NHS
South Norfolk
Clinical Commissioning Group

Agenda item: 7.2

Subject:	**Clostridium Difficile (CDI) Improvement Plan 2015-16**
Presented by:	**Joanna Yellon, Director of Quality Assurance**
Submitted to:	**SNCCG Governing Body**
Date:	**24 March 2015**

Purpose of paper:

For the approval of NHS South Norfolk CCG's CDI Improvement Plan for 2015-16, to commence 1 April 2015.

Executive Summary:

For 2014-15 healthcare organisations were encouraged to assess each case of CDI to determine whether the case was linked to a lapse in the quality of patient care, this process will identify areas where care could be improved. The co-ordinating commissioners can then consider the results of these assessments and where evidence can be supplied that CDI cases are not linked with lapses in care they can be considered as non-trajectory.

The sanction regime which is in place across the five Norfolk CCGs and the specific process that has been adopted by Great Yarmouth and Waveney CCG has been recognised as best practice by NHS England (East). The process ensures that the commissioners and providers within the CCGs gain in-depth knowledge and understanding of every case within its remit to enable it to extrapolate maximum learning. This learning then forms part of the GY&W CCG's multi-agency CDI improvement plan. It is the intention of the Infection Prevention and Control (IP&C) Team at Public Health (PH) Norfolk County Council (NCC) to replicate this same best practice process across the remaining Norfolk CCGs. This is particularly important given the trend across Norfolk 2014-15 which shows CCGs ranging from slightly to significantly higher than trajectory.

The Infection Prevention and Control (IP&C) team at Public Health Norfolk remain proactive and NHS SNCCG has a very good working relationship with them.

This action plan focuses on the on-going monitoring and actions deemed necessary to prevent CDI. The plan focuses on:

Antibiotic prescribing

- Improving public and Primary Care awareness of the importance of using antibiotics appropriately.
- That prescribing is appropriate for patients with symptomatic diarrhoea to avoid preventable harm.

- That appropriate testing is undertaken for patients demonstrating signs and symptoms of CDI.
- To raise awareness regarding unnecessary sending of clearance samples.
- That SNCCG ensures that effective learning from incidents occurs.
- Adherences to appropriate protocols.
- That IP&C training is delivered to the highest standard for all applicable staff including focused training on CDI.
- That reporting of cases is timely to ensure appropriate actions from clinical teams occur.
- That IP&C continues to be a top priority for SNCCG and is reflected within the commissioning of safe and effective services.

The improvement plan will be monitored by IP&C PH NCC on behalf of SNCCG. It will be updated and disseminated in line with the quarterly reports.

The NHS SNCCG threshold for 2015/16 is 65 cases

Recommendation to Governing Body:

The Governing Body is asked to formally receive and endorse the CDI Improvement Plan 2015-16.

Key Risks	
Clinical:	Potential risk that if this is not implemented the areas identified for improvement will have an impact on the quality of patient care.
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	No negative impact
Reputation:	N/A
Legal:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	*Does document promote, highlight awareness of NHS Constitution*

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	Quality and Patient Safety Assurance Committee 3 February 2015 Leadership Team 10 March 2015

NHS
South Norfolk
Clinical Commissioning Group

Clostridium Difficile (CDI) Improvement Plan 2015 – 16

Ref Number:	**Version:** 2	**Status:** Final		**Author:** Infection Prevention & Control Team Public Health
Approval body	South Norfolk CCG Leadership Team		**Date Approved**	
Ratified by	South Norfolk CCG Governing Body		**Date Ratified**	
Date Issued			**Review Date**	
Contact for Review: Quality Assurance Team				

CDI objectives and sanction regime

For 2014-15 healthcare organisations were encouraged to assess each case of CDI to determine whether the case was linked to a lapse in the quality of patient care, this process will identify areas where care could be improved. The co-ordinating commissioners can then consider the results of these assessments and where evidence can be supplied that CDI cases are not linked with lapses in care they can be considered as non-trajectory.

This process is in place across the five Norfolk CCG's and the specific process that has been adopted by GY&W CCG has been recognised as best practice by NHS England Local Area Team. The process ensures that the commissioners and providers within the CCG gain in-depth knowledge and understanding of every case within its remit to enable it to extrapolate maximum learning. This learning then forms part of the GY&W CCG's multi-agency CDI improvement plan. It is the intention of the Infection Prevention and Control (IPAC) Team at Public Health (PH) Norfolk County Council (NCC) to replicate this same best practice process across the remaining Norfolk CCG's. This is particularly important given the trend across Norfolk 2014-15 which shows CCG's ranging from slightly to significantly higher than trajectory (see graphs below for performance data.)

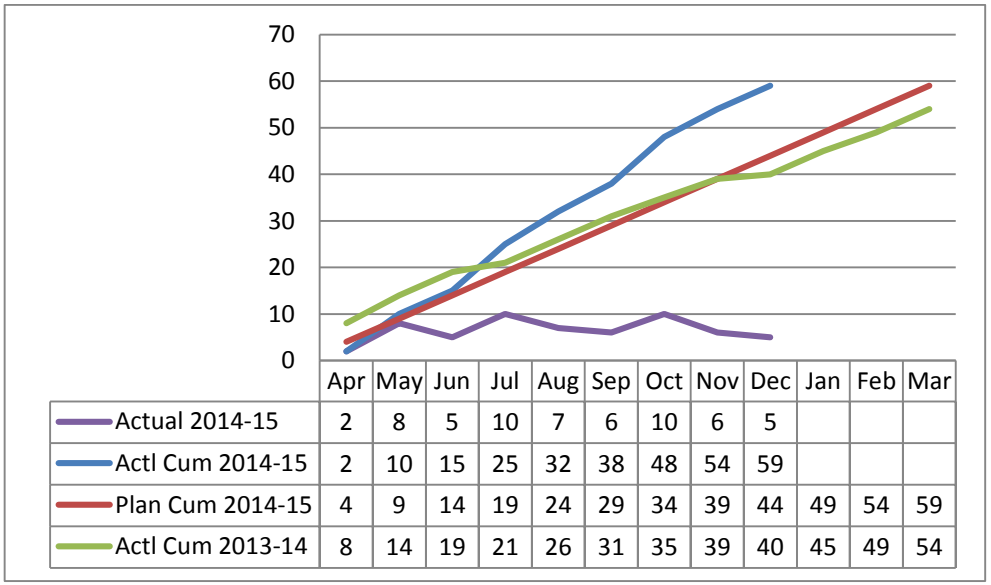
It is the intention that this improvement plan will be monitored by IP&C PH NCC on behalf of SNCCG. It will be updated and disseminated in line with the quarterly reports.

This action plan focuses on the on-going monitoring and actions deemed necessary to prevent CDI.

The SNCCG threshold is 65 cases of CDI for 2015/16

CDI infections by South Norfolk CCG 2014-15 Quarter 3

The chart below DOES NOT reflect successful CDI non-trajectory cases



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual 2014-15	2	8	5	10	7	6	10	6	5			
Actl Cum 2014-15	2	10	15	25	32	38	48	54	59			
Plan Cum 2014-15	4	9	14	19	24	29	34	39	44	49	54	59
Actl Cum 2013-14	8	14	19	21	26	31	35	39	40	45	49	54

CDI South Norfolk CCG 2014-15

Community cases only of CDI SNCCG

	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Actual 2014-15	2	6	5	9	3	4	9	6	4
Actual cum 2014-15	2	8	13	22	25	29	38	44	48
Actual cum 2013-14	5	7	11	12	15	19	22	26	27

Infection Prevention and Control Liaison Nurse

In January 2013 a new post commenced, Infection Prevention and Control Liaison Nurse**, hosted** by NCH&C IP&C team and funded by PH NCC for 6 months and then Norfolk CCG's on-going. This post holder completes a root cause analysis (RCA) process for all community cases of CDI. The Regional Epidemiology unit are working with IP&C in Public Health to produce a database which will provide themes and trend reports for community CDI cases. These reports will be circulated to primary care to ensure learning identified from this process is provided for General Practitioners.

Requirement	Actions	Responsible	Target/ Review date	Completion date	How measured	Comment/Update
Clearly defined and clinically appropriate antibiotic formulary in use within South Norfolk Primary Care	**1. Ensure that antibiotic prescribing is compliant with approved formulary** 1.1 Ensure formulary reviewed against national guidance	Prescribing advisor for CSU NEL on behalf of SNCCG	Annually	31.3.16		 antibiotic_quick_ref.pdf
	1.2 Antibiotic prescribing audits to be undertaken to monitor compliance and address concerns	Prescribing advisor for CSU NEL on behalf of SNCCG	Annually	31.3.16	Audit data from community pharmacists	Any concerns identified by audit will trigger visit to surgery by prescribing advisor
	1.3 Ensure reporting of sensitivities for South Norfolk patients in line with Norfolk antibiotic formulary	NNUH laboratory	Annually	31.3.16		
Improve public and primary care	**2. Raise public awareness of**	IPAC team PH NCC				

Requirement	Actions	Responsible	Target/ Review date	Completion date	How measured	Comment/Update
awareness of the importance of using antibiotics appropriately	**importance of using antibiotics appropriately**	Communication team PH NCC				2014/15 successful awareness campaigns to be run again for 2015/16
	2.1 Organise a media campaign for the winter period to reinforce messages that self-limiting conditions do not require antibiotics	IPAC team PH NCC GP practices SNCCG OOH teams	June 2015	Sept 2015		Utilise GP newsletter, antibiotic awareness day resources, NCC website
	2.2 GP practices and OOH locations to display posters for public awareness on the appropriate use of antibiotics	GP's	June 2015	Sept 2015		
	2.3 Practices to provide patient leaflets for the management of self - limiting conditions without antibiotics	GP's	June 2015	Sept 2015		

Requirement	Actions	Responsible	Target/ Review date	Completion date	How measured	Comment/Update
Prescribing is appropriate for patients with symptomatic diarrhoea to avoid preventable harm	**3. Anti-motility agents are not prescribed for patients with unexplained diarrhoea**					
	3.1 Share learning with all GP practices/prescribing staff in SNCCG regarding inappropriate use of anti-motility agents in CDI cases.	IPAC team PH NCC IPAC Liaison Nurse NCH&C	On going	31.3.16	RCA's	GP Practice Newsletter Presentation at Council of Members Meeting Individual communications with prescribers following RCA process
	3.2 Communication to be disseminated to all pharmacies to support customers that have unexplained diarrhoea. Discourage the use of anti-motility drugs, encourage customers to contact their GP if symptoms do not resolve in 5 days	IPAC team PH NCC Prescribing Advisor for CSU NEL on behalf of SNCCG	On going	31.3.16	RCA's	

Requirement	Actions	Responsible	Target/ Review date	Completion date	How measured	Comment/Update
Appropriate testing undertaken for patients demonstrating signs and symptoms of CDI	**4. Ensure stool sample is sent to confirm diagnosis of CDI prior to commencement of treatment** 4.1 Inform GP's to ensure that where clinically appropriate, stool specimens are taken	IPAC team PH IPAC Liaison Nurse NCH&C IPAC provider team	On going	31.3.16	RCA's	GP Practice Newsletter Individual communications with prescribers following RCA process Presentation at Council of Members Meeting
Unnecessary sending of clearance samples	**5. Root cause analysis has identified unnecessary sending of clearance samples** 5.1 Inform GP's that clearance samples for CDI are not required	IPAC PH NCC IPAC Liaison Nurse NCH&C	On going	31.3.16	RCA's	GP Practice Newsletter Individual communications with prescribers following RCA process Presentation at Council of Members Meeting
SNCCG is an organisation that ensures effective learning from	**6. It is vital that the root cause analysis is used to ensure learning from**					

Requirement	Actions	Responsible	Target/ Review date	Completion date	How measured	Comment/Update
incidents	**incidence of CDI; particularly GP involvement** 6.1 Ensure contact made by Liaison Nurse to GP's in event of a CDI 6.2 GP's to review completed RCA's and highlighted best practice with expectation to address improvements where necessary 6.3 Themes and trends reports will be circulated to GPs from new database. This is to identify learning points for management of community CDI patients for improvement in practice.	Liaison Nurse NCH&C GP's SNCCG Liaison Nurse NCH&C IPAC team PH NCC GP's SNCCG	On going On going Quarterly	31.3.16 31.3.16 31.3.16	RCA's RCA's RCA's	Completed RCA's sent to the practice concerned and prescribing advisor. IP&C team attend CoM meetings. Feedback from GPs re learning from RCAs to be sought at these meetings.

Requirement	Actions	Responsible	Target/ Review date	Completion date	How measured	Comment/Up date
Ensure that the SIGHT mnemonic protocol is adhered to during the management of patients with suspected CDI	**7. S-** Suspect that a case may be infective where there is no clear alternative cause for diarrhoea **I-**Isolate the patient and consult with the infection control team while determining the cause of the diarrhoea **G-** Gloves and aprons must be used for all contacts with the patient and their environment **H-** hand washing with soap and water should be carried out before and after each contact with the patient and the patients environment **T-** Test the stool toxin, by sending a specimen immediately	Clinical staff responsible for patient care	On going	31.3.16	RCA's	Lapses in care will be identified at RCA meetings and addressed to ensure learning is gained
IPAC training is delivered to the highest standard for all applicable staff including focused training on CDI	**8. Evidence of adherence to IPC training requirements to be reviewed for NSFT** 8.2 All clinical staff to receive 'face to face' IPAC training on induction to the trust 8.3 Appropriate annual IPAC training to be available for existing staff.	 IPAC Lead of provider trust IPAC Lead of provider trust	 On going On going	 31.3.16 31.3.16	 Staff training matrix RCA's	
Ensure a clean Environment	**9.Minimise risk of transmission of infection from the environment**					

Requirement	Actions	Responsible	Target/ Review date	Completion date	How measured	Comment/Up date
	9.1 95% compliance with environmental of care audit (cleaning elements)	Hotel services and ward staff of provider trust	Quarterly	31.3.16	IPAC audits	Environmental audits completed monthly in each clinical area
Clearly defined and clinically appropriate antibiotic formulary in use within provider trust	**10. Prudent antibiotic prescribing to minimise vulnerability of patients to developing CDI** 10.1 Ensure antibiotic formulary reviewed against national guidance	Microbiologist/ prescribing adviser for provider trust	Annually	31.3.16		
	10.2 Antibiotic prescribing audits to be undertaken to monitor compliance and address concerns	Prescribing adviser for provider trust	Monthly	31.3.16	IPAC audit data (monthly in each clinical area) RCA's	Data to be fed back to clinicians during RCA process
Efficient reporting to enable appropriate actions from clinical teams	**11. Timely receipt of CDI reports from microbiology lab.** 11.1 Monitor time from obtaining					

Requirement	Actions	Responsible	Target/ Review date	Completion date	How measured	Comment/Up date
	sample to receiving authorised results on all cases CDI	Eastern Pathology Alliance	On going	31.3.16	RCA's	Lapses in reporting will be addressed with laboratory
Infection prevention & control performance is a patient safety priority of SNCCG	**12. Assurance to be sought that CDI performance is recognised as a significant risk to SNCCG** 12.1 Ensure inclusion and review of CDI performance within SNCCG Clinical Risk Register	SNCCG PS&Q Lead	31.3.15	31.3.16	To be reviewed at monthly QPASC	
IP&C is a dominant patient safety priority and is reflected within commissioning of safe and effective services	**13. Commissioning and contract management of providers will enable IP&C performance to be managed** 13.1 IPAC to be standing item on SNCCG PS&Q meetings	PS&Q Lead SNCCG	Monthly	31.3.16		Mandatory reporting of CDI to PHE
	13.2 CDI performance is a standing item on SNCCG PS&Q to ensure that the participants are aware of SNCCG CDI	PS&Q Lead SNCCG	Monthly	31.3.16		Updates provided at meetings held

Requirement	Actions	Responsible	Target/ Review date	Completion date	How measured	Comment/Up date
	performance 13.2 Total CDI cases to be monitored against trajectory	IPAC PH NCC IPAC PH NCC	 On going	 31.3.16	 Data tool provided by PHE	between CCG, provider trust and IP&C PH