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<td>Advancing Quality (AQ): Hip Fracture</td>
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<td>11</td>
<td>Advancing Quality (AQ): Sepsis</td>
<td>20</td>
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<tr>
<td>12</td>
<td>Advancing Quality (AQ): Acute Kidney Injury</td>
<td>21</td>
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<tr>
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<td>Advancing Quality (AQ): Diabetes</td>
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<td>14</td>
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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 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 4 (January – March 2015).
## Performance Summary

**Quarter 4 (January – March 2015)**

<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 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Friends &amp; Family Test (F&amp;F Test)</td>
<td>Part 1: Further Implementation of the F&amp;F Test Implement the staff F&amp;F Test Implement the F&amp;F Test in outpatient and day case departments by 1 October 2014.</td>
<td>97,966/71,196</td>
<td>✓/✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part 2: Increase response rates Increase response rates in acute inpatient services Quarter 1 – at least 25% Quarter 4 – at least 30%. Increase response rates in A&amp;E Quarter 1 – at least 15% Quarter 4 – at least 20%.</td>
<td>71,196</td>
<td>✓/✓/✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part 3: Further increase response rates within inpatient services 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>Reduce pressure ulcer prevalence as measured by the Safety Thermometer to 3.7%</td>
<td>177,991</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Dementia: 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>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>---</td>
<td>-------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>--------</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>14,3239</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 elderly ward and the trauma orthopaedic ward to ensure socialisation and normalisation of daily activities.</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>Project Description</td>
<td>Goal</td>
<td>Cost</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>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>Part 1: adult general outpatients</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td></td>
<td></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></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part 2: urology patients</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>To progress nurse led services for urology patients to reduce waiting times, improve outcomes and improve patient experience.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part 3: triage service for pregnant women</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>To review the effective use of the triage service for pregnant women to improve patient experience.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part 4: paediatric outpatient facilities</td>
<td>244,631</td>
<td></td>
</tr>
<tr>
<td></td>
<td></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></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>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>Neonal 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>
<td></td>
</tr>
<tr>
<td>Neonal 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>
<td></td>
</tr>
<tr>
<td>Neonal 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>
<td></td>
</tr>
</tbody>
</table>

**RAG status:**

- **Achieved**: ✓
- **Partially Achieved**: ✓
- **Off track but recoverable** (Applies only to Advancing Quality CQUIN where data is delayed by up to 4 months)
- **Not achieved**: ✗
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.

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.

Trust staff were offered the option to complete the survey in quarter 3 and staff in Estates & Facilities and Diagnostics & Clinical Support Services were offered the same opportunity in quarter 4. The results will be submitted by the national deadline of 28th April 2015.

Survey completion rates were as follows:
- Estates & Facilities - 18
- Diagnostics & Clinical Support Services - 45
- Bank staff - 12

F&F Test in outpatient and day case departments

The Trust introduced the F&F Test into the fracture clinic; ophthalmology; ear, nose and throat (ENT) and urology outpatient departments in August 2014:

The F&F test commenced in the dermatology outpatient department and the planned investigation unit (PIU) in February.

To date, 1,756 patients have responded after attending the above clinics. Results show that 94% of patients would recommend the outpatient clinics.

The F&F Test has also been rolled out to day case patients.

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 for accident and emergency services:
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>36%</td>
<td>16%</td>
</tr>
<tr>
<td>February 2015</td>
<td>34%</td>
<td>15%</td>
</tr>
<tr>
<td>March 2015</td>
<td>50%</td>
<td>25%</td>
</tr>
</tbody>
</table>

The targets for quarter 1 for both acute inpatient services and accident and emergency services were achieved.
The target for quarter 4 for the acute inpatient services was achieved.
The target for quarter 4 for the accident and emergency services was not achieved as the overall response rate for quarter 4 was 19%.

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 meant the Trust was slightly off track to achieve this element of the CQUIN.

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

The average response rate for quarter 4 was 40% and the response rate for March 2015 was 50%. This means the Trust achieved this element of the CQUIN.

Status
✓
Goal 2: NHS Safety Thermometer

Aim
Reduce pressure ulcer prevalence as measured by the Safety Thermometer to 3.7%. 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 4 of 2014/15, 234 pressure ulcers were reported. This is a reduction of 28 based on the same position last year (a reduction of 11%).

<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>20</td>
</tr>
<tr>
<td>February</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>March</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Total reported</td>
<td>262</td>
<td>234</td>
</tr>
</tbody>
</table>

(Data Source: Safety Thermometer, 2015)

However, to achieve the CQUIN, a median of 3.7% was required based on the median number of pressure ulcers reported via the safety thermometer tool when comparing the results from October 2013 to March 2014. For October 2014 to March 2015, the Trust achieved a median of 3.69%. This was achieved through a significant reduction in hospital acquired pressure ulcers and means the CQUIN was achieved.
The following graphs show the breakdown of the overall number of pressure ulcers by new and old 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.

(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 4, there had been 150 hospital acquired pressure ulcers compared with 239 which developed during the same timeframe during 2013/14 (a reduction of 37%).

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 has not been achieved.

(Data Source: Ulysses 2015)

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 ✔
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.

During quarter 4, 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
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 93% for clinical staff and 93% for non-clinical staff. This equates to a total of 93% for all Trust staff.

There have been 232 staff who have completed the e-learning modules (an increase of 114 during quarter 4) and 122 staff are undertaking or have completed the workbook equivalent of the e-learning training (an increase of 8 during quarter 4).

The CQC inspection in October 2014 found that the Trust had demonstrated improvements in dementia care and that 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. It is anticipated that response rates will improve now that the new dementia care bundle is fully implemented and confidence in its use increases.

During October and November 2014, the new dementia care bundle was piloted on four wards. The information pack created for carers was incorporated into this bundle (as a tear off section) including the carer survey in its revised format. In December 2014, the care bundle was implemented throughout the hospital.

Audit results for this quarter show that all respondents have felt adequately supported during the patient’s stay in hospital. All clinical areas have an increasing awareness of the dementia lead nurse role and refer for clinical and carer support as needed. Dementia information boards are evident throughout the hospital as a resource for staff, patients and visitors.

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 and involving carers from the outset as experts in their person’s needs. Carers are given an appointment to meet with staff as near as possible to the person’s initial admission to hospital, where they are assisted to complete the personal support plan and have the opportunity to ask any unanswered questions.

Carers are also provided with an “Open Visiting Pass” within the bundle to enable them to visit without restriction to support the person with dementia during their stay in hospital.

All wards are aware that early identification and referral of people with dementia is key. The emergency department has revised their documentation so that people with dementia can be identified early in admission. Work is in progress to establish an identifier code to support this. This will improve both the patient and carer journey through the hospital by enhancing communication and reducing unnecessary anxiety.

The role of ward/department dementia link staff has been rejuvenated and regular link support sessions have been planned throughout 2015. All wards and departments now have link staff to use as a resource for training/information.

Clear information has been put in place for carers of people living with dementia to access via the hospital website and Trust Intranet.
The Alzheimer’s Society has an information stand in the main outpatient department for use by all.

Links have been established with the local Alzheimer’s Society to encourage them to feedback any carer concerns to the dementia lead in order that issues can be explored and addressed as they arise. Focus groups have been attended by the dementia lead to open communication further in order to explore 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 until December 2014. There was no data entered for November and there is currently a gap in data entry provision for this focus area. Performance is noted to have dropped significantly and it is believed this is due to data entry errors. Work is ongoing to rectify this.

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 January 2015. It can be seen that the Trust will have to maintain an improved performance to meet the target, which is marginally off track (1.3% below target).

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 January 2015.

It can be seen that the Trust is on track to meet the target.

Status

\[\checkmark\]
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

Data collection has continued to be a challenge for the Trust. It has therefore been agreed with the commissioners to cease data collection for this financial year to concentrate on the improvements that are required for the next financial year.

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 January 2015. It can be seen that the Trust is not going to meet the target this year. The main challenge is access to a stroke bed within 4 hours and, for other Trusts that are failing in the region, this also represents the most challenging measure. In the next financial year, stroke performance will be measured by SSNAP alone and will not be part of the Advancing Quality project.

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 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

It can be seen that limited data is currently available on the system. Early indications are that there are opportunities for improvement for all aspects of care. September to November is a data collection only phase then performance monitoring will begin.

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>September Population</th>
<th>Cases Remaining</th>
<th>October Population</th>
<th>Cases Remaining</th>
<th>November Population</th>
<th>Cases Remaining</th>
<th>December Population</th>
<th>Cases Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>20</td>
<td>12</td>
<td>15</td>
<td>7</td>
<td>8</td>
<td>7</td>
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</table>

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.

The Trust has an embedded care pathway that incorporates all these elements and the Trust has achieved the target for data completeness. Performance monitoring has commenced for patients discharged in January.

![Hip Fracture Chart]

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.

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

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>Cases Remaining</td>
<td>Population</td>
<td>Cases Remaining</td>
<td>Population</td>
</tr>
<tr>
<td>Sepsis</td>
<td>55</td>
<td>10</td>
<td>77</td>
<td>32</td>
<td>56</td>
</tr>
</tbody>
</table>

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

A small clinical team have reviewed the results so far. However, there is no process or person identified to enter the data onto the system. The table below shows the number of cases outstanding.

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>August Population</th>
<th>September Population</th>
<th>October Population</th>
<th>November Population</th>
<th>December Population</th>
<th>Cases Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
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</tbody>
</table>

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.

The data collection phase has started for patients discharged in January.

A team with a clinical lead has conducted an informal gap analysis against the measures to inform service improvement.

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 report for the year was presented to the commissioners at the clinical quality and safety meeting held on 19 March. The presentation included some of the findings from the completed audit forms:

- 14 (48%) patients were sent to the emergency department with unified do not attempt resuscitation plans in place. These patients could possibly have been safely managed by the patients’ GP or within their own place of care.
- 21 (72%) patients were referred to the emergency department via the ambulance service. All these patients were assessed and it was felt that they did not require an admission as an emergency.
- 6 (21%) patients were re-admissions and 5 of these were from nursing homes.

The actions from the review were discussed with the commissioners and agreed as follows:

1. To progress a working group for the following year to review the data in more detail and look at feedback mechanisms to both GP’s and nursing/residential homes to reduce avoidable admissions.
2. To maintain the review and data collection and share this at quarterly meetings.
3. For the commissioners to communicate the need to all nursing homes and GP’s for a review of patients in nursing homes before admission to secondary care.

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 has remained 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.

Following the success of open visiting on the care of the elderly ward, it was agreed to implement this on an acute ward within the division. This was agreed as the respiratory ward (ward 5) and the process used for ward 14 has been replicated there. Open visiting has been successfully commenced on the respiratory ward and is about to commence on one of the cardiology wards (ward 19).

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.

Meetings between the ward staff and the volunteers now take place and a comments book is being made available to capture the positive feedback from staff which will be directly available to the volunteers.

The **patient passport** ‘About Me to Help You’ is included within the dementia care bundle. It has a tear off facility within the bundle and is also available as an ‘stand alone’ document.

Staff have found the passports to be extremely helpful and felt they should be kept at the end of the bed. Their main reasons for reading a passport are to provide an insight into the patient and discussion point when delivering personal care.

Use of the passports continues to be monitored on a monthly basis and the lead nurse for dementia also audits 15 dementia care bundles each month. Results are discussed with the ward manager.

As a means to further improve the use of passports for patients with different communication difficulties, a separate ‘Hospital Passport’ is currently undergoing its first trial on ward 14. Staff report that they find the ‘Hospital Passport’ very easy and user friendly. Comments from patients and relatives will be sought during the pilot phase and prior to presentation at patient involvement groups.

**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

Following the quarter three audit which identified that the assessments were not always conducted in a timely manner, there has been an admission assessment template devised which clearly states the time frames agreed to promote the self-medication programme.

There has been further training and education for staff to ensure they have the confidence and competence to commit to the promotion of and implementation of self-medication.

A patient satisfaction survey was carried out in the final quarter. This involved telephone interviews for 9 patients who had been discharged and a face to face interview for one inpatient.

All 10 patients had been on level 2 of the self-medication programme (meaning they were taking their medications fully independently of a nurse). The results indicated that all patients were confident in managing their medication at home, understood why they were taking their medication and felt that their medication had been explained to them in a way that they understood. One patient did note that the side effects of their medication had not been fully explained.

Some of the comments made by the participant's note good communication and that the nurses delivered the programme in a caring and a compassionate manner. Specific feedback included:

- The staff explained clearly how to take my tablets
- Very happy with scheme and glad that only put on scheme when feeling better
- Very good idea, it gives patients independence and takes pressure of the nurse
- Good scheme, able to take medication when needed
- Very happy to be doing own medication

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 was undertaken to identify the approximate number of inpatients who might 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 been trained in counselling patients with Diabetes and Parkinsons.

An audit/interview tool has been developed and five patients/carers have been counselled then interviewed. The results will be presented to the Safe Medicines Practice Committee in May.

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

Phase two of the planned refurbishment of the outpatient main hall is now complete and everywhere has a much lighter and brighter aspect. The access doors to the entrance have been replaced and are fully operational, complete with wind curtain to improve the patient experience by helping to maintain warmth in this area.

Quality boards have been installed in the main department which will display the results of the outpatients’ key performance indicators. Clinic information boards are also in place in each suite which provides visual information on staffing details and any clinic delays. A trial of hourly communication rounds has commenced in the main outpatient department and, if successful, will be rolled out to the Victoria Infirmary, Northwich in May 2015.

A task and finish group is being formed across with the commissioners and Trust staff to support an increased use of e-referral systems offering patients greater choice in the booking of their appointment and how they wish the Trust to communicate with them about that appointment.

Improvements have been made in the way that outpatient appointments are scheduled through the introduction of a partial booking system. This means that follow up appointments are not booked more than 6 weeks in advance to reduce the risk of cancellations due to annual leave or study. The Trust monitors the number of appointments each speciality cancels or re-books and challenges any specialities with large numbers of these. As a result of this, hospital initiated cancellations reduced by 20% during 2014-15.

Work is also underway to improve the patient experience during clinic visits. Timeslots allocated to patient appointments have been reviewed and adjusted to ensure they are of sufficient length so that excessive waits can be prevented. It is recognised that delays are sometimes impossible to avoid and, should they occur, outpatient staff keep patients fully informed of the nature of the delay and the expected wait times.

The Fifteen Steps audit was repeated in October 2014 and showed vast improvement from the initial audit completed in July 2014 with many of the recommendations now complete.

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

GP’s now have electronic access to the referral pathway, enabling them to directly refer any patients with microscopic haematuria.

A patient satisfaction survey was developed in December 2014 and has been distributed to patients who have accessed the service during Quarter 4. The Advanced Practitioner in urology has analysed the results and reported the findings. The majority of the patients were satisfied with the service, suggesting that there was no requirement for any refinements.

No patients completing the questionnaire had worsening symptoms whilst waiting for their appointment.

Upon arrival for their appointment, no patients where keep waiting longer than 20 minutes before they saw the advanced practitioner and, as shown in the graph below, all patients were satisfied with the service received in the haematuria clinic.

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.

In October 2014, an audit of women being seen within 15 minutes of arrival was performed which showed 78% of women were triaged within this timeframe. The results showed that delays to triage occurred at regular times. The staff were informed of the results to aid better compliance and a band 6 midwife was introduced to the triage team to manage the process. Posters were displayed reminding staff of various actions that should be undertaken.

The January 2015 triage audit identified 91% of women were triaged within 15 minutes and it was also noted that women were triaged more effectively.

A triage patient questionnaire was undertaken for women who waited. All women were happy with the care they received and, if they needed to wait for an obstetric review, they believed the wait time was acceptable. As a result of the findings, the waiting times board now includes the name of the triage midwife.

Plans are in place to capture further patient experience information in the near future. A suggestion box will be installed in the triage waiting room so that women may anonymously give suggestions regarding the triage service and environment.

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

TOP’s = ![Smiley face]

PANTS = ![Sad face]

The TOP’s & PANT’s survey took place between September 14 and January 2015 with 100 respondents.

Overall, the results were extremely positive as shown in the charts below. The only negative comments related to car parking.

<table>
<thead>
<tr>
<th>Were you happy with the amount of information you received prior to your visit?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
</tr>
<tr>
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<tr>
<td>Too much</td>
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</table>

<table>
<thead>
<tr>
<th>Did the appointment meet your expectations?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
</tr>
<tr>
<td>0%</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall, how would you/your child rate the care you recived?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
</tr>
<tr>
<td>0%</td>
</tr>
<tr>
<td>Excellent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How likely are you to recommend Leighton hospital to friends and family if they needed similar care or treatment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
</tr>
<tr>
<td>0%</td>
</tr>
<tr>
<td>Extremely likely</td>
</tr>
</tbody>
</table>

The survey results are currently being shared with staff and will be displayed for patients to see in May.

Status

![Checkmark]
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 report has been completed compiling the information relating to patients who have self-discharged from the designated areas in the Surgery and Cancer Division and the Division of Medicine and Emergency Care. The information has been analysed in an endeavour to identify any themes or trends. A meeting has been arranged with the commissioners to share the findings.

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 and 3, 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. This was followed by an indepth case note review to examine the experiences of seven patients with a learning disability who were cared for by the Trust. The findings highlighted the following:

Coding: It was identified that not every patient coded as a learning disability actually did have such a condition. Several patients who had mental health illnesses were also coded as having a learning disability.

Carer Involvement: There was good evidence recorded of carer involvement with most patients. The carer guidelines have been approved and are available on the wards to support effective and compassionate involvement of carers.

Making reasonable adjustments: There were some examples of reasonable adjustments recorded but there is room for improvement in relation to documenting the many reasonable adjustments that take place on a daily basis.

Documenting capacity assessments: On the whole, most case notes did not clarify if a capacity assessment had been undertaken. Where capacity assessments were recorded, these were comprehensive and accurate.

Use of the patient passport: Many inpatients had use of a patient passport, but this was less evident for emergency assessments.

Role of the Dignity Matron: Many patients were known to or had been referred to the Dignity Matron. Feedback was very positive about the support and compassion shown to patients.

Actions - An action plan addressing the issues highlighted from the CAS cards and case note review will be presented to the Learning Disability Development Group in June.

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:

“We are absolutely overwhelmed at all the preparations that you have put in place for our son….wow ….thank you so very much to everyone involved.”

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 took place with the commissioners 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 commissioners were identified to champion and sponsor the project.

Meetings with the commissioning leads have continued.

By quarter 4, all actions have been completed.

The Trust’s home care policy is in place and all service level agreements have been submitted to the joint medicines management committee and approved.

The process of reconciling the prescription against the invoice is in place and the budget has been transferred over.

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

The Trust is still awaiting confirmation of on-going resources from the commissioners.

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).

Contact has been initiated with the Gypsy & Traveller liaison for Cheshire West and Chester by the BCSP.

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.

Contact has been established with the Crewe and Macclesfield units with a health promotion stand being displayed in the Macclesfield unit during Bowel Cancer awareness month and one planned to be displayed at the Crewe unit.

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.

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

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.

The GP screening feedback letter has been amended and will be sent to GP practices prior to appointments being sent out to that practice. Feedback from these returned forms will be sent to the Screening and Immunisation Team.

Further development of the transgender screening pathway is being undertaken and involves all the screening centres in the North West region.

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.

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 also includes the type of delivery.

There were no patients in quarter 4 who met the eligibility criteria. The fetal medicine survey was completed with the results being very positive indicating that all the patients that completed the survey were happy with the information they were given during their consultation and felt adequately supported.

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>
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</tr>
<tr>
<td>July – Sep 2014</td>
<td>7</td>
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</tr>
<tr>
<td>Oct – Dec 2014</td>
<td>9</td>
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<td>100%</td>
</tr>
<tr>
<td>Jan – Mar 2015</td>
<td>5</td>
<td>5</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**

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 results from auditing foetal loss following invasive diagnostic procedures showed no foetal losses occurred.

A foetal medicine unit patient survey has been produced and ratified at the divisional patient information group. The patient satisfaction survey was undertaken in quarter 3. The results were very positive with 100% of patients that completed the survey indicating they were happy with the information given during their consultation and felt adequately supported.

Slight improvement was needed with supplying written information to support the consultation. The main area of concern identified was the waiting times where some patients were waiting up to an hour past their appointment time.

In response to these findings, a shared file for all maternity staff to access has been developed which contains written information for a range of different conditions to be given out where appropriate. Three new patient information leaflets are also being updated to include a list of support organisations.

Staff have also looked at how waiting times can be improved, but have found this difficult due to the unpredictable nature of the foetal medicine clinics. However, the staff have improved their communication of waiting times with the implementation of a traffic light system in for all antenatal clinics.

**Status**

✅