Adult Social Care and Health Committee

Quality Account 2016-17 – Additional Information from NTH FT

1. Further information in relation to development of stroke services (following the earlier update received this year)

The Trust has implemented a new standard of one hour CT scan for all stroke patients - Since November 2016 the Trust has shown consistent improvement. Currently the Trust has achieved 67% in January and 80% in February of CT scans within one hour.

2. Progress in relation to the summit/action plan on C.Diff.

The Clostridium difficile summit was a one off event intended to bring together key partners from the trust and other organisations to agree additional actions to be taken to reduce the risk of further C difficile cases. The outcome of the meeting was the agreement of 16 core standards to be applied across all wards and these standards are now monitored via the HCAI Operational Group and the CDI Improvement Group which meet in alternate months. Many of the standards were simple to achieve and the remit of the groups is to receive exception reports from clinical areas to monitor the on-going implementation. Other standards required further work and the groups receive feedback from the clinical areas about any barriers to implementation and agree actions to assist. These standards have been built into the improvement plan for 2016-17 which is updated monthly and will roll over to the plan for 2017-18. (See Appendix A).

Work is underway to raise awareness of the standards across all clinical areas and to receive feedback from clinical staff about additional standards that could be added over the coming year. The improvement plan covers all actions considered and put in place on top of the routine measures such as cleaning and hand hygiene which are part of core business. The Trust is working with NHS Improvement, NHS England and Commissioners to further understand why performance has deteriorated and to utilise expertise available from NHS Improvement to assist with improving performance and patient safety in 2017-18

3. Progress on operation of the Discharge Lounge (following this year's Healthwatch reports)

Discharge lounge

The Trust has already identified the Discharge Lounge as an area for improvement and has instigated a number of work streams that dove tail with the action plan that was initiated following receipt of the Healthwatch report last year.

Since the report in April 2016 and subsequent visits in October and December 2016, the Trust has in place an Action plan with a focus on the staffing model, looking at the skill mix and the possibility of pharmacy technician time in the lounge.

Environment
A television was installed in the Lounge last year and has helped create a more relaxed environment. We have recently been successful in receiving a grant from the Women's Royal Voluntary Service (WRVS) to have a beverage bay in place within the Lounge. Plans around how we do this are on-going to make sure we create something that is fit for purpose and sustainable in the longer term.

Volunteers
With the support of our volunteer coordinator we have recruited 2 volunteers who are working in the Lounge a couple of sessions per week. This has helped us to encourage Patients to relax and talk at ease about any anxieties they might have about going home and has also helped us to support the staffing model in the Lounge by offering an additional Person to sign post Patients to other areas, make refreshments and collect medications from Pharmacy.

Citizens Advice Bureau (CAB) and Stockton Information Directory
CAB have been in discussions with the Trust to see how they can support patients leading up to their discharge from hospital as well as following discharge. This is including in the **NESTA** 100 day challenge in Stockton, this is supported by all partners (Trust, CCG, Local Authority and voluntary and community sector). The focus of the Challenge is to provide a 'personalised' approach to discharge planning by having a 'different' conversation and utilising none mainstream Services provided by the voluntary and community sector.

Man in a van
Since Oct 16, 'Man in a Van' initiative has been in place, this supports the discharge process by following up a discharge with the medication and discharge letter**. To note**, this is only for patients who do not immediately need medication and are able to self-medicate.

Daily Huddles (ward rounds)
The Trust has re-launched the daily huddles with a focus on prioritising tasks to support patient flow and discharge, the aim is to discharge patients before 12pm each day. The Trust is looking at ways to utilise technology in a way to aid the discharge process.

Hand overs
Trakcare fully utilised to ensure a good hand over of care including any risks identified during the in-patient stay, this supports good management when the patient is in the lounge.

Food and clothes bank
In the Autumn last year we joined forces with the Stockton Food Bank service based in Billingham. We now have a small stock of food parcels containing none perishable items that can be given to Patients on discharge if they require them. Patients sometimes do not have anyone to get them any shopping and might not have the energy to head out to the shops following a hospital stay, this initiatve is to support these Patients to make sure they

have basic food provision to enable them to settle in back at home. We have the food parcels available in both the discharge lounge and A&E.
It has been brought to our attention that there are some Patients who do not have suitable attire to be discharged home in. This might be because they have left home in an emergency or because their clothes have been soiled. We are in the process of teaming up with Age UK to look providing a variety of basic clothes parcels to ensure Patients can always be clothed appropriately, if they want to be, when they leave hospital.

4. Trust assessment against the CQC report recommendations on 'Not Seen, Not Heard - A review of the arrangements for child safeguarding and health care for looked after children in England'

The CQC has been reviewing the health care aspects of children's services in England since September 2013. The 'Children Looked After and Safeguarding' (CLAS) in-depth inspections assess how health services in a local authority area work together to provide early help to children in need, improve the health and wellbeing of looked after children, and identify and protect children who are at risk of harm. These reports were analysed in 'Not Seen, Not Heard' and recommendations were made. Full report is here:
http://www.cqc.org.uk/sites/default/files/20160707_not_seen_not_heard_report.pdf

Reference to local CLAS inspections can be found in the Quality Account from page 25 onwards.

The Trust's Board considered a response to the national Not Seen Not Heard report and a summary of its response was contained in the following Board report extract:

'Detail

3.1 The CQC report was presented at NTHFT Safeguarding Children's Steering Group 14/09/16 to share findings and recommendations

3.2 At this meeting it was agreed that a Task and Finish Group be established to complete a gap analysis of the recommendations within the report against current practice.

3.3 The first session of the Task and Finish Group was held 11/11/16. At this meeting the scope and representatives of future meeting was agreed.

3.4 Of the 38 recommendations reviewed, 22 were identified as either being met or were considered to be outside the domain of the Trust's responsibilities.

3.5 A triangulation of the gap analysis and to provide assurances that those recommendations not included in the planned action plan are being achieved fully by the Trust.

3.6 A work plan that has been created addressing the 16 identified recommendations that the Trust is currently not achieving, the work plan will include agreed leads and timescales.

3.7 The CQC report has been shared via the Trusts' internal communications system

3.8 The final work plan will be ratified at the next Safeguarding Children's Steering Group.

Voice of the Child:

Will be clearly identified in final work plan.'

Annex A

North Tees and Hartlepool NHS
NHS Foundation Trust

CDI Improvement plan 2016-17

Issue	Actions for implementation	Lead	Timescale	Measures of success	Progress/ updates due
Environmental cleaning	1. Implement decant programme to facilitate maintenance, deep cleaning and fogging 2. Equipment cleaning project as part of 90 day improvement programme 3. Consideration of housekeeper role for high risk areas 4. Review of roles of decontamination team to facilitate wider access to reactive fogging 5. Implement template for reporting of cleaning scores to Infection Control Committee to facilitate monitoring of progress (RAG reporting)	1. G Kelly 2. IPC Project team 3. IPC project team 4. G Kelly 5. G Kelly/ L Wharton	1. Ongoing from May 2016 2. November 2016 3. November 2016 4. November 2016 5. July 2016	1. All high risk wards completed by November 2016 2. Improvement in patient equipment cleaning scores and rollout plan 3.Paper to Executive Team for consideration 4. 24/7 access to HPV fogging 5. Accurate and relevant information reported to ICC	1. Programme developed and commenced June 2016 and completed November 2016. **Utilising UV light technology which reduces down time of room for cleaning. Evaluation planned for March 2017** 2. 90 day programme completed and objective was achieved ie to increase the equipment cleaning score to 93%. **Costs for rollout plan being prepared for presentation to Executive Team** 3. Will be part of recommendations as above. Already implemented in EAU 4. Ongoing and involves organisational change 5. Template agreed for use at each ICC. **Complete**
Hand hygiene	1. Use of hand hygiene champions in clinical areas to observe and encourage hand hygiene practice 2. Participation in initiatives such as World Hand Hygiene Day and International Infection Prevention Week to raise awareness with staff patients and visitors. Use such things to support revalidation in nurses to increase engagement 3. Continued use of RAG report to highlight areas of concern and monitor progress 4. Focus on problematic groups of staff 5. Use of hand hygiene survey on trust website to gain patient feedback on observed hand hygiene	1. IPCNs 2. IPCT 3. D Jenkins/ L Wharton 4. IPCT 5. IPCT	1. Ongoing from April 2016 2. Ongoing from April 2016 3. Ongoing from April 2016 4. Ongoing from April 2016 5. Ongoing from April 2016	1. Consistent improvement in hand hygiene scores across all clinical areas and all staff groups 2. Raised awareness in patients and greater patient participation in hand hygiene survey on trust website	1. Monthly champions challenges being utilised to raise awareness in wards/departments. The **March** challenge is to encourage colleagues to c**ontinue to practice high standards of hand hygiene even at times of higher activity** 2. Activities undertaken as part of WHO Hand hygiene day in May/**IPS Hand Hygiene Torch Tour/ International Infection Prevention Week. Planning now underway for 5th May campaign for 2017** 3. RAG report used within directorates to target problem areas and led to specific campaign in Emergency Care **Complete** 4. As above regarding Emergency care. Also supporting an initiative on Critical Care (medical staff) 5. Improved response to survey on website following distribution of information cards **but still quite low numbers of respondents**
Antibiotic stewardship	1. Continue to expand audit information utilising pharmacy technician hours, junior doctor audits and antimicrobial pharmacist 2. Revise format of Trust Antibiotic Group and monitor attendance 3. Implement template for reporting of antibiotic audit data to Infection Control Committee 4. Utilise CQUIN work to support reduction of antibiotic consumption, particularly carbapenems and pip/taz 5. Participate in PHE PPS including antibiotic stewardship 6. Participate in European Antibiotic awareness day	1. B Alexander 2. P Dean 3. B Alexander/ L Wharton 4. B Alexander/ R Dube 5. IPCT/ R Alexander 6 R Alexander/ R Dube	1. Ongoing from April 2016 2. May 2016 3. July 2016 4. Ongoing from May 2016 5. December 2016 6. November 2016	1. Improved compliance with antibiotic policy 2. Improved engagement from clinical staff/ attendance at meeting 3. Accurate and relevant information reported to ICC	1. **Third** round of core audit, prophylaxis audit and IV audit underway. 2. The new format Antibiotic Group is running as planned in conjunction with the D&T Committee and has had improved attendance as a result Complete 3. Dashboard developed and available to staff. Utilised for reporting at ICC Updated dashboard shared with clinicians via all trust users bulletin **Complete** 4. CQUIN audits underway to support stewardship. Utilising TDG to receive feedback from directorates on actions to reduce antibiotic use. **Carbapenem and Tazocin use reduced. Overall antibiotic consumption appears to have increased but likely to be due to Sepsis campaign and complexity of patients admitted.** 5. Trust participated in PHE point prevalence survey which includes antibiotic stewardship. **Trust results received and will be presented at April ICC prior to wider circulation.** 6. Awareness programme carried out for EAAD in November 2016 with events on trust sites and community settings
Governance	1. Review process for completion of and challenge to root cause analysis 2. Consider holding C difficile 'summit' to engage all relevant stakeholders and encourage sharing of ideas 3. Explore appeals process with commissioners	1. L Wharton/ J Lane 2. L Wharton/ J Lane 3. L Wharton	1. June 2016 2. July 2016 3. July 2016	1. Robust RCA with learning identified 2. Additional actions identified	1. Process agreed and RCAS where lapse in care thought to have occurred will be presented to the Incident Review panel bimonthly. 2. CDI summit held on October 13th with good attendance. Agreed standards of practice to be monitored as below. 3. Working with commissioners to establish appeals process for Tees. LW attended DDES appeals panel in December to understand process.
Training	1. Provision of training to ward based staff by a variety of means eg attendance at ward away days, development of workbook/elearning 2. Reintroduction of IPC mandatory training 3 yearly	1. IPCT 2. IPCT	1. Ongoing from June 2016 2. October 2016	1. Raised awareness of preventative measures in trust staff	1. C Difficile e-learning package developed and available on the trust intranet. Trigger for completion is period of increased incidence or request from ward matron/SCM **Complete** 2. 3 yearly training in IPC for clinical staff agreed and in place using various methods of training **Complete**
Collaborative working	1. Provision of training/ awareness to key partners eg care home staff/ GP/ social care staff 2. Work with CCG colleagues to facilitate RCA process for non trust cases 3. Working collaboratively with other provider trusts to share good practice	1. IPCT 2. L Wharton 3. L Wharton 4. IPCT/SCMs 5. LWharton 6. L Wharton/ J	1. Ongoing from April 2016 2. Ongoing from May 2016 3. Ongoing from June 2016 4. Ongoing from August 2016 5. December 2016	1. Whole health economy engagement and action to reduce risk of infection 2. Shared learning from RCAs 3. Learning from good practice elsewhere	1. Training for social care developed and on offer to care homes and social care organisations from August 2016 2. Regular meetings between AD N&IPC/ HQ&AS to discuss RCA and other IPC matters 3. Trust participates in regional HCAI forum and share good practice and learning with other local trusts

Issue	Actions for implementation	Lead	Timescale	Measures of success	Progress/ updates due
	4. Re-visit basic infection prevention and control measures aimed at minimising spread to determine if improvements can be made. Explore ways of improving practice. 5. Contact made with successful trusts to understand any gaps in current measures 6. Consider independent review by IPC nurse and /or microbiologist	Lane	6. February 2017	4. Additional actions identified. 5. Assurance received or additional actions identified 6. Assurance received or recommendations identified	4. Trust participated in national IPC collaborative as above and has agreed standards for implementation and monitoring as below 5. **Responses received collated for presentation to April ICC and meeting with NHSE/ NHSI/CCG. Review shows successful trusts are not taking any additional measures that are not in place at NTH.** 6. **On hold until discussions with NHSE/NHSI/CCG on March 23rd are completed.**
Point of care practises	1. C difficile summit on 13th October agreed the following standards which will be implemented and monitored via the newly formed CDI Improvement Group. Directorates will be required to provide assurance around achievement of the standards and identify any barriers to achievement which can be acted upon appropriately • Each room vacated by a CDI positive patient will be fogged prior to re-use • A bay that has housed a positive patient should undergo an enhanced clean to include stripping of all beds in the bay • Each ward should be vacuumed daily with particular attention to areas which are not easily cleaned • Bed making should minimise the dispersal of spores • Each ward toilet should be cleaned four times per day • Each toilet clean includes surfaces and objects that are most likely to be contaminated with spores • Each patient should practise hand hygiene before eating and after using the toilet • Patients should be taken to a toilet rather than using a commode in a bay, where possible • Case notes and case note trolleys should be cleaned regularly and frequently • Patients with diarrhoea should have regular showers • Sporicidal wipes should be used for all toilet and commode cleans • At all times there should be minimal clutter in clinical areas • Gel and soap dispensers should be cleaned on a daily basis • Food trays should be removed from CDI patient rooms promptly and decontaminated appropriately • Each dirty utility room should contain a hand wash basin • Single room doors should be kept closed when CDI patient is present	1. L Wharton/ C Dyson	1. Ongoing from October 2016	1. Assurance of compliance is provided to the CDI Improvement Group and audit supports compliance	1. Terms of Reference for CDI Improvement Group drafted. Meeting bimonthly and standards discussed in alternate months at HCAI Operational Group to reduce duplication. The 16 standards have been allocated as high priority (immediate), medium (1-6 months) or low priority (6-12 months) and will be addressed by the CDI IG in order of priority. 2. Standards reviewed at initial meeting and assurance received that many are implemented. 3. Template for exception reporting by directorates developed for use at both meetings.