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Introduction

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes.

These schemes require the development of clear plans and goals through agreement between providers and commissioners.

The goals have a proportion of the provider’s contract income linked to them which is earned by the provider upon achievement of the goals.

The overall financial value of CQUIN schemes is currently 2.5% of the provider’s contract value.

For MCHFT, the financial value of the 2014/15 CQUIN scheme is £3,855,822.

For 2014/15, there are three national CQUIN goals which focus on the Friends and Family Test (goal one), NHS Safety Thermometer (goal two) and Dementia Care (goal three).

MCHFT and the Clinical Commissioning Groups (CCGs) for Vale Royal and South Cheshire have agreed a further nineteen goals (goals four to twenty two).

The financial allocation for the locally negotiated CQUIN goals has still to be confirmed. This will be concluded in quarter 4.

The North West Specialised Commissioning Group (SCG) negotiated two goals in relation to the screening services (goals twenty three and twenty four) for vulnerable and deprived groups. Goals for the neonatal services provided at Mid Cheshire Hospitals NHS Foundation Trust have been agreed with the Local Area Team and were commenced in quarter 2 (goals twenty five to twenty seven).

This paper summarises progress against the CQUIN goals for quarter 3 (October – December 2014).
## Performance Summary

**Quarter 3 (October – December 2014)**

<table>
<thead>
<tr>
<th>Goal No.</th>
<th>Goal Name</th>
<th>Description of Goal</th>
<th>Expected Financial Value of goal (£)</th>
<th>RAG Status Quarter 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Friends &amp; Family Test (F&amp;F Test)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 1: Further Implementation of the F&amp;F Test</td>
<td>Implement the staff F&amp;F Test</td>
<td>97,966</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Implement the F&amp;F Test in outpatient and day case departments by 1 October 2014.</td>
<td>71,196</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 2: Increase response rates</td>
<td>Increase response rates in acute inpatient services</td>
<td>71,196</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 1 – at least 25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 4 – at least 30%.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase response rates in A&amp;E</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 1 – at least 15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 4 – at least 20%.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 3: Further increase response rates within inpatient services</td>
<td>Further increase response rates within inpatient services to achieve a response rate of 40% or more for the month of March 2015.</td>
<td>71,196</td>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td>NHS Safety Thermometer</td>
<td>Achieve a reduction in pressure ulcer prevalence (based on safety thermometer data).</td>
<td>177,991</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Dementia:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 1: Assess and Refer</td>
<td>The proportion of patients aged 75 and over to whom the case finding question is applied following emergency admission; the proportion of those identified as potentially having dementia who are appropriately assessed and the number referred to on GP services.</td>
<td>106,794</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 2: Training</td>
<td>Named lead clinician for dementia and appropriate training for staff.</td>
<td>17,799</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 3: Supporting carers</td>
<td>Ensuring carers feel supported.</td>
<td>97,824</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>Advancing Quality (AQ): Acute Myocardial Infarction</td>
<td>Implement the AQ care pathway for Acute Myocardial Infarction.</td>
<td>14,239</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>Advancing Quality (AQ): Heart Failure</td>
<td>Implement the AQ care pathway for Heart Failure.</td>
<td>14,239</td>
<td>☹️</td>
</tr>
<tr>
<td></td>
<td>Topic Description</td>
<td>Implementation Details</td>
<td>Score</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Advancing Quality (AQ): Hip and Knee Replacement</td>
<td>Implement the AQ care pathway for Hip and Knee Replacement.</td>
<td>14,239</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Advancing Quality (AQ): Pneumonia</td>
<td>Implement the AQ care pathway for Pneumonia.</td>
<td>14,239</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Advancing Quality (AQ): Stroke</td>
<td>Implement the AQ care pathway for Stroke.</td>
<td>14,239</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Advancing Quality (AQ): Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Implement the AQ care pathway for COPD.</td>
<td>14,239</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Advancing Quality (AQ): Hip Fracture</td>
<td>Implement the AQ care pathway for Hip Fracture.</td>
<td>14,239</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Advancing Quality (AQ): Sepsis</td>
<td>Implement the AQ care pathway for Sepsis.</td>
<td>14,239</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Advancing Quality (AQ): Acute Kidney Injury</td>
<td>Implement the AQ care pathway for Acute Kidney Injury.</td>
<td>14,239</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Advancing Quality (AQ): Diabetes</td>
<td>Implement the AQ care pathway for Diabetes.</td>
<td>14,239</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Advancing Quality (AQ): Alcoholic Liver Disease</td>
<td>Implement the AQ care pathway for Alcoholic Liver Disease.</td>
<td>14,323</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Prevention of inappropriate emergency admissions</td>
<td>To review each emergency admission over the age of 85 who is living in a nursing or residential home to determine if the admission could have been prevented. This will be progressed in partnership with local care homes.</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Promoting the elderly voice and carer involvement</td>
<td>To use patient passports for elderly patients who do not have capacity, on the elderly care ward in the first instance. To improve communication with care home facilities at the earliest point of intervention to ensure passports are comprehensive and accurate. To involve carers/relatives in the care of the elderly patient as much as they wish. This will be progressed through the process of open visiting. To involve the RVS volunteer scheme as part of the care team on the care of the</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>elderly ward and the trauma orthopaedic ward to ensure socialisation and normalisation of daily activities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Promoting self management in patients with long term conditions at Elmhurst</td>
<td>To implement self administration of medicines at Elmhurst Intermediate Care Centre to promote independence, participation in self care and improve understanding of medication regimes.</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Promoting self management in patients with long term conditions (Diabetes or Parkinson's)</td>
<td>To develop self care pathways for patients who have Diabetes or Parkinsons to manage their medicines</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Improving outpatient experiences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 1: adult general outpatients</td>
<td>To review the current use of adult general outpatients facilities and work closely with patient focus groups to prioritise and improve patient experience.</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 2: urology patients</td>
<td>To progress nurse led services for urology patients to reduce waiting times, improve outcomes and improve patient experience.</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 3: triage service for pregnant women</td>
<td>To review the effective use of the triage service for pregnant women to improve patient experience.</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 4: paediatric outpatient facilities</td>
<td>To review the current use of paediatric outpatient facilities and work closely with patient/parent focus groups to prioritise and improve patient experience.</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Liaison between acute care and primary care for patients who self discharge</td>
<td>To review communication with primary care in relation to admissions who self discharge from assessment areas; gastroenterology wards and the female surgical ward.</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Management of people with complex learning disabilities</td>
<td>To improve the experience of patients with learning disabilities who access hospital services as an emergency.</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Implementing Medicine Homecare Services</td>
<td>To develop robust policies and processes to manage the provision of medicines via the Homecare route.</td>
<td>244,915</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Bowel screening service for vulnerable and deprived groups</td>
<td>Ensure that a health inequalities action plan is in place to provide a bowel screening service for vulnerable and deprived groups.</td>
<td>21,000</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Description</td>
<td>Description</td>
<td>Status</td>
<td>Status</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>24</td>
<td>Breast screening service for vulnerable and deprived groups</td>
<td>Ensure that a health inequalities action plan is in place to provide a breast screening service for vulnerable and deprived groups.</td>
<td>14,000</td>
<td>✓</td>
</tr>
<tr>
<td>25</td>
<td>Neonatal specialised commissioning: Medical genetics</td>
<td>To increase the availability of array CGH as a first line test to replace karyotyping on prenatal samples to provide a rapid and detailed screen for chromosome imbalance in pregnancies at increased risk of a genetic abnormality.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>26</td>
<td>Neonatal specialised commissioning: Retinopathy of prematurity (ROP) screening</td>
<td>To achieve an increase in screening to a target of 95% of babies with a birth weight of &lt;1501g or a gestation of &lt;32+0 weeks who undergo 1st Retinopathy of Prematurity (ROP) screening whilst still an in-patient and screened ‘on time’.</td>
<td>96,000</td>
<td>✓</td>
</tr>
<tr>
<td>27</td>
<td>Neonatal specialised commissioning foetal medicine dashboard</td>
<td>To measure parental involvement in decision making and the foetal loss rate after invasive diagnostic procedures.</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

**RAG status:**

- **On track**
- **Off track but recoverable**
- **Off track and unlikely to recover**
Goal 1: Friends and Family Test (F&F Test)

Part 1: Further Implementation of the F&F Test

Aim

Implement the staff F&F Test

Implement the F&F Test in outpatient and day case departments by 1 October 2014.

Progress Report

Staff F&F Test

- The Trust implemented the Staff F&F Test on 1 April 2014.
- Data collection was separated into quarters
  - Q1- Emergency Care and Corporate
  - Q2- Women, Children & Sexual Health and Surgery & Cancer
  - Q3- Bank staff (results to be added to Q4 return)
  - Q4- Estates & Facilities and Diagnostics & Clinical Support Services
- The Trust’s own bespoke electronic survey was utilised and postcards were attached to payslips.
- There was not a national return required for Q3 and so the Trust took the decision to survey Bank staff during this period. Results will be added to the Q4 return.

F&F Test in outpatient and day case departments

- The Trust introduced the F&F Test into the following outpatient departments in August 2014:
  - Fracture clinic
  - Ophthalmology
  - Ear, Nose and Throat (ENT) and
  - Urology
To date 1058 patients have responded after attending the above clinics. Results show that 93% of patients would recommend the outpatient clinics.
- The F&F Test will commence in the dermatology outpatient department and the planned investigation unit (PIU) in February 2015.
- Plans are also in progress to roll out the F&F Test to day case patients and general out patients in Quarter 4.
- A child friendly F&F Test card has been developed by paediatric staff in liaison with patients to encourage responses.

Status
Goal 1: Friends and Family Test (F&F Test)

Part 2: Increase response rates

Aim

Increase response rates in acute inpatient services:
Quarter 1 – at least 25%
Quarter 4 – at least 30%

Increase response rates in the accident and emergency department (including assessment areas):
Quarter 1 – at least 15%
Quarter 4 – at least 20%

Progress Report

The response rates for the F&F Test have been as follows:

<table>
<thead>
<tr>
<th>Month</th>
<th>Acute inpatient services</th>
<th>Accident &amp; emergency department and assessment areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2014</td>
<td>46%</td>
<td>23%</td>
</tr>
<tr>
<td>May 2014</td>
<td>46%</td>
<td>21%</td>
</tr>
<tr>
<td>June 2014</td>
<td>50%</td>
<td>21%</td>
</tr>
<tr>
<td>July 2014</td>
<td>45%</td>
<td>20%</td>
</tr>
<tr>
<td>August 2014</td>
<td>36%</td>
<td>17%</td>
</tr>
<tr>
<td>September 2014</td>
<td>34%</td>
<td>23%</td>
</tr>
<tr>
<td>October 2014</td>
<td>50%</td>
<td>18%</td>
</tr>
<tr>
<td>November 2014</td>
<td>46%</td>
<td>15%</td>
</tr>
<tr>
<td>December 2014</td>
<td>39%</td>
<td>22%</td>
</tr>
<tr>
<td>January 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 2015</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Status

✓
Goal 1: Friends and Family Test (F&F Test)

Part 3: Further increase response rates within inpatient services

Aim

Further increase response rates within inpatient services to achieve a response rate of 40% or more for the month of March 2015.

Progress Report

The average response rate for quarter 1 was 47% which meant the Trust was on track to achieve this element of the CQUIN.

The average response rate for quarter 2 was 38% which means the Trust was slightly off track to achieve this element of the CQUIN.

The average response rate for Quarter 3 was 45% which means the Trust is on track to achieve this element of the CQUIN.

Status

✅
Aim

Achieve a reduction in pressure ulcer prevalence (based on Safety Thermometer data). For the CQUIN, no distinction is made between ‘old’ (present on admission) and ‘new’ (developed after 72 hours of admission) pressure ulcers. For the safety thermometer, data is collected on the first Wednesday of each month.

Progress Report

During 2013/14, 262 pressure ulcers were reported via the Safety Thermometer.

By the end of quarter 3 of 2014/15, 176 pressure ulcers have been reported. This is a reduction of 35 based on the same position last year (a reduction of 16%).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of pressure ulcers reported 2013/2014</th>
<th>Number of pressure ulcers reported 2014/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>May</td>
<td>29</td>
<td>11</td>
</tr>
<tr>
<td>June</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>July</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>August</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>September</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>October</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>November</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>December</td>
<td>29</td>
<td>12</td>
</tr>
<tr>
<td>January</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>262</td>
<td>176</td>
</tr>
</tbody>
</table>

(Data Source: Safety Thermometer, 2015)
The following graphs show the breakdown of the overall number of pressure ulcers by new and old pressure ulcers.

**Safety Thermometer April 2013 to December 2014**

**New Pressure Ulcers**

(Data Source: Safety Thermometer, 2015)

The chart above shows a comparison of the 'new' (hospital acquired) pressure ulcers for 2013/14 and 2014/15.

**Safety Thermometer April 2013 to December 2014**

**Old Pressure Ulcers**

(Data Source: Safety Thermometer, 2015)

The chart above shows a comparison of the ‘old (admitted with) pressure ulcers for 2013/14 and 2014/15.
The Trust has a skin care committee which meets monthly and reviews all hospital acquired pressure ulcers. At the end of quarter 3, there had been 105 hospital acquired pressure ulcers compared with 209 which developed during the same timeframe during 2013/14 (a reduction of 49.7%).

This is slightly off the internal stretch target of a 50% reduction for 2014/15 when compared with the overall numbers of hospital acquired pressure ulcers from 2013/14.

The Trust has two internal stretch targets in relation to reducing pressure ulcers for this financial year.

The aim in the Trust’s Quality and Safety Improvement Strategy is to have no avoidable hospital acquired pressure ulcers reported by April 2016. Avoidable pressure ulcers are shown as the blue bar on the above chart. A mini root cause analysis (RCA) is undertaken for each incident and immediate feedback provided to the staff involved in the patient’s care.

The aim for 2014/15 is to reduce hospital acquired pressure ulcers by 50% by the end of March 2015. This target is shown on the above chart as the black line. A number of actions have been taken to reduce the number of hospital acquired pressure ulcers. These include:

- Establishment of the skin care committee with clinical representation from all divisions
- Development and implementation of the adult inpatient skin bundle
- Development and implementation of a pressure ulcer assessment chart for the emergency department and planned investigation unit
- Development of a tissue viability link nurse programme
- Speciality specific skin bundles have been developed for critical care, neonates and paediatrics.

**Status**

![Checkmark]
Goal 3: Dementia

Part 1: Assess and Refer

Aim

The proportion of patients aged 75 and over to whom the case finding question is applied following emergency admission; the proportion of those identified as potentially having dementia who are appropriately assessed and the number referred to on GP services.

Progress Report

During quarter 1, over 90% of relevant patients were asked the case finding question.

During quarter 2, over 90% of relevant patients were asked the case finding question.

During quarter 3, over 90% of relevant patients were asked the case finding question.

Of those who were identified as potentially having dementia, all were assessed and then referred onto GP services.

Status

✅
Goal 3: Dementia

Part 2: Training

Aim

To have a named lead clinician for dementia and implement appropriate training for staff.

Progress Report

Dr. L. Kalathil, an elderly care Consultant, is the named lead clinician for dementia. He is supported by the named strategic lead for dementia: Phil Pordes, Dignity Matron and the dementia lead nurse: Anna Chadwick. Claire Hassall is the dementia support worker who assists the team, particularly in relation to obtaining data for the national dementia CQUIN.

All new staff to the Trust receive dementia awareness training at induction as do all other staff via mandatory training which they receive bi-annually on BEMU. In addition to this, there are a number of ad hoc learning opportunities provided, including Dementia Friends sessions and education events led by an Advanced Practitioner in Dementia working for the Cheshire and Wirral Partnership Trust.

The Trust has also implemented electronic learning modules for dementia and mental capacity/deprivation of liberty safeguards. These are mandatory for nominated groups of staff. A workbook equivalent for dementia training has also been introduced for those staff who prefer this method of training.

Numbers trained so far:

Dementia Friends sessions: 95 (an increase of 43 during quarter 3)
Advanced Practitioner in Dementia events: 83
The figures for dementia awareness training are calculated as a percentage on a rolling programme. To date, the Trust has achieved 88% for clinical staff and 86% for non-clinical staff. This equates to a total of 87% for all Trust staff.

There have been 118 staff who have completed the e-learning modules (an increase of 65 during quarter 3) and 114 staff are undertaking or have completed the workbook equivalent of the e-learning training (an increase of 29 during quarter 3).

The recent CQC inspection in October found that the Trust had demonstrated improvements in dementia care and the overall experience for patients and their carers was good. The dementia care bundle has been well received by staff and its roll out has been enhanced by support from the Partnership Trust in relation to delirium screening training for clinical and therapy staff.

Status

✅
Goal 3: Dementia

Part 3: Supporting Carers

Aim:

To support carers of people with dementia. A monthly audit must be undertaken to test whether carers feel supported. The results should be reported to the board.

Progress Report:

A monthly audit continues to monitor support within the hospital for carers of people living with dementia. It has been a recurrent theme that responses to the audit have been low, despite all carers being given an information pack (containing audit questionnaire). It is anticipated that response rates will improve once the new dementia care bundle is fully implemented.

During October and November 2014, the dementia care bundle was piloted on four wards. The information pack created for carers was incorporated into this bundle (as a tear off section) which also includes the carer survey in its revised format. The use of the bundle was evaluated at the end of November and the updated document went “live” throughout the hospital in early December 2014.

Audit results show that the majority of respondents felt both supported by the hospital and were able to find someone to discuss any concerns they had regarding their person’s care. All clinical areas have an increasing awareness of the dementia lead nurse role and will refer for clinical and carer support as needed. Information boards are in place in all wards/departments containing points of contact for staff, patients, carers and visitors.

The “Information about Me to Help You” document is supplied to carers of all people living with dementia as near to admission as possible. All carers report receiving this and found it useful as a pen portrait of needs. Staff reiterate its value in offering sensitive, individualised care. This document has been reviewed and is an integral part of the dementia care bundle which is to be used as the individual’s personal support plan throughout their stay in hospital.

Throughout this quarter, the majority of carers reported feeling involved in their person’s care. The dementia care bundle supports this by enhancing partnership working with carers and involving carers from the outset as experts in their person’s needs. Audit figures show that most carers have been able to visit without restriction if required.

During this quarter, most of those surveyed felt updated about the medical treatment that their person was receiving. However, the majority of these felt that this was only when they actively enquired. Most of those surveyed in this quarter that felt that discharge planning had been relevant at the time of survey completion and reported being involved in discharge planning for their relative to some extent.
The dementia nurse continues to work alongside ward staff and social care colleagues to improve carers’ experiences in relation to information provision and involvement in discharge planning.

The majority of carers audited throughout the quarter reported that they felt staff had a good understanding of dementia. Ongoing informal training and support is provided on a day to day basis by the dementia lead nurse and dignity matron. Dementia awareness and update sessions have taken place and further sessions will be planned. ‘Dementia Friends’ sessions have been arranged via the Alzheimer’s Society to encourage staff to be more dementia friendly in their approach. Dementia training is now mandatory within the Trust.

The dementia link worker role is being revitalised to support improvements in care of people with dementia in hospital and their carers. A study day took place in early October to move this forward and further forums are planned into 2015.

All carers who completed the audit reported that they had received written information about organisations representing people with dementia, plus detailed literature from the Alzheimer’s Society and were signposted to available resources, including how to access a carer’s assessment. The Alzheimer’s Society also has an information stand in the main out patients department where information can be accessed by all. Links have been established with the local Alzheimer’s Society to encourage them to feedback any carer concerns to the dementia lead so that issues can be explored and addressed as they arise.

Focus groups are in progress (in collaboration with the Alzheimer’s Society) for people living with dementia and their carers to discuss personal experiences of the Trust in order to explore ways of improving the service we provide.

Status

✅
Goal 4: AQ: Acute Myocardial Infarction (AMI)

Aim

Implement the AQ care pathway for Acute Myocardial Infarction.

Progress Report

This financial year, the Trust performance of the elements of the pathway is being measured using an appropriate care score (ACS). To meet the target, 95% of patients will have to receive all the care elements listed below:

1. Aspirin at arrival
2. Aspirin prescribed at discharge
3. ACEI or ARB for LVSD*
4. Smoking cessation advice/counselling
5. Beta blocker on discharge
6. Evaluation of left ventricular function
7. Statin prescribed
8. Referral made for cardiac rehabilitation

Current performance is summarised in the graph below. It represents the performance of the Trust against target until October 2014. It can be seen that the Trust is highly likely to achieve the target this year.

Status

✅
Goal 5: AQ: Heart Failure

Aim

Implement the AQ care pathway for Heart Failure.

Progress Report

The Trust performance of the elements of the pathway is measured using an appropriate care score (ACS). To meet the target, 80.3% of patients will have to receive all the care elements listed below:

1. Left Ventricular Systolic (LVS) assessment
2. Detailed discharge instructions
3. ACEI or ARB for LSVD
4. Smoking cessation advice/counselling
5. Beta blocker at discharge
6. Specialist review

Current performance is summarised in the graph below. It represents the performance of the Trust against target until October 2014. It can be seen that the Trust will have to maintain an improved performance to meet the target, which is marginally off track (0.75% below target).

![Graph showing Heart Failure performance](image)

Status

🙂🙂
Goal 6: AQ: Hip and Knee Replacement

Aim

Implement the AQ care pathway for Hip and Knee replacement.

Progress Report

This financial year, the Trust performance of the elements of the pathway is being measured using an appropriate care score (ACS). To meet the new target, 84.6% of patients will have to receive all the care elements listed below:

1. Prophylactic antibiotic received within one hour prior to surgical incision
2. Prophylactic antibiotic selection for surgical patients
3. Prophylactic antibiotics discontinued within 24 hours after surgery end time
4. Recommended Venous Thromboembolism (VTE) prophylaxis ordered
5. Appropriate and timely Venous Thromboembolism prophylaxis
6. VTE appropriate duration

Current performance is summarised in the graph below. It represents the performance of the Trust against target until October 2014. It can be seen that the Trust will have to maintain an improved performance to meet the target.

Approach:

- Exception audit to be undertaken by the MDT for patients who do not receive the care expected.
- The cohort of patients will change so elective and trauma patients will be treated using different standard pathways. This may make the required performance more achievable and will be reflected in the figures from October onwards.

Status

😢
Goal 7: AQ: Pneumonia

Aim

Implement the AQ care pathway for Pneumonia.

Progress Report

This financial year, the Trust performance of the elements of the pathway is being measured using an appropriate care score (ACS). To meet the new target, 72.5% of patients will have to receive all the care elements listed below:

1. Oxygenation assessment within 24 hours prior to or after hospital arrival
2. Initial antibiotic selection
3. First dose of antibiotics within six hours after hospital arrival
4. Smoking cessation advice/counselling
5. CURB-65 assessment

The graph below shows the performance of the Trust until July 2014. Please note that due to delays inputting patients on the system this is only a representative figure as not all eligible cases have been analysed. It can be seen that the Trust will have to improve performance significantly to meet the target this year. Additionally, the Trust will fail if the data entry completeness is below 95%.

Consistent data entry and consistent performance remain a challenge for this focus area. The table below shows the number of cases for data entry which are outstanding.

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<th>Focus Area</th>
<th>Jun</th>
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<td>54</td>
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Status

🤔
Goal 8: AQ: Stroke

Aim

Implement the AQ care pathway for stroke.

Progress Report

This financial year, the Trust performance of the elements of the pathway is being measured using an appropriate care score (ACS). To meet the new target, 59.5% of patients will have to receive all the care elements listed below:

1. Direct admission to a stroke unit within 4 hours of hospital arrival
2. Screened for swallowing disorders within 24 hours of admission
3. Brain scan within 24 hours of admission
4. Aspirin within 24 hours of admission
5. Physiotherapy assessment within first 72 hours of admission
6. Assessment by an Occupational Therapist within first 72 hours of admission
7. Weighed at least once during admission

Current performance is summarised in the graph below. It represents the performance of the Trust against target until October 2014. It can be seen that the Trust will have to improve and maintain performance to meet the target this year.

Planned Improvements:

- The provision of a stroke assessment trolley is expected to support timely assessment, appropriate treatment and placement of the patient with a suspected stroke to meet quality targets.
- Partnership working with the University Hospitals of North Midlands will work towards 24/7 access to Thrombolysis for patients. As part of this project, nursing staff at the Trust will receive extra training and support to enable timely assessment of the stroke patient.
- Work is ongoing to scope out therapist provision versus need.
The specialist community stroke rehabilitation team began accepting patients on 1 December 2014. In the first month, 16 patients accessed this programme of specialist therapy in the community. This has enabled earlier discharge from the stroke unit.
Goal 9: AQ: Chronic Obstructive Pulmonary Disease (COPD)

Aim

Implement the AQ care pathway for COPD

Progress Report

This is a new focus area. All participating Trusts have been set a target of 50% ACS. The measures are as follows:

1. Pulse Oximetry and targeted Oxygen prescribed
2. Corticosteroids appropriately administered
3. Bronchodilators appropriately administered
4. Antibiotics appropriately administered
5. Offer Smoking cessation support
6. Offer Pulmonary Rehabilitation referral
7. Review inhaler technique
8. Provide a written self management plan
9. Arrange referral for Home oxygen therapy assessment if appropriate
10. Arrange referral for spirometry if appropriate
11. Ceiling of Care if on Non-invasive ventilation

Additionally, information will be collected as a shadow measure:

- Arrange appropriate follow up within 72 hours

There is no data currently available for Trust performance at present. The AQ process went “live” in September and early results will be available January 2015. For the first three months, the Trust will be measured for data completeness and the target for this is 95%.

The Trust has designed a care pathway that incorporates all the measures. However, there is no process or person identified to enter the data onto the system. The table below shows the number of cases outstanding.

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<tr>
<th>Focus Area</th>
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Status

😢
Goal 10: AQ: Hip Fracture

Aim

Implement the AQ care pathway for hip fracture

Progress Report

This is a new focus area. All participating Trusts have been set a target of 50% ACS. The measures are as follows:

1. Validated pain score assessment and analgesia within 60 minutes of arrival
2. Admission to appropriate Orthopaedic or Orthogeriatric ward within 4 hours of arrival
3. Jointly agreed protocol commenced within 6 hours of arrival.
4. Pressure Ulcer assessment within 6 hours of arrival.
5. Consultant/ senior clinician supervision during surgery.
6. Documentation in the post-operative notes that the patient should fully weight bear.
7. Physiotherapy assessment within 24 hours of surgery
8. Nutritional Screen within 24 hours of arrival.

Additionally, information will be collected as a shadow measure:

- Referral to early supported discharge
- Known to fracture liaison service.

There is no data currently available for Trust performance at present. The AQ process went “live” in October and early results will be available in the next financial year.

The Trust has an embedded care pathway that incorporates all these elements and the Trust has achieved the target for data completeness for the first month.

Status

✅
Goal 11: AQ: Sepsis

Aim

Implement the AQ care pathway for sepsis

Progress Report

This is a new focus area. All participating Trusts have been set a target of 50% ACS. The measures are as follows:

1. Early warning score recorded within 60 minutes of hospital arrival.
2. Evidence of two or more SIRS criteria and documentation of suspected sepsis source within 2 hours of hospital arrival.
3. Blood cultures taken within 3 hours of hospital arrival.
4. Antibiotics administered within 3 hours of hospital arrival.
5. Serum lactate taken within 3 hours of hospital arrival.
6. Second Litre of IV fluids within 4 hours of hospital arrival.
7. Oxygen therapy administered within 4 hours of hospital arrival.
8. Fluid Balance Chart commenced within 4 hours of hospital arrival.
9. Senior review or assessment by Critical Care within 4 hours of hospital arrival.

Additionally, information will be collected as a shadow measure:

- Severity of sepsis documented.
- Antibiotic review within 72 hours.

There is no data currently available for Trust performance at present. The AQ process went “live” in September and early results will be available in the next financial year. For the first three months, the Trust will be measured for data completeness.

The Trust has a care pathway that incorporates these elements. However, the Trust is currently behind the 95% data completeness target. The table below shows how many cases are outstanding.

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<th>Focus Area</th>
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Status

😢
Goal 12: AQ: Acute Kidney Injury

Aim
Implement the AQ care pathway for acute kidney injury

Progress Report
This is a new focus area. All participating Trusts have been set a target of 50% ACS. The measures are as follows:

1. Urine dipstick test within 24 hours of first AKI alert.
2. Stop Angiotensin Converting Enzyme (ACE) inhibitors and Angiotensin Receptor Blockers (ARB) within 24 hours of first AKI alert.
3. Serum Creatinine test repeated within 24 hours of first AKI alert
4. Ultrasound scan of urinary tract within 24 hours of first AKI alert
5. Specialist Renal/ Critical care Discussion within 12 hours of first ‘AKI 3’ alert.
6. Give patients self-management information prior to discharge.

Additionally, information will be collected as a shadow measure:

- Pharmacist medication review within 24 hours of 1st AKI alert.

There is no data currently available for Trust performance at present and the “go live” date of the AQ process is still to be confirmed.

Main Achievement:

- The Trust has a risk assessment tool and care pathway that incorporates these elements

Main Challenge:

- There is no process or person identified to enter the data onto the system.

Status

✓
Goal 13: AQ: Diabetes

Aim

Implement the AQ care pathway for diabetes

Progress Report

This is a new focus area. All participating Trusts have been set a target of 50% ACS. Not all measures will apply to all patients as the measures cover several discrete conditions associated with diabetes. The measures are as follows:

1. Blood Glucose within 30 mins of hospital arrival
2. Foot Inspection is documented within 24 hours of hospital arrival
3. Quick acting Carbohydrates administered within 15 mins of hypoglycaemia detection
4. Blood Glucose Monitored after carbohydrate administration
5. Care escalated if Blood Glucose <4mmol/l at 45 minutes after administration of carbohydrate
6. Cause of hypoglycaemia discussed with patient/ carer before discharge
7. EWS and GCS carried out and repeated at recommended intervals
8. Blood and urine tests to be taken and repeated at regular intervals
9. IV fluids should be commenced within 60 minutes of DKA detection
10. Fixed rate of IV insulin should be commenced within 60 minutes of DKA detection.
11. Documented senior review of the patient
12. Detail of the foot ulcer documented within 4 hours
13. Antibiotic given within 6 hours of foot ulcer detection
14. Patient referred to the hospital foot care team within 24 hours.
15. Patient seen by hospital foot care team within 72 hours of referral
16. Outpatient appointment booked within 6 weeks of discharge

There is no data currently available for Trust performance at present and performance reports will commence in the next financial year.

A small clinical team have conducted an informal gap analysis against the measures. However, there is no process or person identified to enter the data onto the system. The table below shows the number of cases outstanding.

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<th>Focus Area</th>
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<td>Diabetes</td>
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Status

✅
Goal 14: AQ: Alcoholic Liver Disease

Aim

Implement the AQ care pathway for alcoholic liver disease

Progress Report

This is a new focus area. All participating Trusts have been set a target of 50% ACS. The measures are listed below:

1. Early Warning Score recorded within 60 minutes of hospital arrival
2. Screening for Alcohol misuse to be completed within 4 hours of hospital arrival
3. Variceal bleeds have antibiotics and terlipressin administered within 4 hours or hospital arrival or onset of bleed.
4. IV Pabrinex to be administered within 6 hours of hospital arrival.
5. Results of appropriate blood tests to be available within 4 hours of hospital arrival.
6. Ascitic tap performed within 8 hours of hospital arrival
7. Patient admitted to a designated Gastroenterology or hepatology ward within 48 hours of hospital arrival OR review by Specialist Gastroenterologist/Hepatologist within 48 hours of hospital arrival
8. Patient seen by or referred to appropriate alcohol services prior to discharge

Additionally, information will be collected as a shadow measure:

- Was a validated tool used to assess the risk of alcohol withdrawal within 4 hours of hospital arrival?
- Was the patient commenced on an appropriate care bundle?
- Date and time of serum lactate taken.

There is no data currently available for Trust performance at present. The “go live” date of the AQ process will be patients discharged in January and there will be a data collection phase from March to May.

A team with a clinical lead has conducted an informal gap analysis against the measures to inform service improvement. However, there is currently there is no process or person identified to enter the data onto the system.

Status

✅
Goal 15: Prevention of inappropriate emergency admissions

Aim

To review each emergency admission over the age of 85 who is living in a nursing or residential home to determine if the admission could have been prevented. This will be progressed in partnership with local care homes.

Progress Report

A meeting took place with the quality team from the Clinical Commissioning Groups (CCGs) on 16 July 2014 to discuss the milestones to deliver this CQUIN and consider how processes can be put in place that meet the needs for acute care and local care homes who form part of this goal.

The milestones for delivery have been jointly agreed. The data collection form relating to emergency admissions over the age of 85 from nursing or residential homes has been implemented in the emergency department (ED), the primary assessment area (PAA) and the assessment medical unit (AMU).

The data that has been collected includes a review of the place of admission, the date of admission, whether the patient has been readmitted within 30 days and why the clinician thinks the admission is inappropriate.

A provisional review of the results indicates that there are lessons to be learned in relation to increased support and training in the community which can lead to the prevention of inappropriate admissions.

The responses are being collated and will be discussed with the CCGs and other partner organisations during quarter 4.

Status

✅
Goal 16: Promoting the elderly voice and carer involvement

Aim

To use patient passports for elderly patients who do not have capacity, on the elderly care ward in the first instance.
To improve communication with care home facilities at the earliest point of intervention to ensure passports are comprehensive and accurate.
To involve carers/relatives in the care of the elderly patient as much as they wish. This will be progressed through the process of open visiting.
To involve the RVS volunteer scheme as part of the care team on the care of the elderly ward and the trauma orthopaedic ward to ensure socialisation and normalisation of daily activities.

Progress Report

The care of the elderly ward is the designated ward for this CQUIN.

The **open visiting** trial was introduced on ward 14 at the end of July 2014. Patient / visitor feedback has been overwhelmingly positive. Flexibility around working hours, better opportunities to find car parking spaces and the potential to spend as much time as they wished with their relative were the key identified benefits. Comments have included:

‘It is nice to be able to see dad when he is really ill. Prevented us from worrying. Staff are friendly, relaxed and open.’ ‘It is so much better when your relative is ill to be able to be with them. My dad said it boosted his morale having his family around him. Just being able to sit quietly with dad has been invaluable. Thank you’

Staff feedback was also very positive and included comments such as ‘**staff have more time to speak to visitors**’ and ‘**patients love to see their relatives and I think it helps their recovery from an emotional point of view**’

As a result of the positive comments received from all parties, open visiting will remain a permanent feature on ward 14. Visitors have been very happy to wait in the dayroom if requested during ward rounds and a separate area of the dayroom has been refurbished to accommodate relatives, whilst maintaining a comfortable, relaxing area for patients.

The **Royal Voluntary Service scheme** was introduced in January 2014 on ward 14 and has proved very popular with the ward staff and patients and very rewarding for the volunteers themselves. There are currently eight volunteers covering six days a week. The recruitment drive is ongoing and there are two part time RVS service managers employed to facilitate this. Currently, the volunteers spend their time interacting with patients who have been identified for them by the ward staff or whom the volunteer has approached directly. They make drinks and have access to short story books /newspapers to read to the patients. The volunteers are also trialling the use of a hand held tablet as a way to share pictures from the ‘House of Memories’ website. Three of the volunteers are also undertaking training to assist patients at mealtimes. A quarterly update report is compiled by the RVS and shared with the steering group.
The patient passport ‘About Me to Help You’ was introduced in its revised format as part of the dementia care bundle in October 2014 and was piloted on wards 14 and 15. Audits were undertaken over an 8 week period to monitor the completion and location of passports. An outcome of this has been an agreement with the lead nurse for dementia that passports will have a tear off facility within the bundle and will also be available as an individual document. Staff found passports extremely helpful and felt they should be kept at the end of the bed. Their main reasons for reading a passport were to provide an insight and discussion point when delivering personal care.

Use of the passports will continue to be monitored on a weekly basis and the lead nurse for dementia will also audit 15 dementia bundles each month.
Goal 17: Promoting self-management in patients with long term conditions at Elmhurst

Aim

To implement self administration of medicines at Elmhurst Intermediate Care Centre to promote independence, participation in self care and improve understanding of medication regimes.

Progress Report

An audit has been completed involving a review of the healthcare records of 10 inpatients and the healthcare records of 10 patients who have been discharged. The audit looked at the completeness of the assessment process and the quality of the nursing documentation.

The results showed that, of the 20 patients reviewed, 11 patients were assessed as appropriate to be on level 1 of self-medication which means that they were self-medicating supervised by a nurse and one patient was assessed as appropriate for level 2 medication meaning they were taking their medications fully independent of a nurse.

One recommendation has been made following review of the results and this has been progressed into an action plan which is progressing.

The self-medication policy has been reviewed in relation to the nomad packs. It has been decided that no changes should take place at this time. A further review of the policy will follow after full implementation of the action plan.

Status

✔️
Goal 18: Promoting self management in patients with long term conditions
(Diabetes or Parkinsons)

Aim

To develop self care pathways for patients who have Diabetes or Parkinson’s to manage their medicines

Progress Report

A meeting took place with members of the Clinical Commissioning Groups (CCGs) and representation from Pharmacy to agree milestones for quarters 2, 3 and 4.

A snapshot audit has been undertaken to identify the approximate number of inpatients who may be eligible for education relating to self management of their Diabetes or Parkinsons. This highlighted that, of the 236 patients who were reviewed, 16 patients with diabetes and five patients with Parkinsons would be eligible.

All relevant pharmacy staff have now been trained in counselling patients with Diabetes and Parkinsons.

An audit tool is being developed to assess any benefits to the patient following counselling and their ability to self-care. This will be carried out in April 2015.

Status

✓
Goal 19: Improving outpatient experience

Part 1: Adult general outpatients

Aim

To review the current use of adult general outpatients facilities and work closely with patient focus groups to prioritise and improve patient experience.

Progress Report

The Friends and Family Test has been implemented in specialty Outpatient areas and rollout will continue to include General Outpatients up to end of March 2015. It is planned to extend this to Northwich Victoria Outpatients as the next phase of the project.

The department is currently in phase two of planned refurbishment works and the main entrance doors are being replaced to improve the environment and access for both able bodied and disabled patients. The estates team are looking at plans to improve access to the reception desk by lowering the height to facilitate disabled patients.

Patient information boards, including a quality and a clinic information board, have been developed and will be on display in the main hall and each suite to give patients visual information about key performance indicators, staffing details and clinic delays.

As part of the outpatients rationalisation programme, the use of visual information systems in the main hall is being considered, although there are challenges with the installation of these due to the asbestos risk in the fabric of the estate.

Hourly communication (care) rounds have commenced in the main outpatients department and it is planned to extend this to Northwich Victoria Outpatients department from February 2015

Status

✔️
Goal 19: Improving outpatient experience

Part 2: Urology patients

Aim

To progress nurse led services for urology patients to reduce waiting times, improve outcomes and improve patient experience.

Progress Report

The direct referral form has been agreed with the urology advanced nurse practitioner and the nurse and GP quality leads from the CCGs. The form is now in place in primary care for G.P’s to use in the case of Microscopic Haematuria, which will be referred under the two week pathway rule.
Aim

To review the effective use of the triage service for pregnant women to improve patient experience.

Progress Report

A meeting took place on 22 July 2014 with the quality team from the Clinical Commissioning Group and milestones for the year were agreed.

A “walkthrough” took place on 29 September 2014 which was a very positive process. A number of areas were highlighted as good practice, including:

- clean clinically safe facilities with a homely feel
- the provision of juice and water for the women
- triaging women within 15 minutes of arrival
- firmly embedded and well utilised safeguarding practices
- requesting women to go back to the waiting room whilst awaiting further investigations / review to avoid blocking triage rooms.
- a flowchart describing the patient journey through triage which is posted in the triage waiting area.

Several recommendations were made including:

- availability of a printed poster for women to read
- an increase of clerical hours
- changes to the vending machine promoting water availability
- triage audits

Progress has been made in quarter 3 with:

- poster redesigned incorporating the patient user group’s comments
- triage re-audit planned for January 2015
- triage patient questionnaire undertaken in October 2014
- suggestion box to capture views of the women admitted to the ward
- water poster promoting the availability of water within the vending machine

Status

✓
Goal 19: Improving outpatient experience

Part 4: Paediatric outpatient facilities

Aim

To review the current use of paediatric outpatient facilities and work closely with patient/parent focus groups to prioritise and improve patient experience.

Progress Report

A meeting took place on 22 July 2014 with the quality team from the Clinical Commissioning Groups (CCGs) and milestones for the year were agreed.

A “walkthrough” took place with the CCGs on 21 October 2014, which was positive.

It was agreed to use ‘TOP’s and PANTS’ to gain patient feedback on how to improve patient services.

TOP’s =

The play team will help the children to complete the TOP’s and PANTS survey.

Pegs and washing line have been obtained ready for the survey start in April 2015.

Status

✓
Goal 20: Liaison between acute care and primary care for patients who self discharge

Aim

To review communication with primary care in relation to admissions who self discharge from assessment areas; gastroenterology wards and the female surgical ward.

Progress Report

Following development of a proforma to use to advise primary care of any patients who self discharges from the nominated wards, the proforma has been implemented in all areas. If any patients self-discharge, the proforma is completed and faxed to their G.P.

Status

✅
Goal 21: Management of people with complex learning disabilities

Aim

To improve the experience of patients with learning disabilities who access hospital services as an emergency.

Progress Report

A meeting took place on 2 July with the quality team from the Clinical Commissioning Groups (CCGs) to discuss and agree the milestones for the year.

During quarter 2, a review of 26 emergency department admissions relating to patients identified as having a learning disability was undertaken by staff from the CCGs and the Trust.

The patient’s usual residence was recorded in addition to the day and date of admission, length of stay, reason for admission, involvement of carers, reference to reasonable adjustments, capacity assessments and adverse incidents / complaints.

During quarter 3, in-depth case note reviews were undertaken to examine the experiences of seven patients with a learning disability who were cared for by the trust.

The findings are to be analysed for review in quarter 4.

A number of engagement sessions have taken place with patients and carers to discuss their experiences of being an inpatient at the Trust. This work is being undertaken collaboratively with the learning disability team from Cheshire and Wirral Partnership Trust and the Learning Disabilities Partnership Board. Feedback has included:

‘Absolutely brilliant, the whole process ran very smoothly. A really great person centred approach, getting to know the person, asking pertinent questions and ensuring the hospital support staff receive all the right information. Even more important .... always providing marmite crisps, chocolate and something red for after the procedure and, for me, a nice cup of tea and biscuits’

‘An invaluable service, having all the inside knowledge of how the hospital works and getting the best out of the supporting staff. There should be a dignity matron in every hospital - she is worth every penny and more as she looks after everyone involved in every hospital contact and keeping them informed’

Status

✅
Goal 22: Implementing Medicine Homecare Services

Aim

To develop robust policies and processes to manage the provision of medicines via the Homecare route.

Progress Report

A meeting has taken place with Clinical Commissioning Groups (CCGs) to discuss the milestones for the year. These have been progressed into a project initiation document (PID) which has been approved by the diagnostics and support services division.

The project lead and key clinical, governance, contracting and finance leads within the Trust and CCGs have been identified to champion and sponsor the project.

The ‘self-assessment tool for the management of homecare services in the provider acute trusts’ has been completed.

The home care policy has been developed and is scheduled to be approved by the joint medicines management committee (JMMC) in October.

Meetings with the CCG leads have continued.

The model for reconciling prescriptions with invoices is to be piloted until December 2014 with full roll out planned for March 2015. The first prescriptions have been put through the new invoice system.

All service level agreements and key performance indicators for existing homecare contracts are to be submitted to JMMC in February.

Finance have agreed that the cost associated with home care will be transferred to the Trust from April 2015 and reclaimed from the CCGs. Contractual discussions have started with the CCGs.

A proposal has been submitted to the CCGs setting out the resources required to continue the support of this new system.

Status

✓
Goal 23: Bowel screening service for vulnerable and deprived groups

Aim

Ensure that a health inequalities action plan is in place to provide a bowel screening service for vulnerable and deprived groups

Progress Report

Development of pathways for travellers/homeless community

Plan: To visit a traveller site with assistance from the Local Area Team who will do the introductions.
To attend drop in centres, salvation army, and others such as soup kitchen, food banks with the aim to provide information and education and bowel cancer screening awareness.
To discuss with other screening services such as Breast and Cervical including other BCSP sites & how they outreach travellers and homeless communities

Evidence: Purple day was attended in October in Lache, Chester. This was organised by Chester and District Housing Trust’s Group of Older people living in Sheltered Housing (GOSH Enterprises).

Continued work with the prisons including the capture of screening uptake. To offer an update of work to date to benchmark future progress

Plan: Styal prison to be contacted to handover with new programme manager and lead specialist screening practitioner (SSP)

Evidence: The progress of bowel screening at Styal Prison is being monitored and reported on quarterly at the Programme Board meetings.

Scoping of links with secure mental health units to determine screening pathway and uptake issues.

Plan: SSP’s to liaise with the dignity matron to consult and to build links with Macclesfield/Chester mental health units run by Cheshire & Wirral Partnership (CWP).

Update: SSP/Admin team to attend study day on improving the uptake of cancer screening services by people with learning disabilities and regional screening and training on the management of patients with learning disabilities in April 2015.

Outcome: Providing education and understanding to staff and patients (leaflets and attending health promotion events)

Review of equality and diversity monitoring and scope potential to benchmark attendance in more groups

Evidence: On an ongoing basis there are health promotion activity audits including ethnicity and demographic audits.

43
Following each complex patient or patient requiring reasonable adjustments, the SSP’s complete a reflective piece of work. This helps to ensure that the screening programme provides the best possible care and reasonable adjustments when required.

**Examples are as follows:**

Providing bariatric beds as required

Offering a female consultant (based at the Countess of Chester Hospital) to carry their procedure. Historically, this offer has been taken up by Muslim female patients or by patients who prefer to see a female consultant.

Home visits for those patients are in a wheelchair or who have complex health needs.

South and Western Cheshire has a high Eastern European population e.g. Polish. The screening programme has had a health promotion banner translated into Polish to ensure that understanding the programme is as easy as possible. Interpreters are booked for those patients who require them.

The screening centre also provides deafness support for those who are deaf or hard of hearing and assistance for those who are blind or partially sighted.

**Identification of LD patients and reasonable adjustments offered in the department.**

Following identification of patients with a learning disability in the assessment clinic, or by other means, the learning disability nurses, social worker and other professionals as required are contacted and consulted.

If reasonable adjustments are required then the use of CT scanning is an alternative procedure.

The SSP’s liaise with the dignity matron in relation to consent & capacity.

Health promotion completed at the Oakley Centre (assisting people with learning disabilities) in Crewe on 30.09.2014 and is planned on an annual basis.

**Status**

✅
Goal 24: Breast screening service for vulnerable and deprived groups

Aim

Ensure that a health inequalities action plan is in place to provide a breast screening service for vulnerable and deprived groups

Progress Report

A further meeting with the commissioning group took place on November 13 2014 to discuss the phase 2 actions.

Evidence has been submitted to commissioning group for all the phase 2 requirements.

Health promotion information is currently being sent to all GP practices prior to screening.

All GP practices are invited to submit the details of eligible patients who fall into the group of learning disabilities to allow appropriate appointments to be sent out.

This could be expanded for other groups of eligible women by amending this GP request letter. Information could be gathered for the traveller workers, homeless, prisoners, patients under the care of a mental secure unit and patients with known physical disabilities.

Ethnicity and sexual orientation data is not currently available on the national breast screening system. This requirement is being explored further by the Screening and Immunisation Team.

A transgender pathway has been initially developed by the breast screening units in the Cheshire region and is to be developed further.

Status

✅
Aim

To increase the availability of array CGH as a first line test to replace karyotyping on prenatal samples to provide a rapid and detailed screen for chromosome imbalance in pregnancies at increased risk of a genetic abnormality.

Progress Report

Microarray testing is offered to women with a family history of a genetic disorder which may not be identified through traditional karyotyping, therefore the eligibility criteria are definitive.

The purpose of the test is to have a diagnosis prior to the birth of the baby. In the past, karyotyping would not have identified these babies and diagnosis would have been delayed until the child’s early years.

The microarray test is being offered to all women who meet the eligibility criteria (which are currently small numbers). Our current role is to refer to Liverpool Womens Hospital (LWH) for the test and ensure close liaison with LWH following the tests. The number of referrals, results and outcomes are recorded on a database.

A database exists detailing all fetal medicine screening including results and outcomes for each case. The data also includes the type of delivery.

During quarter 3, one patient met the eligibility criteria and the microarray test was completed with a normal result. The sample was sent to cytogenetics at LWH and the results have been recorded in the maternity notes and on the fetal medicine database.

The fetal medicine patient questionnaire has been completed with responses being collated to report in quarter 4.
Goal 26: Neonatal specialised commissioning: 
Retinopathy of prematurity (ROP) screening

Aim

To achieve an increase in screening to a target of 95% of babies with a birth weight of <1501g or a gestation of <32+0 weeks who undergo 1st Retinopathy of Prematurity (ROP) screening whilst still an in-patient and screened ‘on time’.

Progress Report

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of babies (excluding those transferred out) with a birth weight of &lt;1501g or a gestation of &lt;32+0 weeks.</th>
<th>Number of babies meeting the criteria for inclusion, screened prior to discharge.</th>
<th>Percentage achieved.</th>
</tr>
</thead>
<tbody>
<tr>
<td>April – June 2014</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>July – Sep 2014</td>
<td>7</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td>Oct – Dec 2014</td>
<td>9</td>
<td>9</td>
<td>100%</td>
</tr>
</tbody>
</table>

An action plan is not required to achieve a 95% screening rate for retinopathy of prematurity as this target has been achieved.

Status

✔️
Goal 27: Neonatal specialised commissioning foetal medicine dashboard

Aim

To measure parental involvement in decision making and the foetal loss rate after invasive diagnostic procedures.

Progress Report

The parents are involved in any decision making regarding invasive diagnostic procedures and receive verbal and written information. The discussion and rationale for the procedure is recorded on the Maternity Medway system.

Following the procedure, written information and contact numbers are given to the parents. There is also an audit form inserted into the maternal record. In the event that foetal loss should occur, the form is completed and returned to the screening midwife. The audit results from these forms will be reported on in quarter 4.

A foetal medicine unit patient survey has been produced and ratified at the divisional patient information group. The survey was undertaken in quarter 3 and the results will be reported in quarter 4.

The foetal medicine dashboard and the outcomes (audit) form are in use.

Status

✅