thank you, Gayti.

Natasha Ratnaraja 52:52

So the final question is



Martin has bravely agreed to take the lead on this one.

Martin Kiernan 53:05

Yeah, this is the one of the ones where everybody else stepped back. The problem with social media is just massive, isn't it? That's the issue. You've got WhatsApp, you've got YouTube, you've got Instagram. You've got WeChat if you're in China, you've got Tik Tok. You've got Snapchat, LinkedIn, Facebook. How do you keep an eye on all of that lot? And where people are actually getting their news is really changing. I mean that, you know, people spend hours on it every day, and it's so difficult to actually try and keep on top of it. So what I tend to try and think about is, firstly, I mean, a lot of people

will tell you don't ignore it, you know, but actually, that's really difficult to do. So what I tend to try and do is assess the reason for the disinformation or the alternative infection narrative. Is this an honest mistake? Or is it deliberate misinformation and unfortunately, misinformation, travels better than correct information. So I gave a talk on this sort of thing at a meeting a earlier on this year, and actually, it's the posts from influencers on Tik Tok, who actually behave badly, that actually get more likes than the ones who actually the even the influencers are doing correctly. So that's it, but you don't know the reason for that. So that makes it really, really tricky. So I think I think try and assess the reason for the disinformation and if it's an honest mistake, and somebody has misinterpreted something, or they've read something and they their opinion isn't quite correct, I think you can try and do it and but you have to be quite polite about it and do it in a in a sort of a friendly way, if you like and I quite like using ABC which is acknowledge, bridge and communicate, which has seen politicians do all the time, you know, is today Wednesday minister? Well, yes, of course. Today is Wednesday. And that's a very important day, but tomorrow, Thursday, we're gonna be announcing our new 5 million pound investment.

So what you do is you say I can understand how you think or might have thought that from that paper, but actually, here's my interpretation of it and actually give you the evidence base and sometimes you might have half a chance of getting people to actually withdraw that and actually, my daughter did that with an influencer. She saw him posting a load of rubbish on Instagram, and actually was messaging him back and after a while, he actually started personal messaging her to say, is that really quite correct. And then he withdrew it all, which I thought was pretty brave of her to be absolutely honest. But I think what you then have to do is present the facts and data from various verified sources, and that's really as much as you can do. The issue then is, of course, if it's deliberate misinformation, and people are deliberately being mischievous, no matter what, you come back, all you're feeding is the flames. So I'm afraid those sorts of ones I don't tend to engage with but if it's if it's a bit of honest, an honest mistake, then it is worth trying to engage if it's a reasonable person, but there's a lot of accounts out there that are just there to breed disinformation, sew discontent and fear and I'm afraid there's not a lot we can do about that and they have huge numbers of followers. And so it's a very difficult I mean, sometimes actually tried to seize the narrative and get your information out first, and I think we don't do as well with putting information out on Twitter and certainly things like Instagram and TikTok.

Clearly I don't do TikTok because A I have my hair colour and B I can't dance. But actually, there's some studies that show if you include music and movement and humour in your posts, they're much more likely to get read, and much more likely for the information to be gained. And I think putting out sterile information to a changing demographic, maybe isn't helping us either. Those people spreading misinformation are far better at doing memes and all the rest of this stuff that I don't really quite understand, to be honest, but they're better at doing it than we are and we're not we're not as nimble and we're not as fast, you've only got to have some, you know, MP fall ill or something like that and the memes are out within seconds. So we've got other things to do. So that's it's really very difficult. I think professional societies may be able to think about having somebody dedicated to social media to actually start posting more and more engaging information out to people but it's a really tough one which as I suspect was why the others didn't want to touch this one.

Natasha Ratnaraja 57:19

Thank you. Someone just commented to your previous comment that said I dislike it too and have struggled with an alternative. We have about a minute left if Cariad or Sarah want to jump in.

Cariad Evans 57:38

I just think we need professional people to help us with communication. And I just, it's not our skill set. And I also find a lot of the hospital communication processes also a little bit, not contemporary to the to the moment of what's out there with social media and all the things that Martin suggested. We need influencers for IPC. We do need a social media presence and we need young experts to lead that and engage with us to deliver that message.

Martin Kiernan 58:13

And I think we could use it better. And that you know, Sarah mentioned WhatsApp groups are very popular amongst doctors. I do wonder about having local hospital podcasts where the infection control team say right, there's a new guideline out, we'll do a five-minute update and it goes out verbally and if it's accessible outside, people might actually listen to it in the car on the way home, whereas they're not going to take much notice of it while they're at work. So you know that I think there are opportunities to use social media if you can localize them, and personalize them and make it nice and short and snappy. I think there are chances there. If you have a QR code this this week's hospital podcast is on this and here's the topic, people might engage with it. Who knows? I don't know.

Natasha Ratnaraja 58:51

That's great. Thank you everyone. I think that's given us some food for thought perhaps RCPath and HIS could collaborate again and think of those and take those forward because certainly it's very important. We've actually run out of time now, but I just want to thank all the panellists for what I think has been a very stimulating and interesting discussion, and I'm hoping that the participants and the attendees have found it as interesting as I have and have got some food for thought and some ideas because one idea may not fit every organization or department, but certainly we've had a wide range of tools that could help us and I have really enjoyed hearing your experiences that's been really, really, really useful for me. Just to let you know that both the RCPath and the HIS websites will have this webinar posted on their websites very shortly, so that you'll be able to see that as well. And you'll have certificates of attendance emailed in the next week.

Natasha Ratnaraja 59:59

So it just leaves me to thank all the participants and attendees and for posting questions beforehand and during this, I can just see a late thank you. So thanks everyone and thank you again to the panellists for stimulating conversations and thank you to Gayti for co-chairing with me and thank you to the college pathologists and HIS for hosting this webinar. And just to wish you all a very good evening thank you, goodbye.