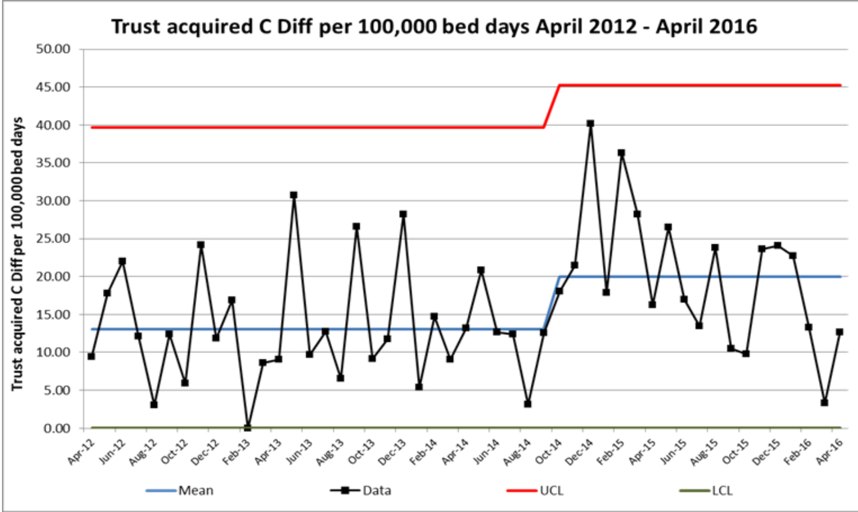
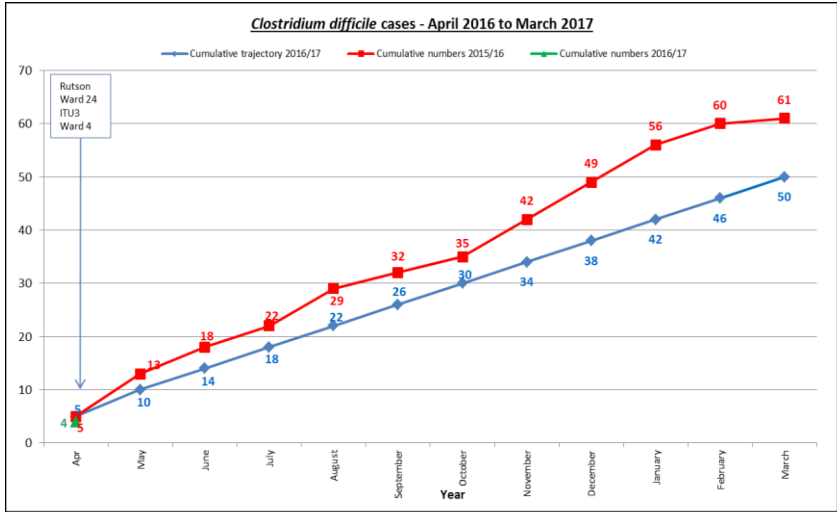
CDI Key Performance Indicators Dashboard





	Target	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Compliance with assessment of diarrhoea in A&E	>=90%	93.0%	98.7%	98.2%	96.2%	97.5%	95.0%	96.2%	97.5%	96.2%	95.0%	92.5%	97.50%
Stool chart compliance	>=95%	96.0%	83.0%	97.5%	98.4%	98.1%	96.1%	98.9%	95.8%	97.0%	89.9%	90.0%	
All elements of DATchart completed	>=95%												25%
C. Diff patients isolated within 2 hours (%)	>=90%	93.0%	77.0%	100.0%	81.0%	85.7%	71.4%	70.0%	66.7%	77.7%	71.0%	60.0%	60.0%
C. Diff patients isolated within 2 hours (actual number)		13 out of 14	10 out of 13	8 out of 8	13 out of 16	6 out of 7	5 out of 7	7 out of 10	6 out of 9	7 out of 9	5 out of 7	3 out of 5	3 out of 5
Antibiotic prescribing													
Antibiotic audit - Audit of choice of antibiotic regimen	>=90%	98.6%	98.5%	97.2%	99.5%	98.9%	99.4%	99.0%	97.4%	98.8%	****	****	99.30%
Antibiotic audit - Stop date recorded	>=90%	68.0%	71.5%	76.6%		70%	74%	77%	72.4%	75.5%	****	****	76.30%
Hand hygiene competencies													
Hand hygiene competencies (Trajectory Q1-25%, Q2-50%, Q3 -75%,Q4->=95%)	>=95%	****	29%	****	****	58.4%	****	****	75.24%	****	****	98.53%	****
Clean your Hands compliance	>=90%	86.4%	86.7%	87.7%	88.1%	88.5%	93.2%	92.5%	93.7%	92.9%	93.4%	94.2%	91.80%
Environmental cleanliness and decontamination strategy													
Externally validated cleaning score													

**** reported quarterly

South Tees Hospitals NHS FT
CDI Annual Plan – APRIL 2016 (version 1)

RAG rating of actions	
	Action not commenced
	Action in progress, off target
	Action in progress, on target
	Action fully completed

Sections have been RAG rated in accordance with performance metrics

Diarrhoea Control

	Executive Lead: Gill Hunt - Director of Nursing / DIPC	**Operational Lead:** Judith Connor Assistant Director of Nursing / Deputy DIPC
Achievements	A&E audits above 90%.	
Benefits	Additional resources focussed on CDI. Increased knowledge of patients CDI status prior to admission allowing immediate action to contain CDI. Increased compliance with 2hr Isolation window for patients with suspected infectious diarrhoea. Consistent advice and support for staff to facilitate early intervention and management.	
Concerns	Sustainability of improved compliance. Risk of not achieving agreed CDI threshold.	
Do next	Continue monthly audits of diarrhoea assessment in A&E, stool chart compliance and isolation within 2 hours. Continue with weekly audit of DAT for patients with symptoms of diarrhoea. Audit compliance with escalation process to ensure isolation standards are achieved 24/7. Work with IT and Transformation office to develop work plan to adapt CAMIS system to support management of isolation. Implement change project.	

ID	Task Name / Description	31/05/2015	Date initiated	Forecast Completion Date	Actual Completion Date	Status	Priority	Evidence / Comment	RAG
DC14	Develop and implement IT solution to support isolation of patients in the appropriate facilities for the patients needs.	Judith Connor	Nov-15	31/01/2016		Open	High	Update May 16 IPC attendance at daily bed meeting. To meet with members of the Transformation Office to link with patient flow review project.	Amber
DC17 *(New)*	Weekly audit of DAT for 5 patients identified from pathology system who are experiencing symptoms of diarrhoea	Judith Connor	Feb-16	on-going		Open	High	Update May 16: Results discussed at weekly CDI meeting. Develop monitoring system for Matrons.	Amber

Estate quality									
	Executive Lead: Maxime Hewitt- Smith Director of Finance			**Operational Lead:** Director of Estates					
Achievements	Review of re-alignment of tower block accommodation commenced (alongside work to reduce bed complement at JCUH as part of the revision of the emergency pathway).								
Benefits	Reduction in the number of patients cared for in sub standard accommodation and improved accommodation for those who remain in the tower block. Increase in isolation facilities.								
Concerns	Organisational ability to achieve financial savings by closing beds while delivering 18 week and emergency care standard Costs associated with refurbishment and timing of delivery. Based on detailed feasibility study permanent modular block to replace the tower block is not feasible.								
Do next	Develop and implement plan for bed reconfiguration and refurbishment of existing estate.								
ID	**Task Name / Description**	**Resource Name(s)**	**Date initiated**	**Forecast Completion Date**	**Actual Completion Date**	**Status**	**Priority**	**Evidence /Comment**	**RAG**
EQ3	Refurbishment of ward 4. Provisional capital funding has been approved for ward 4 development.	Gary Owens, Jim O'Connell (from May 16)	May-16	tbc		Open	High	Update May 16: Working group established to develop plan for bed reconfiguration / refurbishment of existing estate. Scoping meeting held. Time out session to be set following detailed demand and capacity work.	Amber
EQ5	Redesign the bed base on the JCUH site to ensure optimum use of estate	Jim O'Connell	Apr-16	tbc		Open	High	Working group established, scoping meeting held. Two day workshop to be arranged to agree bed reconfiguration alongside estate upgrade.	Amber

Antibiotic Prescribing									
	Executive Lead: Dr Sath Nag, Medical Director Urgent Care centre		**Operation Lead:** Dr Sath Nag Medical Director Urgent Care Centre & Debbie Lockwood,						
Achievements	New data on antibiotic usage in primary care obtained and increased engagement. Pilot complete on AAUs on JCUH site highlighting real time deficits in antimicrobial prescribing. Series of workshops aimed at Non-medical prescribers commenced.								
Benefits	Improved compliance with the recording of review and stop dates evidenced by Ared. Focussed audit programme led and owned by Clinical Directors.								
Concerns	Ensuring actions on antibiotic prescribing become embedded throughout the organisation.								
Do next	Collate actions of antibiotic audits by clinical centre and confirm next cycle of audit.. Follow up with Clinical Commissioning group regarding actions following recent antibiotic usage report. Develop antibiotic dashboard. Develop register of antibiotic Guardians. Action plan for use of extended spectrum antibiotics to be developed. To plan GP engagement event with CCG.								
ID	**Task Name / Description**	**Resource Name(s)**	**Date initiated**	**Forecast Completion Date**	**Actual Completion Date**	**Status**	**Priority**	**Evidence /Comment**	**RAG**
A11 ***(NEW)***	Continued Engagement with CCG to reduce community wide incidence Cdiff by reduction antibiotic usage- evidence activity in primary care	Sath Nag	Nov-15	31/12/2016		Open	High	Update May 16. CCG contacted to plan GP engagement event.	Green
A12 ***(NEW)***	Procalcitonin pilot to refine antibiotic usage	Sath Nag	Nov-15	01/03/2016 Revised End May 2016		Open	Medium	Pilot PCT in write up stage. Dr Nag currently collating evaluation of pilot. and recommendations to implement. Update April audit complete, paper to be produced and presented to IPAG in May 2016	Green
A13 ***(NEW)***	Extend pilot of highlighting review of antibiotics on prescription charts on AAUs to full roll out across trust.	Sath Nag / Debbie Lockwood	May-16	30/09/2016		Open	High	Update May 2016: Evaluation of pilot to be presented to IPAG in May 2016. Full roll out by the end of June 2016	Amber
A14 ***(NEW)***	Develop a log of antibiotic audits by centre, analyse data and present to centre leads to disseminate and develop centre action plans as well as agree audit cycle timescales.	Sath Nag	May-16	30/06/2016		Open	High	Centre action plans to improve antibiotic prescribing and usage. Update 11th Feb : need to engage with centre MD's and agreed individual action plans. Update April 2016 Email to centre MD's/CD's with results of antibiotic audits requesting local plans to be submitted by the end of June 2016.	Amber
A15 ***(NEW)***	Review medication prescription chart to promote daily review of antibiotic prescribing and duration.	Sath Nag & Debbie Lockwood	May-16	30/09/2016		Open	High	Contact Dr Caroline Wroe (chair of safer medication practice group).	Red

A16 ***(NEW)***	Achieve national CQUIN for reduction in antibiotic prescribing	Sath Nag & Debbie Lockwood	Apr-16	31/03/2017		Open	High	Establishing base line data to be submitted to national team. Awaiting confirmation of proforma for data collection.	Amber
A17 ***(NEW)***	Participate in European point prevalence audit	Sath Nag & Debbie Lockwood	Nov-16	TBC		Open	Medium	Confirmed participation with national team. Await data collection for Nov 2016.	Red
A18 ***(NEW)***	Deliver three engagement events with non-medical prescribers.	Eileen Aylott, Sath Nag & D Lockwood	Apr-16	30/09/2016		Open	Medium	First session delivered with 45 participants who have also logged to be antibiotic guardians.	Amber

Hand hygiene									
	Executive Lead: Gill Hunt - Director of Nursing / DIPC			**Operation Lead:** Judith Connor Assistant Director of Nursing					
Achievements	Hand hygiene steering group meeting re-established. Programme of triangulation of data commenced. Reviewed HH training for NHSP temporary staff, Trust IPCN staff to deliver training going forward. Letter to medical staff from Medical Director to reiterate target and responsibility to complete assessment before March 2017. Implemented certificate of competence which transfers to next placement for doctors in training. Monthly reports to be generated by clinical centre for Chiefs of Service. Medical Champion for Hand Hygiene.								
Benefits	Ability to obtain data which is reflective of clinical practice which will help make improvements.								
Concerns	Maintenance of competency and assurance re on-going practice.								
Do next	Continue with quality checks to ensure that all doctors in training are captured when rotating to next clinical placement. Develop and agree plan with HENE for Doctors in training. Send briefing out in relation to objective for hand hygiene competencies.								
ID	**Task Name / Description**	**Resource Name(s)**	**Date initiated**	**Forecast Completion Date**	**Actual Completion Date**	**Status**	**Priority**	**Evidence / Comment**	**RAG**
HH1	Plan for substantive medical staff to be 100% compliant with HH competency assessment in 16/17	Centre MD's, Judith Connor & David McCaffrey	Apr-16	31/03/2017		Open	High	Knowledge based element to be incorporated into Core 7 CMAT. Practical element to be confirmed at revalidation.	Red
HH3	HH competency plan for continued compliance for all other relevant clinical staff in 2016/17	Operational Directors	Apr-16	31/3/2017		Open	High	As above (HH1)	Green
HH4	Monthly peer review of HH through either clinical matron / IPCN / assurance audits for identified high risk areas.	David McCaffrey/Judith Connor	Apr-16	01/03/2017		Open	High	Audits continue and data shared with clinical areas.	Green
HH7	Make links with HENE and local Universities to provide assurance of content of training for both Doctors and other clinical based students.	Judith Connor	Apr-16	30/06/2016		Open	High	Contacted educational links for Doctors in training and other students to request named links for educational institutes.	Red

Environmental cleanliness and decontamination strategy									
	Executive Lead: Gill Hunt - Director of Nursing			**Operational Lead:** Director of Estates					
In-house									
Achievements	Decant and deep clean programme completed at the Friarage, commode competencies achieved (100%). Business case for the introduction of wipes agreed by OMB, implementation and training during August 2015. Substantive appointment made to facilitate environmental cleaning 12 hours per day on ward 1 and 15 (inc bed cleaning). Monitoring officers employed by the Trust now in post. Revised deep cleaning programme agreed (Nov 15) Substantive environmental cleaners now in post, training programme completed. DVD produced to support training.								
Benefits	HPV cleaning of all areas, including sluices, most effective when ward is closed and deep cleaned. Increased focus on and improved cleaning of patient equipment due to use of chlorine based wipes. Dedicated resource to bed cleaning in areas of highest patient throughput								
Concerns	Consistent standard of cleaning of beds out of hours.								
Do next	Monitor cleaning standards following introduction of substantive environmental support workers. Consider proposal to use ATP to monitor bed cleaning standards at IPAG. Introduce ATP as monitoring tool to assess equipment cleaning standards. Pilot decontamination unit for front of house.								
Contract									
Achievements	32 areas have achieved 6 months of target cleaning scores and have therefore been stepped down to monthly assessment. Re-deployed cleaning hours from low risk areas to Endoscopy to provide increased toilet and environmental cleaning.								
Benefits	Consistent achievement of cleaning standards as per service specifications and timely resolution of issues.								
Concerns	The need to sustain consistently high cleaning scores								
Do next	Board to Board meetings continue to improve collaboration Regular liaison meetings with PFI provider to deal with matters as they arise to ensure timely resolution. Pilot of decontamination unit.								
ID	**Task Name / Description**	**Resource Name(s)**	**Date initiated**	**Forecast Completion Date**	**Actual Completion Date**	**Status**	**Priority**	**Evidence /Comment**	**RAG**
EC18 *(NEW)*	Develop and test the concept of a decontamination unit for cleaning beds, mattresses and equipment.	Julie Barlow & Denise Foster	May-16	14/07/2016		Open	High	Meeting took place with Denise Foster to discuss the concept on 17.05.16. Visit to ward 2 carried out.	Green
EC19 *(NEW)*	The trust to consider the provision of a rapid response service for terminal cleans, transfer and discharge bed cleaning.	Julie Barlow & Denise Foster	May-16	14/07/2016		Open	High	Meeting took place with Denise Foster to discuss the concept on 17.05.16. Visit to ward 2 carried out.	Green
EC20 *(NEW)*	The trust to consider the provision of a terminal clean service.	Julie Barlow & Denise Foster	May-16	14/07/2016		Open	High	See above (EC19).	Green
EC21 *(NEW)*	Establish the true reflection on nursing staff carrying out bed cleaning	Julie Barlow & Clinical Matrons	May-16	14/07/2016		Open	High	Develop audit tool and gather 1 week snap shot audit for evidence. Update 18/05/16 - audit tool developed and circulated to CM for the audit to be carried out week beg 23/05/16	Green

Ownership & Learning									
	Executive Lead: Gill Hunt - Director of Nursing / DIPC			**Operational Lead:** Judith Connor Assistant Director of Nursing					
Achievements	New central DIPC led RCA panels commenced in Nov 15. Algorithm developed to support decision making for RCA s for trust attributed / non trust attributed CDI. Internal audit complete - achieved medium risk.								
Benefits	Additional learning to accelerate action to reduce CDI.								
Concerns	Standard of RCA's. Communication of key messages to all staff.								
Do next	Progress ICNET business case. Incorporate areas for improvement from internal audit report to strengthen centre action plan completion to provide assurance of learning.								
ID	**Task Name / Description**	**Resource Name(s)**	**Date initiated**	**Forecast Completion Date**	**Actual Completion Date**	**Status**	**Priority**	**Evidence / Comment**	**RAG**
OL14	Develop a business case for Icnet for consideration at Capital Group and charitable funds committee.	David McCaffrey	Apr-15	31/12/2015 revised date 31/05/2016		Open	Medium	Business case remains in development. Will be linked to wider review of IPC strategies. Update 11th Nov Options scoped for 7 day IPC service / skill mix review and Icnet. Further discussion to take place with DIPC re consultation process. Update 18th Dec. 7 day service plans remain on track to commence Feb 2016 Up date Jan 14th 16, consultation for 7 day service complete start date for 7 day service 29th Feb. Full IPC skill mix review to commence April 16 - ICNET provision incorporated into all model considerations. Update April 16 Meeting with ICNET rep took place 21st April 2016.	Amber
OL20	Incorporate areas for improvement from internal audit report to strengthen centre action plan completion to provide assurance of learning.	David McCaffrey	May-16	30/06/2016		Open	Medium	Process established for RCA panel meetings and system in place to ensure follow up of centre action plans. Strengthened framework for the identification of cases that meet the criteria for appeal.	Green