Commissioning for Quality and Innovation (CQUIN)

Quarter 1 Report: April – June 2015

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

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10 July 2015
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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 2015/16 CQUIN scheme is £3,799,075.

For 2015/16, there are four national goals which focus on Acute Kidney Injury (goal one), Sepsis (goal two) Dementia care (goal three) and Mental health diagnosis recording in the emergency department (goal four).

MCHFT and the Clinical Commissioning Groups (CCGs) for Vale Royal and South Cheshire have agreed a further sixteen goals (goals five to twenty) which include 10 focus areas for Advancing Quality.

The financial allocation for the locally negotiated CQUIN goals has yet to be agreed. This will be undertaken during quarter 2.

The North West Specialised Commissioning Group (SCG) have negotiated two goals in relation to the neonatal services (goals twenty one and twenty two).

This paper summarises progress against the CQUIN goals for quarter 1 (April – June 2015).
## Performance Summary

**Quarter 1 (April – June 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 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Acute Kidney Injury (AKI)</td>
<td>Diagnose AKI and provide follow up information to GP’s on discharge</td>
<td>To be agreed</td>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td>Sepsis: Part 1: Screening</td>
<td>Ensure appropriate sepsis screening tool in place and utilised</td>
<td>To be agreed</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 2: Antibiotic administration</td>
<td>Initiation of intravenous antibiotics within one hour of presentation for those patients with suspected severe sepsis or septic shock</td>
<td>To be agreed</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Dementia: Part 1: Find, assess, investgate, refer and inform (FAIRI)</td>
<td>The proportion of patients aged 75 and over to whom the case finding question is applied following an emergency admission; the proportion of those identified as potentially having dementia who are appropriately assessed; the number referred onto GP services and those who have a written plan of care on discharge which is shared with the patient’s GP</td>
<td>To be agreed</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 2: Staff training</td>
<td>Appropriate training is available to staff</td>
<td>To be agreed</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 3: Supporting carers</td>
<td>Ensure carers feel supported</td>
<td>To be agreed</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>Urgent and Emergency Care</td>
<td>Improving the recording of diagnoses in the emergency department of patients with mental health needs</td>
<td>To be agreed</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>Advancing Quality (AQ): Acute Myocardial Infarction</td>
<td>Implement the AQ care pathway for Acute Myocardial Infarction</td>
<td>To be agreed</td>
<td>✓</td>
</tr>
<tr>
<td>6</td>
<td>Advancing Quality (AQ): Heart Failure</td>
<td>Implement the AQ care pathway for Heart Failure</td>
<td>To be agreed</td>
<td>😞</td>
</tr>
<tr>
<td>7</td>
<td>Advancing Quality (AQ): Hip and Knee Replacement</td>
<td>Implement the AQ care pathway for Hip and Knee Replacement</td>
<td>To be agreed</td>
<td>✓</td>
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<tr>
<td>No.</td>
<td>Topic</td>
<td>Description</td>
<td>Status</td>
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<tr>
<td>8</td>
<td>Advancing Quality (AQ): Pneumonia</td>
<td>Implement the AQ care pathway for Pneumonia</td>
<td>To be agreed</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>To be agreed</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>To be agreed</td>
<td></td>
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<tr>
<td>11</td>
<td>Advancing Quality (AQ): Sepsis</td>
<td>Implement the AQ care pathway for Sepsis</td>
<td>To be agreed</td>
<td></td>
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<tr>
<td>12</td>
<td>Advancing Quality (AQ): Acute Kidney Injury</td>
<td>Implement the AQ care pathway for Acute Kidney Injury</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Advancing Quality (AQ): Diabetes</td>
<td>Implement the AQ care pathway for Diabetes.</td>
<td>To be agreed</td>
<td></td>
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<tr>
<td>14</td>
<td>Advancing Quality (AQ): Alcoholic Liver Disease</td>
<td>Implement the AQ care pathway for Alcoholic Liver Disease</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Advancing Quality (AQ): Patient Experience</td>
<td>Engage with patients to elicit their views about their experiences to inform the development of the service:</td>
<td>To be agreed</td>
<td></td>
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<tr>
<td></td>
<td>Part 1: Hip and Knee Replacement</td>
<td>Patients on the elective hip or knee pathway</td>
<td></td>
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<tr>
<td></td>
<td>Part 2: Heart Failure</td>
<td>Patients on the heart failure pathway</td>
<td></td>
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<tr>
<td></td>
<td>Part 3: Sepsis</td>
<td>Patients following the sepsis pathway</td>
<td></td>
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<tr>
<td>16</td>
<td>Transition for young people with Diabetes</td>
<td>Review the transition pathway to improve patient experience and ensure the delivery of effective quality care for young people and their families</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Person centred care for patients who have a diagnosis of cancer of unknown primary (CUP)</td>
<td>Develop self-care pathways and the provision of information to support self-care / self-management for patients to manage their care</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cancer survivorship risk stratification</td>
<td>Patients ending acute treatment for cancer are to be stratified into the following categories: Supported self-management Shared care Complex case management</td>
<td>To be agreed</td>
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<tr>
<td>19</td>
<td>Discharge:</td>
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<tr>
<td></td>
<td>Part 1: Patient Experience</td>
<td>Understand patients' / carers' views of the discharge process</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 2: Discharge Documentation</td>
<td>Review and develop existing documentation used in discharge planning</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 3: E-discharge Correspondence</td>
<td>Improve the quality of correspondence between GPs and Acute Physicians</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 4: Complex Discharge</td>
<td>Review the process of discharge of patients with complex care needs through the use of patient stories</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Integrated care record</td>
<td>Implementation of the integrated digital care record</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Neonatal Specialised Commissioning: Neonatal Admissions</td>
<td>Improve learning from avoidable term admissions (≥ 37 week gestation) into neonatal units</td>
<td>To be agreed</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Neonatal Specialised Commissioning: Neonatal Critical Care</td>
<td>Reduce clinical variation and identify service improvements by ensuring data completeness in the audit questions identified</td>
<td>To be agreed</td>
<td></td>
</tr>
</tbody>
</table>

**RAG status:**

- On track
- Off track but recoverable
- Off track and unlikely to recover
Goal 1: Acute Kidney Injury (AKI)

Aim

A random sample of 25 sets of notes should be reviewed each month to ensure the following key requirements have been included in the discharge summary:

- Stage of AKI
- Evidence of medicines reviews having been undertaken
- Type of blood tests required on discharge for monitoring
- Frequency of blood tests required on discharge for monitoring and who is to perform the test

During quarter one, the process for managing the audit must be agreed and the baseline results must be established. To minimise burden, the data submission is required to be a percentage total for each quarter.

The final aim during quarter four is to achieve 90% or above of the key requirements being included in discharge summaries.

Progress Report

The AKI pathway has been introduced into the Trust and is now accessible via the intranet. In addition, the Trust is introducing patient information leaflets for AKI and these are awaited from the professional printers.

Towards the end of April 2015, the pathology reporting system went live with warnings for the stages of AKI. In practical terms, this enabled patient identification with AKI from May onwards.

In preparation for the enhanced communication with GPs, additions to the e-discharge letter have been made with specific fields for AKI. These fields will promote good practice for communicating information about episodes of AKI and continuing healthcare needs. The revised GP e-discharge letter was implemented from 1 July 2015.

As the method for providing follow up information to GPs was not live during quarter one, the first set of results that serve as a baseline for improvement is zero percent. Discussion is scheduled to take place with the Commissioners to agree the improvement target for quarter two.

Status

✔️
Goal 2: Sepsis

Part 1: Sepsis Screening

Aim

An established local protocol which defines which patients require sepsis screening must be in place.

A random sample of 50 sets of notes should be reviewed each month to ensure all patients who present as an emergency are screened for sepsis as part of the admission process, where this is appropriate. This audit should be undertaken by nursing staff.

The intention is to incentivise screening of adult and child patients, but only those whose clinical condition indicates this is required. The intention is not to incentivise screening for all emergency patients as there are some clinical reasons why screening is unnecessary.

During quarter one, there should be evidence that a sepsis screening tool is in place and the results of the audit should be presented to provide a baseline. These should be presented as an average of the percentage screening completed during the quarter. Discussion is scheduled to take place with the Commissioners to agree an improvement target for quarter two.

The final aim during quarter four is to achieve 90% or above of eligible patients being screened.

Progress Report

A sepsis screening pathway has been introduced into the Trust.

The sepsis screening results for quarter 1 show a percentage compliance with sepsis screening of 14.3%.

These results have been shared with the sepsis committee and plans are being progressed for divisional ownership of the audits and required actions for quarter 2 onwards.

Status
Goal 2: Sepsis

Part 2: Sepsis Antibiotic Administration

Aim

The intention is to incentivise providers to administer intravenous antibiotics within one hour to all patients who present to the emergency department or assessment units with severe sepsis or septic shock.

A random sample of 30 sets of notes, where clinical codes indicate sepsis, should be reviewed each month to ensure patients received antibiotics within 60 minutes of arrival (not time of triage). This audit should be undertaken by consultant staff.

During quarter one, the results of the audit should be presented to provide a baseline. These should be presented as a percentage compliance achieved during the quarter. Discussion is scheduled to take place with the Commissioners to agree an improvement target for quarter two.

The final aim during quarter four is to achieve 90% or above of eligible patients receiving antibiotics.

Progress Report

For quarter 1, the results show a percentage compliance of antibiotic administration within one hour of arrival of 33%.

These results have been shared with the sepsis committee and plans are being progressed for divisional ownership of the audits and required actions for quarter 2 onwards.

Status

✅
Goal 3: Dementia

Part 1: Find, Assess Investigate, Refer and Inform (FAIRI)

Aim

Identify the proportion of patients aged 75 and over to whom the case finding question is applied following an emergency admission; the proportion of those who may potentially have dementia who are appropriately assessed; the number referred onto GP services and those who have a written plan of care on discharge which is shared with the patient’s GP.

Trust staff must continue to collect and submit data each month in relation to the above in line with requirements for the past two years. In addition, this year, Commissioners must collect and submit data about the number of patients who underwent a diagnostic assessment, the number of patients referred for further diagnostic advice and patients who have a care plan on discharge.

Specifically, GPs should be notified about:

- The presence of cognitive impairment
- The patient's diagnosis and READ code (READ codes relate to the standard clinical terminology system used in General Practice)
- Use of antipsychotic or sedative drugs
- Involvement of the multi-disciplinary team
- Abbreviated mental test (AMT) scores on admission and discharge.

Progress Report

To ensure GPs receive the required information, the e-discharge letters have been amended to include the specific information highlighted above. This went live from 1 July 2015.

During quarter one, 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. 26 patients were referred in April and 20 were referred in May. The results for June are not yet available.

Status

✅
Goal 3: Dementia

Part 2: Staff Training

Aim

To ensure that appropriate dementia training is available to staff.

There must be quarterly reports to show the number of staff who have completed their training and the overall percentage of staff that have been trained.

Progress Report

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.

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 during quarter one:

The figures for dementia awareness training are calculated as a percentage on a rolling programme. During quarter 1, the Trust achieved 93% for clinical staff and 93% for non-clinical staff. This equates to a total of 93% for all Trust staff.

The numbers of staff who have completed the e-learning modules or have completed or are undertaking the workbook has continued to increase during quarter 1.

The Trust has recently registered as a ‘Dementia Friendly’ organisation and staff are encouraged to become Dementia Friends. During Dementia Awareness week in May, over 100 Trust staff became Dementia Friends in addition to those who had already attended previous information sessions. The Trust now has a core group of Dementia Champions who can disseminate this awareness further.

The role of ward/department dementia link staff has been rejuvenated and regular link support sessions have been planned throughout 2015. The last session in May was delivered by the new Dementia End of Life Practice Development team to introduce their service and to enhance understanding of issues surrounding end of life care.

Status

✔️
Goal 3: Dementia

Part 3: Supporting Carers

Aim

To ensure carers of people with dementia feel supported. A monthly carer survey must be undertaken to test whether carers feel supported. The results should be reported every six months to the board.

Progress Report:

A monthly audit continues to monitor support within the hospital for carers of people living with dementia.

In December 2014, following a short pilot, the care bundle was implemented throughout the hospital. The information pack created for carers was incorporated into this bundle (as a tear off section) including the carer survey in its revised format.

Audit results for this quarter show that all respondents have felt supported during the patient’s stay in hospital. All clinical areas have an increasing awareness of the dementia lead nurse role and will 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 will be assisted to complete the personal support plan and have 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. Positive feedback has been received about this from carers and staff.

All wards are aware that early identification and referral of people with dementia is essential. The emergency department has revised their documentation so that people with dementia can be identified early in admission.

Clear information has been put in place for carers of people living with dementia to access via the Trust website and 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.

Status
Goal 4: Urgent and Emergency Care

Aim

The intention is to improve the recording of diagnoses of patients with mental health needs in the emergency department.

The codes 38 (diagnosis not classifiable) and R69 (unknown and unspecified causes of morbidity) are classed as invalid. The valid codes are A&E 2 digit diagnosis codes or 3 digit ICD-10 codes.

Data should be collected monthly and include all records of attendances in the emergency department each month.

The final aim during quarter four is to achieve 90% or above of mental health patients being appropriately coded.

Progress Report

During quarter 1, baseline actions have taken place to educate medical staff and emergency nurse practitioners to understand and improve coding in the Emergency Department. To assist this process, the Casualty card has been redesigned to provide clarity in relation to coding.

An initial audit was undertaken for two weeks to pilot the data collection processes. This has shown that patients with mental health needs are being correctly coded. This audit will now be rolled out to encompass more patients.

The intention is also to share learning from this CQUIN with other local Trusts who have emergency departments to determine the best practice in relation to correct coding for these patients.

Status

✓
Goal 5: AQ: Acute Myocardial Infarction (AMI)

Aim

Implement the AQ care pathway for Acute Myocardial Infarction

This financial year, the Trust performance relating to 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

Progress Report

A new process for data collection is being devised to enable collection for the AQ audits.

Due to consistency in clinical performance, and to allow for prioritisation of managing changes in clinical care, the commissioners have agreed to 50% of the cases being analysed in 2015/16.

The clinical performance for April is 100%. The target for this year is 95% clinical compliance.

Status

✅
Goal 6: AQ: Heart Failure

Aim

Implement the AQ care pathway for Heart Failure

The Trust performance relating to the elements of the pathway is measured using an appropriate care score (ACS). To meet the target, 79.9% 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

Progress Report

Current performance is summarised in the graph below. It represents the performance of the Trust against the new target.

![Heart Failure Graph]

It can be seen that the median performance is not far from target. The Trust will need to improve on its consistency in this focus area to remain on track to meet the target.

Due to consistency in clinical performance, and to allow for prioritisation of managing changes in clinical care, the commissioners have agreed to 50% of the cases being analysed in 2015/16.

Status

😊
Goal 7: AQ: Hip and Knee Replacement

Aim

Implement the AQ care pathway for Hip and Knee replacement

Progress Report

This financial year, the Trust performance relating to the elements of the pathway is being measured using an appropriate care score (ACS). To meet the new target, 92.7% 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 can be seen that the Trust is on track to meet the target this year.

![Hip and Knee ACS Graph](image)

Due to consistency in clinical performance, and to allow for prioritisation of managing changes in clinical care, the commissioners have agreed to 50% of the cases being analysed in 2015/16.

Status

✅
Goal 8: AQ: Pneumonia

Aim

Implement the AQ care pathway for Pneumonia

This financial year, the Trust performance relating to the elements of the pathway is being measured using an appropriate care score (ACS). To meet the new target, 75% 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

Progress Report

The Trust suspended data collection during the last financial year. Data collection has started for April and a process is in place to ensure it is captured.

As yet, results are not available for this financial year. However, based on the results from the last financial year, it is recognised that this focus area will remain a challenge. The care element that provides the most significant issue is capturing documentation in relation to smoking cessation advice / counselling.

To allow for prioritisation of managing changes in clinical care, the commissioners have agreed to 25% of the cases being analysed in 2015/16.

Status

🤔
Goal 9: AQ: Chronic Obstructive Pulmonary Disease (COPD)

Aim

Implement the AQ care pathway for COPD

This is a new focus area. All participating Trusts have been set a target of 50% ACS. The care elements 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

The following information will also be collected as a shadow measure:

Arrange appropriate follow up within 72 hours

Progress Report

The Trust suspended data collection during the last financial year. Data collection has started for April and a process is in place to ensure it is captured. There is no data currently available for Trust performance at present.

Status

✅
Goal 10: AQ: Hip Fracture

Aim

Implement the AQ care pathway for hip fracture

This is a new focus area. All participating Trusts have been set a target of 50% ACS. The care elements 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.

The following information will also be collected as a shadow measure:

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

Progress Report

The graph below shows performance against the target to date. The Trust will need to make a number of improvements to achieve the target this year. Physiotherapy assessment within 24 hours of surgery is currently causing the biggest challenge.

Status

😢
Goal 11: AQ: Sepsis

Aim

Implement the AQ care pathway for sepsis

This is a new focus area. All participating Trusts have been set a target of 50% ACS. The care elements 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.

The following information will also be collected as a shadow measure:

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

The graph below shows performance against the target so far. The Trust will need to make some improvement to achieve target this year. Senior review or assessment by Critical Care within 4 hours of hospital arrival is currently causing the biggest challenge.

![Sepsis Graph](image)

**Status**

😊
Goal 12: AQ: Acute Kidney Injury

Aim

Implement the AQ care pathway for acute kidney injury

This is a new focus area. All participating Trusts have been set a target of 50% ACS. The care elements 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.

The following information will also be collected as a shadow measure:

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

Progress Report

Due to a delay in implementing the national algorithm for AKI, data collection did not commence until May 2015. There is no data currently available for Trust performance at present.

Status

✔️
Goal 13: AQ: Diabetes

Aim

Implement the AQ care pathway for diabetes

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 care elements 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

Progress Report

Data collection has started for April and a process is in place to ensure this is captured. Results are not yet available for this financial year.

Status

✅
Goal 14: AQ: Alcoholic Liver Disease

Aim

Implement the AQ care pathway for alcoholic liver disease

This is a new focus area. All participating Trusts have been set a target of 50% ACS. The care elements 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

The following information will also 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.

Progress Report

Clinical performance will be measured for patients discharged in April onwards. Results are not yet available for this financial year.

Status

✅
Goal 15: Advancing Quality – Patient Experience

Part 1: Hip and Knee Replacement

Aim
Engage with patients to elicit their views about their experiences to inform the development of the hip and knee pathway

During quarter one, the aim was to conduct face to face surveys to agree what patients want from a telephone follow up service.

Progress Report
The orthopedic ward manager and ward sister have organised 10 home visits to conduct face to face interviews with patients to elicit their views of a telephone service. The outcomes of these visits will be provided in the quarter 2 report.

Status
✅
Goal 15: Advancing Quality – Patient Experience

Part 2: Heart Failure

Aim
Engage with patients to elicit their views about their experiences to inform the development of the heart failure pathway.

During quarter one, the aim was to plan, develop and conduct an exit survey for patients who have experienced heart failure and who are being discharged from the service.

Progress Report
A patient survey has been designed, approved and undertaken in the heart failure outpatient clinic as scheduled. The results will be reviewed in the quarter 2 CQUIN report.

Status
☑
Goal 15: Advancing Quality – Patient Experience

Part 3: Sepsis

Aim
Engage with patients to elicit their views about their experiences to inform the development of the sepsis pathway

During quarter one, the aim was to meet with the Commissioners to agree the milestones for this element of the CQUIN.

Progress Report
A meeting took place with the quality team from the Clinical Commissioning Groups during June to finalise the requirements of this CQUIN. These will be progressed during quarter two.

Status
✅
Goal 16: Transition for young people with diabetes

Aim:

Review the transition pathway to improve patient experience and ensure the delivery of effective quality care for young people and their families.

The aim during quarter one was to undertake a gap analysis against the key principles of transition and to share the policy for transition of paediatric diabetic patients.

Progress Report

A gap analysis has been undertaken to identify current service provision and actions required against each of the nine principles of transition. The policy for the transition of paediatric diabetic patients is approved and has been shared with the commissioners.

The ‘ready, steady, go’ transition plan has been developed and will be piloted with young people undertaking structured education sessions during quarter 2.

A survey to determine experiences of transition care has been developed and will be completed by young people who attend the paediatric clinic and the 16-19 year old clinics during quarter two.

Status

✅
Goal 17: Person Centred Care for patients who have a diagnosis of cancer of unknown primary (CUP)

Aim

Develop self-care pathways and the provision of information to support self-care / self-management for patients to manage their care.

The aim for quarter one is to understand the number of patients who have been diagnosed with cancer of unknown primary from a retrospective audit for the period of April 2014 – March 2015.

The intention is also to develop a diagnostic pathway of referral for patients presenting acutely at the Trust and develop a standard operating procedure which is linked to the referral pathway.

A gap analysis is also planned to clarify gaps in current patient information and resources available for patients who are diagnosed with cancer of unknown primary.

Progress Report

A retrospective audit of patients with suspected Cancer of the Unknown Primary (CUP) has been undertaken and the results have been analysed. This has influenced the development of the diagnostic pathway.

A diagnostic pathway and standard operating procedure has been developed and was approved by the Trust’s Cancer Governance Committee in June 2015.

A gap analysis has been completed to identify the information provided to patients presenting with CUP. It was noted that the holistic needs of patients are not always assessed to ensure patients receive individualised information. The Acute Oncology Team plan to address the gaps highlighted to ensure CUP patients receive the right information and support to self-manage their care at the right time for them.

Status

✓
Goal 18: Cancer survivorship risk stratification

Aim

Undertake risk assessments and stratify patients who are ending acute treatment for cancer into the following categories:

- Supported self-management
- Shared care
- Complex case management

During quarter one, the aim was to meet with the Commissioners to agree the milestones for this element of the CQUIN.

Progress Report

Meetings have taken place with the quality team from the Clinical Commissioning Groups during quarter one to finalise the requirements of this CQUIN. These will be developed into milestones and progressed during quarter two.

Status

✅
Goal 19: Discharge

Part 1: Patient Experience

Aim

Understand patients’ and carers’ views of the discharge process

During quarter one, the aim was to meet with the Commissioners to agree the milestones for this element of the CQUIN.

Progress Report

A meeting took place with the quality team from the Clinical Commissioning Groups during June to finalise the requirements of this CQUIN. These will be progressed during quarter two.

Status

✓
Goal 19: Discharge

Part 2: Discharge Documentation

Aim

Review and develop existing documentation used in discharge planning

During quarter one, the aim was to meet with the Commissioners to agree the milestones for this element of the CQUIN.

Progress Report

A meeting took place with the quality team from the Clinical Commissioning Groups during June to finalise the requirements of this CQUIN. These will be progressed during quarter two.

Status

✓
Goal 19: Discharge

Part 3: E-discharge Correspondence

Aim

Improve the quality of correspondence between GPs and Acute Physicians in relation to discharge

During quarter one, the aim was to meet with the Commissioners to agree the milestones for this element of the CQUIN.

Progress Report

A meeting took place with the quality team from the Clinical Commissioning Groups during June to finalise the requirements of this CQUIN. These will be progressed during quarter two.
Goal 19: Discharge

Part 4: Complex Discharge

Aim

Review the process of discharge of patients with complex care needs through the use of patient stories.

During quarter one, the aim was to meet with the Commissioners to agree the milestones for this element of the CQUIN.

Progress Report

A meeting took place with the quality team from the Clinical Commissioning Groups during June to finalise the requirements of this CQUIN. These will be progressed during quarter two.

Status

✅
Goal 20: Integrated Care Record

Aim

Implement the integrated care record.

During quarter one, the aim was to meet with the Commissioners to agree the milestones for this element of the CQUIN.

Progress Report

Meetings have taken place with the quality team Commissioners during quarter one to discuss the requirements of this CQUIN. These will be progressed during quarter two.

Status

✓
Goal 2: Neonatal Admissions

Aim

Improve learning from avoidable term admissions (≥ 37 weeks gestation) into neonatal units.

During quarter one; there should be evidence of clinical review being completed for term babies admitted to the neonatal unit. The reviews should be undertaken jointly by maternity and neonatal services so that learning can be fully understood.

A template is provided for the review by the neonatal specialised commissioners which clarifies the primary reason for admission and asks what would have prevented the admission from occurring.

To achieve the CQUIN, 95% of term admissions should receive clinical reviews.

Progress Report

A weekly multi-disciplinary meeting involving neonatal and maternity services has been established to undertake a joint clinical review of term babies with completion of the CQUIN proforma.

Agreement for this CQUIN was finalised with the Commissioners at the end of April 2015. The Trust has reviewed all quarter one babies and the results are as follows:

April 2015
10 term admissions
0% achieved clinical review within 1 month.

May 2015
13 term admissions
0% achieved clinical review within 1 month.

June 2015
26 term admissions
88% (23) achieved clinical review within 1 month.

Status

😊
Goal 22: Neonatal Critical Care

Aim

Reduce clinical variation and identify service improvements by ensuring data completeness in the identified audit requirements:

Temperature taken within the first hour after birth for babies <29 weeks gestation
Retinopathy screening
Mothers milk at discharge for babies <33 weeks at birth
Parental consultation by senior member of the neonatal team within 24 hours of admission

To achieve the CQUIN, 90% of eligible babies admitted to the unit must have responses to all four audit requirements completed.

Progress Report

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<th>Data completeness of</th>
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Status

✅