UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 28 JANUARY 2016

Title:	**CARE QUALITY REPORT (including Infection Prevention & Control)**
Responsible Director:	Philip Norman, Executive Chief Nurse
Contact:	Michele Owen, Deputy Chief Nurse

Purpose:	To provide the Board of Directors with an update on care quality improvement within the Trust, including infection prevention and control.
Confidentiality Level & Reason:	None
Annual Plan Ref:	Aim 1. Always put the needs and care of patients first.
Key Issues Summary:	This paper sets out the position for defined aspects of care quality within the Trust and supporting actions to ensure continued improved performance.
Recommendations:	The Board of Directors is asked to receive this report on the progress with Care Quality.

Approved by:	Philip Norman	**Date:** 18 January 2016

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BOARD OF DIRECTORS
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CARE QUALITY REPORT

PRESENTED BY THE EXECUTIVE CHIEF NURSE

1. Introduction and Executive Summary

This paper provides an update of progress against the Trust's Care Quality agenda. The paper provides an update on infection control performance, falls, discharge management, nutrition & hydration and the action plan following the cancer patient national survey.

2. Infection Control Update

For December 2015 there were 8 cases of Clostridium Difficile Infection (CDI) reported, of which 6 were Trust apportioned. To date there have been 51 Trust apportioned cases of CDI, which is slightly above the annual trajectory of no more than 63 Trust apportioned cases. Actions to further improve CDI performance continue with a specific focus on antimicrobial prescribing, choice of antibiotic and duration of use.

In terms of Meticillin Resistant Staphylococcus Aureus (MRSA), there was 1 non-Trust apportioned case of MRSA reported in December 2015. This sample was taken on admission to the Trust and is therefore non-Trust apportioned and is currently being reviewed by the Clinical Commissioning Group (CCG). In total and as previously reported, we have had 7 Trust apportioned MRSA cases for this financial year, against an annual target of 0 avoidable cases. The last MRSA case was reported in October 2015.

In relation to ensuring MRSA performance, key actions have been agreed with the CCG and have been formulated into a Trust wide MRSA reduction plan. The key actions include:

1. Reinvigorating the focus on hand hygiene and audits of compliance. With strict attention to hand hygiene and the use of personal protective equipment.

2. Screening - ensuring all relevant staff understand the correct procedure for screening patients for MRSA before admission, on admission and the screening of patients with an extended hospital length of stay. This will ensure that decolonisation treatment is instigated at the earliest opportunity. Routine decolonisation of patients within the critical care unit is now in place.

3. Ensuring the optimal management of all patients with MRSA colonisation and infection, including decolonisation treatment, prophylaxis during procedures, and treatment of established infections.

4. Careful attention to the care and documentation of any devices.

5. Ensuring all relevant staff are performing saving lives audits and acting on the results.

6. Ensuring all staff are aware of their responsibility for preventing and controlling infection through mandatory training attendance. With a robust communication strategy around the MRSA reduction plan.

7. Ensuring cleaning standards are reviewed and implemented.

8. Ensuring MRSA Post Infection Review (PIR) investigations are completed and lessons learnt are feedback throughout the Trust.

3. Falls Update

In Quarter 3 (October to December 2015), there were a total of 728 patient falls. This is an increase from Quarter 2 where there were 624 incidents.

Falls data Quarter 2 and Quarter 3 2015/16

Falls Indicator Q2 & Q3 2015/16	**Q2**	**Q3**
Bed days	98208	98801
Total patient falls	624	728
Patient falls per 1000 bed days	6.4	7.4
Patient falls resulting in no harm	498 (79.8%)	582 (79.9%)
Patient falls resulting in minor harm	112 (17.9%)	133 (18.3%)
Patient falls resulting in moderate harm	8 (1.3%)	7 (1.0%)
Patient falls resulting in severe harm	6 (1.0%)	6 (0.8%)

The percentage of patient falls which resulted in ‘no harm’ remains between 79-80%; minor harm remains around 18%, the number of moderate and severe harms (in these cases, fractures) has decreased from 1.0% to 0.8%. During December 2015 there were no severe harm falls.

Actions underway to further reduce the incidence of falls:

- Royal College of Physicians (RCP) national inpatient audit 2015 has been completed and identified some areas for improvement. An action plan has been developed to take forward these actions
- Training and Education - Trust level is currently at 94.17%. Target for the end of Quarter 4 2015/16 is 95%

- Continue to embed CEEPSAFE documentation (falls documentation) and audit its use
- Continued focus on falls prevention
- 25 additional hi/lo bed tables have been purchased and are being distributed to wards during January 2016
- Audit of specialist hi/lo beds is planned for Quarter 4 2015/16.

4. Discharge Management

4.1 Complex Discharge

The focus of the Complex Discharge Team (health and social care) is to further improve the quality of discharge management, enhance communication and improve collaborative working practices. In order to achieve this, teams such as Social Services and the Complex Discharge Nursing Team are involved in discharge work collectively to ensure there are minimal delays in discharge arrangements and/or the transfer of patients to ongoing care settings. The Complex Discharge Team has now located into the Discharge Hub within the Wolfson Centre. This co-located environment is aimed at further improving joint working and further improving processes around the management of referrals through to the allocation of a case worker and the tracking of assessment outcomes to the actual planned discharge of the patient whether it be to the patient's home or to an ongoing care facility.

A number of actions have been identified to further improve the current process for complex discharge. These are:

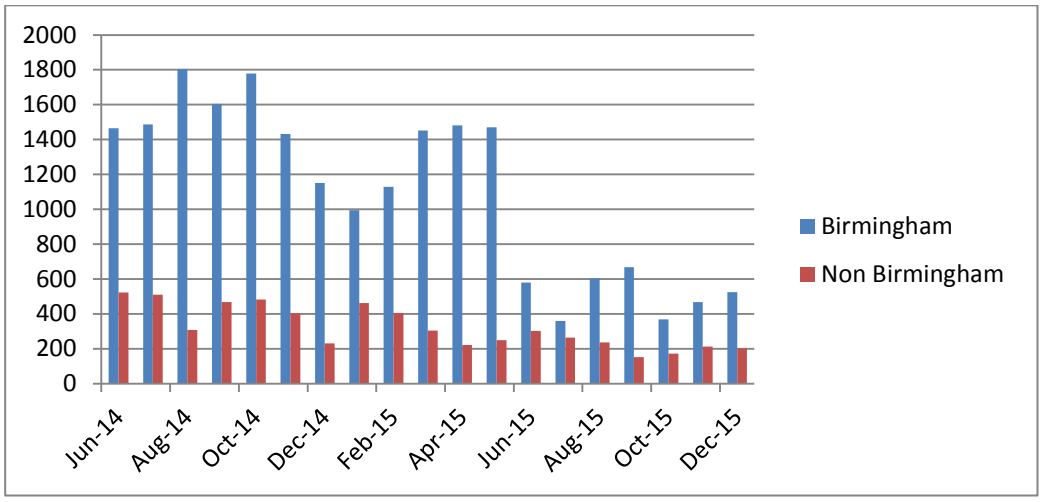
4.1.1 Transfer of Care (TOC) Referral

June 2015 saw the launch of the new combined Transfer of Care referral form for patients requiring assessment by either social services or health as part of the discharge pathway. Embedded within the TOC is the Continuing HealthCare Checklist. By introducing the new referral form, this has enabled screening by healthcare staff of all referral forms submitted, screening by social services to the appropriate member of the social services team for example Social Worker or Care Practitioner. This has led to a more efficient and effective process.

4.1.2 Combined Health and Social Care Meetings

Daily board rounds are now taking place between health and social care. All patients with an active Transfer of Care referral are discussed; this includes Birmingham and Non Birmingham Local Authorities. Outcomes of assessment are tracked within the Discharge Hub Management System (DHMS). To support this process even further, the Enhanced Assessment Bed (EAB) Coordinator attends the meeting which enables appropriate discussions regarding progress of referral to EAB and position on waiting list for placement. Further development of this system is underway with the aim that the Discharge Hub Management System will be available at ward level.

Table 1.0 Number of days delayed within the month for patients reported via the situation (SitRep) report.



4.1.3 Director Led Discharge Group

The Director Led Discharge Group supports clinical areas where complex discharges may have a deviation from the normal pathway or where there is a social element delaying process that requires escalation for further support and assistance. Patients are identified at the Transfer of Care board round or by request for discussion by clinical teams.

Since the Group was formed 25 patient cases have been discussed and reviewed in conjunction with clinical teams, however it should be noted that since the changes in process around the Transfer of Care referrals (outlined above), only one patient has required to be referred to the Director Led Discharge Group.

4.1.4 Workforce

The Clinical Discharge Hub Manager is now in post, 3 additional Discharge Liaison Nurses have also joined the existing team. Ongoing review is taking place with Birmingham City Council around Social Services workforce and case management requirements.

4.1.5 Patient Choice/Bed Utilisation Policy

In line with the launch of the Transfer of Care referral, there has been an opportunity to re-launch in conjunction with the Clinical Commissioning Group the patient choice letters.

4.2 Discharge on the Day

The Discharge Steering Group oversees and leads on the quality and process of discharge planning from the Trust. The Group aims to innovate and implement initiatives to further improve the processes around discharge management and to ensure that key performance indicators and contractual requirements relating to discharge are delivered.

A number of actions have been identified to further improve the current process for discharge on the day. These are:

4.2.1 Criteria Led Discharge

The Criteria Led Discharge Instruction process is now embedded in Divisions B and D. Further work is underway to roll this process out in Division C. Development work has been completed and a tool is available to support clinical teams within the Prescribing Information and Communication System (PICS).

4.2.2 Discharge Lounge

The Discharge Lounge was relaunched on 5 October 2015 with improved systems and arrangements in place to support both patients and staff. Following relaunch, review of the Discharge Lounge usage will take place in early 2016.

4.3 Key Performance Indicators

Following discussion with divisional representatives at the discharge steering group, further work is currently underway to develop a clear vision of the data that is needed to meaningfully track and interpret delays to discharge. Going forward, this information is likely to be sourced from the interactive ward bed viewer boards.

5. Nutrition and Hydration Update

5.1 Dementia Care Crockery

Dementia care crockery and rio freedom crockery has been installed in four wards and has proven extremely successful. Following a further approach to the Friends of UHB in November 2015, further support investment has been secured to provide this crockery in six additional wards (Bournville, Harborne, 410, 513, 517 and 516). The dining plates have an embedded lip which negates the need for a plate guard. This additional rim lip helps all groups of patients to eat independently, such as; patients with an arm in plaster, patients who have suffered a stroke etc.

5.2 Malnutrition Universal Screening Tool (MUST) Training Programme

It was identified that the training and education provided to nursing staff in relation to Malnutrition Universal Screening Tool (MUST) required updating. Nursing staff previously completed MUST training on commencing with the Trust, but there had been no formal follow up training or competency based assessment following the initial training. The dietetic team reviewed the current education and training being provided in collaboration with members of the relevant nursing teams. It was agreed that a change in both the delivery and content of the training was required and an incremental "roll out" was adopted to support this approach. Division C was identified as the test area and this is underway.

Following review, a number of actions have been agreed and are being implemented to better support and strengthen the current knowledge basis of the nursing teams around MUST.

5.3 Shelford Group update

Following collaborative working with the nine other Trusts within the Shelford Group, it was agreed that a review of how each Trust manages Nutrition and Hydration should be undertaken. A baseline measure of each of the Shelford Group Trusts was required and an audit tool was designed by UHB.

Each Trust agreed to undertake two PDSA cycles (Plan, Do, Study, Act). The UHB audit identified that the use of adapted cutlery was not fully embedded within all the older adult wards. This has enabled improvements to be made. A further nutrition and hydration audit will be undertaken in February 2016. Subsequent actions will be agreed based on the findings of the audit.

6. Cancer Patient National Survey - Action Plan Update

The National Cancer Patient Experience Survey was last undertaken in 2013. Following receipt of the survey findings, an action plan was developed to further improve the cancer patient experience. Key areas of focus have been:

- Patient holistic needs assessment continues across all cancer sites by Clinical Nurse Specialist teams
- Patient information continues to be reviewed, updated and uploaded to the Trust website
- Letters to patients now invite a friend or relative to accompany the patient to appointments if desired
- The use of the Prescribing Information and Communication System (PICS) and the clinical portal is routinely used within day case and outpatient departments to ensure all relevant information is available for patient consultation
- Breakthrough Breast Cancer Service Pledge actioned and completed.

The Communication Project with GPs continues to develop (the use of GP Portal). The current focus has been to develop cancer data within the Portal.

The emphasis currently with the Clinical Commissioning Groups is surrounding performance and the Cancer Targets. Survivorship and shared care will be an area of focus for 2016.

Citizens Advice Bureau (CAB) continues to be a very successful project which has supported patients to claim appropriate benefits and receive other financial support and advice. Funding from Macmillan Cancer Support has now been extended until the end of June 2016.

All cancer sites have been through an internal validation process as part of the Peer Review Process. The action plans have been reviewed and good practice discussed and shared, whilst also addressing any outstanding actions. Actions continue to be monitored via the monthly Cancer Steering Group.

The 2016 National Cancer Patient Experience Survey is now in progress. Sampling and patient lists have been submitted to Quality Health and questionnaires have been sent to patients.

Data collation will then take place, and action plans formulated as a result of the responses with the cancer sites.

7. Recommendations

The Board of Directors is asked to receive this report on the progress with Care Quality.

Mr Philip Norman
Executive Chief Nurse
January 2016