Commissioning for Quality and Innovation (CQUIN)

Quarter 2 Report: July – September 2014

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

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Executive Lead: Julie Smith, Director of Nursing & Quality

6 November 2014
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<td>Goal 10: Advancing Quality (AQ): Hip Fracture</td>
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<td>Goal 11: Advancing Quality (AQ): Sepsis</td>
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Goal 18: Promoting self management in patients with long term conditions (diabetes, asthma and Parkinson’s disease)

Goal 19: Improving outpatient experiences:
Part 1: Adult general outpatients
Part 2: Urology patients
Part 3: Triage service for pregnant women
Part 4: Paediatric outpatient facilities

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

Goal 21: Management of people with complex learning disabilities

Goal 22: Implementing Medicine Homecare Services

Goal 23: Bowel screening service for vulnerable and deprived groups

Goal 24: Breast screening service for vulnerable and deprived groups

Goal 25: Neonatal specialised commissioning: Medical genetics

Goal 26: Neonatal specialised commissioning: Retinopathy of prematurity (ROP) screening

Goal 27: Neonatal specialised commissioning dashboard
**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 agreed. This will now be concluded in quarter 3.

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 2 (July – September 2014).
## Performance Summary

**Quarter 2 (July – September 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 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Friends &amp; Family Test (F&amp;F Test)</strong></td>
<td>Implement the staff F&amp;F Test</td>
<td>74,560</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td><strong>Part 1: Further Implementation of</strong></td>
<td>Implement the F&amp;F Test in outpatient and day case departments by 1 October 2014.</td>
<td>37,280</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td><strong>Part 2: Increase response rates</strong></td>
<td></td>
<td>37,280</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td><strong>Part 3: Further increase response rates within inpatient services</strong></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>99,413</td>
<td>😞</td>
</tr>
<tr>
<td>2.</td>
<td><strong>NHS Safety Thermometer</strong></td>
<td>Achieve a reduction in pressure ulcer prevalence (based on safety thermometer data).</td>
<td>248,532</td>
<td>✓</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Dementia:</strong></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>149,119</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td><strong>Part 1: Assess and Refer</strong></td>
<td></td>
<td>149,119</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td><strong>Part 2: Training</strong></td>
<td>Named lead clinician for dementia and appropriate training for staff.</td>
<td>24,853</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td><strong>Part 3: Supporting carers</strong></td>
<td>Ensuring carers feel supported.</td>
<td>74,560</td>
<td>✓</td>
</tr>
<tr>
<td>4.</td>
<td><strong>Advancing Quality (AQ): Acute Myocardial Infarction</strong></td>
<td>Implement the AQ care pathway for Acute Myocardial Infarction.</td>
<td>14,912</td>
<td>✓</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Advancing Quality (AQ): Heart Failure</strong></td>
<td>Implement the AQ care pathway for Heart Failure.</td>
<td>14,912</td>
<td>😞</td>
</tr>
<tr>
<td></td>
<td><strong>Advancing Quality (AQ): Hip and Knee Replacement</strong></td>
<td>Implement the AQ care pathway for Hip and Knee Replacement.</td>
<td>14,912</td>
<td></td>
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<td>-------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>7</td>
<td><strong>Advancing Quality (AQ): Pneumonia</strong></td>
<td>Implement the AQ care pathway for Pneumonia.</td>
<td>14,912</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td><strong>Advancing Quality (AQ): Stroke</strong></td>
<td>Implement the AQ care pathway for Stroke.</td>
<td>14,912</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td><strong>Advancing Quality (AQ): Chronic Obstructive Pulmonary Disease (COPD)</strong></td>
<td>Implement the AQ care pathway for COPD.</td>
<td>14,912</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td><strong>Advancing Quality (AQ): Hip Fracture</strong></td>
<td>Implement the AQ care pathway for Hip Fracture.</td>
<td>14,912</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td><strong>Advancing Quality (AQ): Sepsis</strong></td>
<td>Implement the AQ care pathway for Sepsis.</td>
<td>14,912</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td><strong>Advancing Quality (AQ): Acute Kidney Injury</strong></td>
<td>Implement the AQ care pathway for Acute Kidney Injury.</td>
<td>14,912</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td><strong>Advancing Quality (AQ): Diabetes</strong></td>
<td>Implement the AQ care pathway for Diabetes.</td>
<td>14,912</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td><strong>Advancing Quality (AQ): Alcoholic Liver Disease</strong></td>
<td>Implement the AQ care pathway for Alcoholic Liver Disease.</td>
<td>14,912</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>To be agreed</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 elderly.</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Details</td>
<td>Status</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</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>To be agreed</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 Parkinson's to manage their medicines</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Improving outpatient experiences</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>To be agreed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 1: adult general outpatients</td>
<td>To progress nurse led services for urology patients to reduce waiting times, improve outcomes and improve patient experience.</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 2: urology patients</td>
<td>To review the effective use of the triage service for pregnant women to improve patient experience.</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 3: triage service for pregnant women</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>To be agreed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 4: paediatric outpatient facilities</td>
<td></td>
<td></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>To be agreed</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>To be agreed</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>To be agreed</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>Target</td>
<td>Status</td>
</tr>
<tr>
<td>-----</td>
<td>------------------------------------------------------------------------------</td>
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</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.
- Communication exercises were delivered during the pre-launch period (April) and during the quarter (April to June)
- 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.
- Quarter 2 closed on 30 September 2014 and the return was submitted on the 24th October.

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
- The Trust is working with an external provider and is using postcards to undertake the F&F Test for these areas.
- Plans are progressing to implement the F&F Test into the dermatology outpatient department and the planned investigation unit (PIU) during quarter 3.

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></td>
<td></td>
</tr>
<tr>
<td>November 2014</td>
<td></td>
<td></td>
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<tr>
<td>December 2014</td>
<td></td>
<td></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 is slightly off track to achieve this element of the CQUIN.

Status

😊
Goal 2: NHS Safety Thermometer

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 2, 118 pressure ulcers have been reported. This is a reduction of 16 based on the same position last year (a reduction of 12%).

<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></td>
</tr>
<tr>
<td>November</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>29</td>
<td></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 reported</td>
<td>262</td>
<td>118</td>
</tr>
</tbody>
</table>

(Data Source: Safety Thermometer, 2014)
The following graphs show the breakdown of the overall number of pressure ulcers by new and old pressure ulcers.

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

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 2, there had been 62 hospital acquired pressure ulcers compared with 156 which developed during the same timeframe during 2013/14 (a reduction of 60%).

This is slightly above the calculated trajectory for a 50% reduction for this financial year based on the overall numbers of hospital acquired pressure ulcers from last year.

The Trust has two 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. In September 2014, ten avoidable pressure ulcers were reported. A mini RCA has been undertaken for each incident and immediate feedback provided to the staff involved in the patients 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. The Skin Bundle has been reviewed and will be launched at the Tissue Viability Link Nurse Study Day in November 2014. Speciality specific Skin Bundles are being developed for Critical Care, Neonatal Intensive Care Unit and Paediatrics.

Status
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.

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 including Dementia Friends sessions and education events led by an Advanced Practitioner in Dementia working for the Cheshire and Wirral Partnership Trust.

The Trust is 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: 52 (an increase of 37 during quarter 2)

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 90.3% for clinical staff and 81.8% for non-clinical staff. This equates to a total of 86.8% for all Trust staff.

There have been 53 staff who have completed the e-learning modules and 85 staff are undertaking or have completed the workbook equivalent of the e-learning training.

Feedback from staff undertaking the workbook has included the following: “We are really enjoying the dementia workbook. It makes you think more about the patient as a person. If their behavior becomes difficult to manage then you think that they are frightened or frustrated and that makes it easier to speak with them.”

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 dementia care bundle is fully implemented.

Audit results show that the majority of respondents felt supported by the hospital during their person’s stay. Carers report variability in being able to find someone to discuss any concerns regarding their person’s care. However, 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 their value in offering sensitive, individualised care. This document has been reviewed and is an integral part of the dementia care bundle, due to be piloted through October. This will form an individualised support plan for the person during their stay in hospital.

There has been variation throughout the quarter in carer feedback about how involved they have felt during their person’s admission (20%-80%). The dementia care bundle will aim to address this by enhancing partnership working with carers and involving carers from the outset as experts in their person’s care. Audit figures show that all carers, who have needed to, have been able to visit without restriction.

During this quarter, most of those surveyed felt they had been 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 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 surrounding information provision and involvement in discharge planning.

The majority of carers audited throughout the quarter reported that they felt staff had an understanding of dementia. The dementia link worker role is being revitalised to support improvements in the care of people with dementia in hospital and their carers. A study day is planned for early October to move this forward.
All carers who completed the audit said that they had received written information about organisations representing people with dementia, alongside detailed literature from the Alzheimer’s Society.

All carers were provided with information to signpost them 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. A meeting is scheduled in October to plan focus groups in conjunction with the Alzheimer’s Society for people with dementia and carers to explore their experiences in hospital and look at ways of improving the service we provide.
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 during the first Quarter. 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 during the first Quarter. It can be seen that the Trust will have to slightly improve performance to meet the target this year.

Planned improvements:
- An email referral process has been launched. Patients not under a cardiologist can be referred to the heart failure team for advice or review
- The heart failure nurse specialist will liaise closely with the assessment areas to target heart failure patients on admission

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 during the first Quarter. It can be seen that the Trust will have to significantly improve performance to meet the target this year.

Planned Improvements:

- Exception audit (patients who do not receive the care expected will have their cases reviewed)
- Work with theatres to ensure antibiotic administration can be captured on Theaterman
- 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.

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 against target for the first quarter. 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 to meet the target this year.

Planned Improvements:

- Continue teaching sessions at doctors’ breakfast meetings and handovers to promote the use of patient pathways and championing this group of patients.
- Teaching for the wider team in the assessment areas and the emergency department to ensure the pathway is put into place quickly for patients to enable timely interventions.
- Look at investment needed within the division for consistent and timely data entry.

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 for the first Quarter. 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 NHS Trust 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.

- “Capture Stroke” will be introduced. This is a software package that will enable staff to capture interventions electronically at the point of delivery. It will also act as a reminder for when various interventions are required.
- Work will be ongoing during the financial year 2014-15 to scope out therapist provision versus need.
- Early supported discharge to continue stroke rehabilitation in the community setting which will be implemented from 1st December 2014.

Status

😊
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 agreed 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 receiving non-invasive ventilation (NIV)

Additionally, the following information will be collected as a shadow measure:

- Arrange appropriate follow up within 72 hours

The AQ process went “live” in September and the first results will be available in January 2015.

Main Achievement:

- The Trust has designed a care pathway that incorporates all these elements

Main Challenge:

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

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 agreed measures are as follows:

1. Validated pain score assessment and analgesia within 60 minutes of arrival
2. Admission to appropriate orthopaedic or ortho-geriatric 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, the following information will be collected as a shadow measure:

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

The AQ process goes “live” in October and the first results will be available in the next financial year.

Main Achievement:

- The Trust has an embedded care pathway that incorporates all these elements

Main Challenge:

- There is no current provision for physiotherapy for trauma patients over the weekend.

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 agreed 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, the following information will be collected as a shadow measure:

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

The AQ process went “live” in September and the first results will be available in January 2015.

Main Achievement:
- The Trust has a care pathway that incorporates these elements

Main Challenge:
- There is no process or person identified to enter completed data onto the system

Status

✓
Goal 12: AQ: Acute Kidney Injury (AKI)

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 agreed 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.

Shadow Measures

- Pharmacist medication review within 24 hours of first AKI alert.

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 completed 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 agreed measures are as follows:

1. Blood glucose within 30 minutes of hospital arrival
2. Foot inspection is documented within 24 hours of hospital arrival
3. Quick acting carbohydrates administered within 15 minutes 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. Early warning score and Glasgow coma scale 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 diabetic ketoacidosis (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

The “go live” date of the AQ process is still to be confirmed.

Work planned:
- The Trust has identified a small clinical team who are conducting an informal gap analysis against the measures.
- A business case for a diabetic nurse specialist service is being written and escalated for investment in 2015/16. This role will be targeted to improve foot care, reducing hypoglycemic episodes and reducing length of stay

Main Challenge: There is no process or person identified to enter the completed data onto the system.

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 agreed measures are as follows:

1. Early warning score (EWS) 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 of 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

Shadow Measures:

- 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

The “go live” date of the AQ process is still to be confirmed.

Work Planned:

- Recruit a team with a clinical lead (potential members identified)
- Conduct an informal gap analysis to inform service improvement.

Main Challenge:

- 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 now been jointly agreed. The format for the collection of data relating to emergency admissions over the age of 85 from nursing or residential homes has been formatted. The proforma is currently being used in the emergency department (ED), the primary assessment area (PAA) and the assessment medical unit (AMU). The responses will be reviewed and discussed with the CCGs during quarter 3.

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. A meeting took place on 16 July with the quality team from the Clinical Commissioning Groups (CCGs). At this meeting, the plan for delivery and proposed milestones were discussed. During quart 2, the milestones for the delivery of this CQUIN have now been agreed.

Open visiting has been trialled for three months and a survey was conducted to obtain feedback from visitors and staff.

<table>
<thead>
<tr>
<th>Visiting times</th>
</tr>
</thead>
<tbody>
<tr>
<td>As from Monday 28\textsuperscript{th} July 2014,</td>
</tr>
<tr>
<td>Ward 14 will be encouraging open visiting.</td>
</tr>
<tr>
<td>7 days a week, including Bank Holidays</td>
</tr>
</tbody>
</table>

Feedback from all concerned demonstrated overwhelmingly positive feedback. Elderly relatives have particularly taken to open visiting as they commented that this allows them to visit their loved ones at a time that is most convenient to them and particularly not to have to drive in the dark.

The RVS project has also started its recruitment. There are 14 volunteers who are currently active. Five on ward 14 and nine on ward 15. A meeting was held to gather feedback from the volunteers and their comments included: \textit{Its going better than I thought, I feel I am making a real difference, I've brought in a paper to read to a blind patient, I am training next week to help assist patients with their meals, all patients say thank you which is nice, its brilliant!}

Status

✓
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

A meeting has taken place with members of the quality team from the Clinical Commissioning Groups (CCGs) and representation from Elmhurst to agree milestones for quarters 2, 3 and 4.

A data collection process has been introduced to capture the initial assessment of patients within 24 hours of arriving on the unit and this is recorded in the admission statement and the final level is recorded on the discharge statement. This will help with understanding the progress and final outcomes.

A patient questionnaire has been developed to include patients who are on level 1 or level 2 of the self-medication programme.

The patient’s own medication (POM) boxes have been relocated to a position that enables more patients to progress to the stage where they will be fully self-medicating.

A staff focus group was conducted on 25 September 2014. Attendance included representatives from all members of the multidisciplinary team and a representative from the CCGs quality team. The discussion was very positive and noted that both staff and patients are embracing the self-medication regime.

An audit tool has been devised and this will look at the quality of the patient’s assessment and how this is documented in the patients notes, how many patients have undergone the assessments, how many patients have progressed to level 2 and, if incidents have occurred, how these are reviewed and what learning has taken place. The audit tool will be used to undertake audits in quarter 3.

Status

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

Aim

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

Progress Report

A meeting has taken 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 Parkinson’s. This highlighted that, of the 236 patients who were reviewed, 16 patients with diabetes and five patients with Parkinson’s would be eligible.

The next plan for the CQUIN was to identify pharmacists who have a specific interests in diabetes and Parkinson’s so that they can lead the development of a training programme for pharmacy staff in the self management of these conditions. This has been completed and staff are now being trained to deliver the self management programme.

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

Diagnostics and Clinical support services have appointed a Matron to undertake a review of the outpatient’s facilities and work collaboratively with key individuals to improve patient experience. This role facilitates senior nursing visibility within the department, which increases engagement with the public accessing the general outpatient services.

A milestone meeting with the members of the quality team from the Clinical Commissioning Groups (CCGs) took place on 29 July 2014, at which point the milestones for quarters 2 - 4 were agreed.

Process mapping has been completed with all members of the multidisciplinary team, service users and CCGs. A further meeting date is to be confirmed in November 2014 to progress key issues identified from the exercise.

Local environmental improvements have been completed with positive feedback from service users. A re-audit of the environment is scheduled to take place in November 2014.

The Friends and Family Test is also planned to commence in the general outpatients department in November 2014.

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

A meeting took place on 11 July with the quality team from the Clinical Commissioning Groups (CCGs) to discuss the milestones for the year.

The CQUIN milestones have now been agreed.

Clinic capacity has been identified in the Michael Heal Unit to enable the advanced practitioner in urology to undertake nurse led haematuria clinics.

The referral process and the referral proforma have been developed which will enable General Practitioners to refer directly into the service from quarter 3.

Status

✔️
Goal 19: Improving outpatient experience

Part 3: Triage service for pregnant women

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 of a minor nature which will be implemented during quarter three and reported on in quarter four.

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 and milestones for the year were agreed.

A “walkthrough” has been scheduled with the CCGs for 21 October 2014

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

A meeting took place on 8 July with the quality team from the Clinical Commissioning Groups (CCGs) to agree the milestones for the year.

The CQUIN milestones have been agreed.

A proforma has been developed which will be used to inform primary care of any patients who self-discharge.

The process for advising primary care about these patients has also been agreed.

This will be implemented in quarter 3.

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 25 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. The findings are to be analysed for review in quarter 3.

It has also been agreed to undertake focus groups with patients and carers to discuss their experiences of being an inpatient at the Trust. These will be undertaken in quarter 3.

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 Clinical Commissioning Groups 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

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

The Cheshire bowel cancer screening programme manager and a specialist screening practitioner, visited Styal women’s prison and met with the matron, health promotion officer and deputy healthcare administrator. The programme is in the preliminary stages with Styal for collating the evidence and formulating processes and procedures in order to be ready for the bowel screening, faecal occult blood tests (FOBt) invites to be generated to the inmates within the 60-75 age range. Additionally, the programme manager is liaising with the regional screening hub in Rugby, which the programme is attached to, in order to start the process for the prisoners to be screened. If in the event one of the prisoners does have a positive test kit, then reasonable adjustments will be made so the ladies will be able to attend.

The screening centre has taken part in numerous health promotion events including: the Nantwich food and drink festival, the health & wellbeing event at the Oakley Centre, Crewe and the health & wellbeing event at Nantwich civic hall.

Over the coming months, Vale Royal CCG area will be targeted due to their uptake dipping off in recent months (60.19% uptake in February against a 52% uptake in August).

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

The required benchmarking process has been completed and was submitted to the Commissioners in September 2014.

The breast screening equality impact assessment has been updated and the risk assessment has been completed. Control measures are in place for the specified vulnerable and deprived groups.

The commissioners’ phase 2 has been issued and is to be completed by the end of November 2014.

Actions to be undertaken for phase 2 are

1. Consideration of deprivation and population factors in relation to screening coverage and actions to be taken.

2. Contact GP practices with responsibility for the homeless and traveller population to look at access to breast screening.

3. Scope mental health secure unit.

4. Review screening data received for women in the ethnicity, disability and sexual orientation cohorts.

5. Develop a transgender screening pathway and attempt to capture data prospectively.


Further meetings with Commissioners and breast screening programme managers are to be arranged to assist with completion of the above requirements.

Status

✅
Goal 25: Neonatal specialised commissioning: Medical genetics

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. The women have detailed verbal and written information regarding the array testing.

A database exists detailing all fetal medicine screening including results and outcomes for each case the data includes type of delivery. A patient questionnaire is in progress and responses are being monitored.

Status

✓
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>
</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 fetal 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 fetal medicine unit patient survey has been produced and ratified at the divisional patient information group. The survey will be implemented in quarter 3 and reported in quarter 4.

Status

✓