Mid Cheshire Hospitals NHS
NHS Foundation Trust

Commissioning for Quality and Innovation (CQUIN)

Quarter 2 Summary Report: July - September 2015

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

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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 3.

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 2 (July - September 2015).

Performance Summary

Quarter 2 (July - September 2015)

Goal No.	Goal Name	Description of Goal	Expected Financial Value of goal (£)	RAG Status Quarter 2
1.	Acute Kidney Injury (AKI)	Diagnose AKI and provide follow up information to GP's on discharge	To be agreed	✓
2.	Sepsis: Part 1: Screening	Ensure appropriate sepsis screening tool in place and utilised	To be agreed	✓
	Part 2: Antibiotic administration	Initiation of intravenous antibiotics within one hour of presentation for those patients with suspected severe sepsis or septic shock	To be agreed	✓
3	Dementia: Part 1: Find, assess, investigate, refer and inform (FAIRI)	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	To be agreed	✓
	Part 2: Staff training	Appropriate training is available to staff	To be agreed	✓
	Part 3: Supporting carers	Ensure carers feel supported	To be agreed	✓
4	Urgent and Emergency Care	Improving the recording of diagnoses in the emergency department of patients with mental health needs	To be agreed	✓
5	Advancing Quality (AQ): Acute Myocardial Infarction	Implement the AQ care pathway for Acute Myocardial Infarction	To be agreed	✓
6	Advancing Quality (AQ): Heart Failure	Implement the AQ care pathway for Heart Failure	To be agreed	✓
7	Advancing Quality (AQ): Hip and Knee Replacement	Implement the AQ care pathway for Hip and Knee Replacement	To be agreed	✓

8	Advancing Quality (AQ): Pneumonia	Implement the AQ care pathway for Pneumonia	To be agreed	
9	Advancing Quality (AQ): Chronic Obstructive Pulmonary Disease (COPD)	Implement the AQ care pathway for COPD	To be agreed	
10	Advancing Quality (AQ): Hip Fracture	Implement the AQ care pathway for Hip Fracture	To be agreed	
11	Advancing Quality (AQ): Sepsis	Implement the AQ care pathway for Sepsis	To be agreed	
12	Advancing Quality (AQ): Acute Kidney Injury	Implement the AQ care pathway for Acute Kidney Injury	To be agreed	
13	Advancing Quality (AQ): Diabetes	Implement the AQ care pathway for Diabetes.	To be agreed	
14	Advancing Quality (AQ): Alcoholic Liver Disease	Implement the AQ care pathway for Alcoholic Liver Disease	To be agreed	
15	Advancing Quality (AQ): Patient Experience Part 1: Hip and Knee Replacement Part 2: Heart Failure Part 3: Sepsis	Engage with patients to elicit their views about their experiences to inform the development of the service: Patients on the elective hip or knee pathway Patients on the heart failure pathway Patients following the sepsis pathway	To be agreed To be agreed To be agreed	  
16	Transition for young people with Diabetes	Review the transition pathway to improve patient experience and ensure the delivery of effective quality care for young people and their families	To be agreed	
17	Person centred care for patients who have a diagnosis of cancer of unknown primary (CUP)	Develop self-care pathways and the provision of information to support self-care / self-management for patients to manage their care	To be agreed	

18	Cancer survivorship risk stratification	Patients ending acute treatment for cancer are to be stratified into the following categories: Supported self-management Shared care Complex case management	To be agreed	
19	Discharge: Part 1:Patient Experience Part 2:Discharge Documentation Part 3:E-discharge Correspondence Part 4: Complex Discharge	 Understand patients' / carers' views of the discharge process Review and develop existing documentation used in discharge planning Improve the quality of correspondence between GPs and Acute Physicians Review the process of discharge of patients with complex care needs through the use of patient stories	 To be agreed To be agreed To be agreed To be agreed	    
20	Integrated care record	Implementation of the integrated digital care record	To be agreed	
21	Neonatal Specialised Commissioning: Neonatal Admissions	Improve learning from avoidable term admissions (≥ 37 week gestation) into neonatal units	To be agreed	
22	Neonatal Specialised Commissioning: Neonatal Critical Care	Reduce clinical variation and identify service improvements by ensuring data completeness in the audit questions identified	To be agreed	

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

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 introduction of the laboratory alerting system for AKI warning and staging is now established, as is the presence of AKI information fields within the e-discharge letter. Together these processes are driving improvement to meet the requirements of this CQUIN.

At the start of quarter two, an improvement target of 10% was agreed with the Commissioners. The results below confirm that this target was met during the quarter.

Month	Target	Percentage Achieved
July	10%	50%
August	10%	51%
September	10%	57%

There are opportunities to further improve compliance and discussions are planned with IT to make additional amendments to the fields within the e-discharge summary.

Discussion is scheduled to take place with the Commissioners to agree the improvement target for quarter 3.

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.

The results should be presented as an average of the percentage screening completed during the quarter.

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

Progress Report

Quarter	Target	Percentage Achieved
Quarter 1		14.3%
Quarter 2	15%	40%
Quarter 3	To be agreed at the end of Q2	
Quarter 4	90%	

These results confirm that the agreed target was met during the quarter.

The following actions have been taken to further improve results:

- Development of a sepsis champion programme
- Each area has nominated a sepsis champion and an education programme has commenced
- The revised sepsis pathway has been launched across the organisation
- The vital signs chart is being reviewed to reflect the revised sepsis pathway

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.

The results should be presented as a percentage compliance achieved during the quarter.

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

Progress Report

Quarter	Target	Percentage Achieved
Quarter 1		33%
Quarter 2		33.3%
Quarter 3	To be agreed at the end of Q2	
Quarter 4	90%	

For quarter 2, the results show a percentage compliance of antibiotic administration within one hour of arrival of 33.3%.

The following actions have been taken to further improve results:

- Development of a sepsis champion programme
- Each area has nominated a sepsis champion and an education programme has commenced
- The revised sepsis pathway has been launched across the organisation
- The vital signs chart is being reviewed to reflect the revised sepsis pathway

Discussion is scheduled to take place with the Commissioners to agree the improvement target for quarter 3.

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 patents 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

The Trust's e-discharge letters have been amended to include the specific information highlighted above. This will ensure GPs receive the required information and went live from 1 July 2015.

During quarter two, 93% 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. 12 patients were referred in July, 12 were referred in August and 17 were referred in September.

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. In addition, all staff receive dementia awareness training via mandatory training which they receive bi-annually.

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.

There are also a number of ad hoc learning opportunities provided, including Dementia Friends sessions. The Trust is registered as a 'Dementia Friendly' organisation and staff are encouraged to become Dementia Friends. The Trust has a core group of Dementia Champions who disseminate this awareness further.

The role of ward/department dementia link staff continues to be supported with regular link study sessions. The last session in August was well attended and focused on the importance of person centred care to maintain dignity in hospital.

The dementia team also deliver a session around dignity and dementia as part of the Health Care Assistant Care Certificate training.

The Dementia Team at the Trust is currently working with the End of Life Partnership to facilitate a study day at St Luke's Hospice for both the dementia and palliative care link nurses. The focus for the study day will be oral care at end of life, with a variety of speakers from different specialties, including dentistry and speech and language therapy. The afternoon is aimed to equip staff to cascade knowledge and skills gained within their working environments.

Numbers trained so far during quarter two:

The figures for dementia awareness training are calculated as a percentage on a rolling programme. During quarter 2, the Trust achieved 90% for clinical staff and 88% for non-clinical staff. This equates to a total of 89.36% 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 2.

Status 

Goal 3: Dementia

Part 3: Supporting Carers

Aim:

To ensure carers of people living 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. This survey is provided to carers as part of an information pack contained within the dementia care bundle.

Results for this quarter show that all respondents have felt adequately supported during the person's stay in hospital. All clinical areas have an 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, positive feedback has been received from carers about the care, compassion and commitment shown by staff, the "Open Visiting Pass" and about feeling involved in the person's care. The dementia care bundle underpins this by enhancing partnership working from the outset, acknowledging carers as experts in their person's needs. Carers are encouraged to work together with hospital staff to complete a personal support plan for/with the person living with dementia to use during their hospital stay.

Feedback from carers during this quarter has identified the following areas for improved outcomes: carer involvement in discharge planning, staff communication between shifts and emotional support for carers.

All wards are aware that early identification and referral of people with dementia is key to enhancing both the patient and carer journey through the hospital. An identifier code is now in place on the electronic patient record to support this.

Regular support sessions for dementia link staff are held and most wards and departments now have link staff to use as a resource for training, information and advice.

Clear information for carers/people living with dementia is available on the Trust's website and Intranet.

The Alzheimer's Society has an information stand in the main outpatient department for use by all. Further links have been established with the local Alzheimer's Society to encourage them to feedback any carer concerns and user groups have been attended to open communication further in order to explore ways of improving the service we provide. The Alzheimer's Society is also supporting staff who are carers at home, by offering drop- in support sessions.

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

The Emergency Department (ED) records have a number of coding sections which are completed by medical staff. This helps to ensure accurate data recording.

The first coding section in the ED record relates to patient group. A mental health code (code 07) and self harm (code 02) are within the category choices in this section. These coding categories are in keeping with national ED codes.

The second section in the ED record is under the heading ED diagnosis notes. Mental health (code 34) and overdose/self poisoning (code 33) must be completed for mental health attendances. Again, these codes are in keeping with national guidance for ED coding.

An initial audit of patients presenting with a mental health condition confirmed that over 85% were correctly coded.

For the September 2015 audit, 100% patients with mental health needs (104 patients) were coded to one of the mental health codes mentioned above. None of these patients were coded under the category of “other” or “diagnosis not classifiable”. There are no “unknown” categories on the Trust’s ED record.

The ED staff liaise very closely with the mental health (MH) liaison team and there is an internal standard that, once referred, patients are seen by MH liaison within one hour.

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.

Progress Report

For 2015/16, it has been agreed with the Commissioners that 50% of cases for AMI will be analysed.

Data collection for AQ runs approximately 10 weeks behind the current date. This means available results do not demonstrate an accurate reflection of Quarter 2. The data below shows performance from April 2015 up to and including July 2015.

Care elements:

		MCHFT				
	Measure	**Excluded**	**Missing Data**	**Numerator**	**Denominator**	**Rate**
CLA-53	Evaluation of LV function	11	0	29	29	100%
CLA-54	Statins prescribed	10	0	30	30	100%
CLA-55	Referral made	12	0	27	28	96.4%
NHS-1	Antiplatelet prescribed within 24 hours before or after arrival, or start of symptoms	4	0	36	36	100%
NHS-2	Antiplatelet prescribed at discharge	13	0	27	27	100%
NHS-3	ACEI Or ARB	9	0	31	31	100%
NHS-4	Smoking cessation advice/counselling	32	0	8	8	100%
NHS-5	Beta-blocker at discharge	12	0	28	28	100%

The clinical focus area population between April and July 2015 for AMI is 40 patients.

Data completeness for this focus area is 100%.

The appropriate care score achieved is currently 97.4%

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.

Progress Report

For 2015/16, it has been agreed with the Commissioners that 50% of cases for heart failure will be analysed.

Data collection for AQ runs approximately 10 weeks behind the current date. This means available results do not demonstrate an accurate reflection of Quarter 2. The data below shows performance from April 2015 up to and including July 2015.

Care elements:

		MCHFT				
	Measure	**Excluded**	**Missing Data**	**Numerator**	**Denominator**	**Rate**
CLA-63	Beta-blocker at discharge	59	2	27	28	96.4%
CLA-64	Specialist review	56	2	31	31	100%
NHS-24	LV function evaluation	27	2	59	60	98.3%
NHS-25	ACEI or ARB at discharge	59	2	28	28	100%
NHS-26	Discharge instructions	28	2	49	59	83.1%
NHS-27	Adult smoking cessation advice/counselling	79	2	8	8	100%

The clinical focus area population between April and July 2015 for heart failure is 89 patients.

Data completeness for this focus area is 97.8%.

The appropriate care score achieved is currently 82.5%

Status

Goal 7: AQ: Hip and Knee Replacement

Aim

Implement the AQ care pathway for Hip and Knee replacement

The Trust performance relating to the elements of the pathway is being measured using an appropriate care score (ACS). To meet the target, 92.7% of patients will have to receive **all** the care elements.

Progress Report

For 2015/16, it has been agreed with the Commissioners that 50% of cases for hip and knee replacement will be analysed.

Data collection for AQ runs approximately 10 weeks behind the current date. This means available results do not demonstrate an accurate reflection of Quarter 2. The data below shows performance from April 2015 up to and including July 2015.

Care elements:

		MCHFT				
	Measure	**Excluded**	**Missing Data**	**Numerator**	**Denominator**	**Rate**
CLA-51	Appropriate Duration	13	0	106	108	98.1%
NHS-45	Antibiotics one hour prior to surgery	2	0	117	119	98.3%
NHS-46	Antibiotics recommended by local guidelines	2	0	118	119	99.2%
NHS-47	Antibiotics discontinued within 24 hours	3	0	118	118	100%
NHS-48	VTE prophylaxis ordered	54	0	67	67	100%
NHS-49	VTE prophylaxis given	54	0	66	67	98.5%

The clinical focus area population for hip and knee replacement between April and July 2015 is 121 patients.

Data completeness for this focus area is 100%.

The appropriate care score achieved is currently 95.7%

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.

Progress Report

For 2015/16, it has been agreed with the Commissioners that 25% of cases for pneumonia will be analysed.

Data collection for AQ runs approximately 10 weeks behind the current date. This means available results do not demonstrate an accurate reflection of Quarter 2. The data below shows performance from April 2015 up to and including July 2015.

Care elements:

		MCHFT				
	Measure	**Excluded**	**Missing Data**	**Numerator**	**Denominator**	**Rate**
NHS-33	Oxygenation assessment	45	16	89	98	90.8%
NHS-34	Initial antibiotic selection for CAP in immunocompetent patients	94	16	31	49	63.3%
NHS-38	Initial antibiotic received within 6 hours of arrival	91	16	39	52	75.0%
NHS-39	Adult smoking cessation advice/counselling	131	15	6	13	46.2%
NHS-50	CURB-65 score	64	16	60	79	75.9%

The clinical focus area population for pneumonia between April and July 2015 is 159 patients.

Data completeness for this focus area is 89.9%.

The appropriate care score achieved is currently 59.4%

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% appropriate care score (ACS).

Progress Report

Data collection for AQ runs approximately 10 weeks behind the current date. This means available results do not demonstrate an accurate reflection of Quarter 2. The data below shows performance from April 2015 up to and including July 2015.

Care elements:

		MCHFT				
	Measure	**Excluded**	**Missing Data**	**Numerator**	**Denominator**	**Rate**
COPD-A12	Arrange appropriate follow-up within 72 hours of discharge: Hospital Community Primary Care Team	2	3	9	68	13.2%
COPD-A1	Pulse oximetry performed and targeted oxygen administered within 4 hours of hospital arrival	47	2	16	24	66.7%
COPD-A10	Arrange referral for spirometry if appropriate	31	3	6	39	15.4%
COPD-A11	Patient requiring Non-Invasive Ventilation (NIV) should have documented evidence about their ceiling of care options	65	2	4	6	66.7%
COPD-A2	Corticosteriods administered appropriately within 4 hours of hospital arrival	12	3	33	58	56.9%
COPD-A3	Bronchodilators administered appropriately within 4 hours of hospital arrival	10	3	38	60	63.3%
COPD-A4	Antibiotics administered appropriately with 4 hours of hospital arrival	24	3	21	46	45.7%
COPD-A5	Offer smoking cessation report	50	2	6	21	28.6%
COPD-A6	Offer pulmonary rehab referral	8	3	4	62	6.5%
COPD-A7	Review inhaler technique	15	3	7	55	12.7%

COPD-A8	Provide written self – management plan, including use of rescue medications and contact numbers	2	3	2	68	2.9%
COPD-A9	If the patient oxygen saturations is 92% or less arrange referral for home oxygen therapy assessment	57	2	3	14	21.4%

The clinical focus area population for COPD between April and July 2015 is 73 patients.

Data completeness for this focus area is 95.9%.

The appropriate care score achieved is currently 0%

A COPD care bundle has been implemented from August 2015 to support best practice and capture the care elements of the AQ focus area. Performance of the AQ measures will continue to be monitored through Clarity Assure for Quarters 3 and 4.

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.

Progress Report

Data collection for AQ runs approximately 10 weeks behind the current date. This means available results do not demonstrate an accurate reflection of Quarter 2. The data below shows performance from April 2015 up to and including July 2015.

Care elements:

				MCHFT		
	Measure	**Excluded**	**Missing Data**	**Numerator**	**Denominator**	**Rate**
HFR-01	Validated pain score assessment and analgesia within 60 minutes of arrival	14	1	51	93	54.8%
HFR-02	Admission to an appropriate Orthopaedic or Orthogeriatric ward within four hours of arrival	3	1	73	104	70.2%
HFR-03	Jointly agreed protocol commenced within six hours of arrival	0	1	63	107	58.9%
HFR-04	Pressure ulcer assessment within 6 hours of arrival	0	1	89	107	83.2%
HFR-05	Consultant / senior clinician supervision during surgery	3	1	87	104	83.7%
HFR-06	Documentation in the post-operative notes that the patient should fully weight bear	3	1	101	104	97.1%
HFR-07	Physiotherapy assessment within 24 hours of surgery	7	1	43	100	43.0%
HFR-08	Nutritional screen within 24 hours of arrival	0	1	86	107	80.4%

The clinical focus area population for hip fracture between April and July 2015 is 108 patients

Data completeness for this focus area is 99.1%.

The appropriate care score achieved is currently 6.5%

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.

Progress Report

Data collection for AQ runs approximately 10 weeks behind the current date. This means available results do not demonstrate an accurate reflection of Quarter 2. The data below shows performance from April 2015 up to and including July 2015.

Care elements:

		MCHFT				
	Measure	**Excluded**	**Missing Data**	**Numerator**	**Denominator**	**Rate**
SEPS-10	Severity of sepsis documented	89	56	90	90	100%
SEPS-11	Antibiotic review within 72hrs of therapy commencing	91	56	76	88	86%
SEPS-01	EWS recorded within 60 minutes of hospital arrival	27	58	132	150	88%
SEPS-02	Evidence of 2 or more SIRS and documentation of suspected sepsis source within 2 hours of hospital arrival	80	56	82	99	82.8%
SEPS-03	Blood cultures taken within 3 hours of hospital arrival	80	58	43	97	44.3%
SEPS-04	Antibiotics administered within 3 hours of hospital arrival	79	58	59	98	60.2%
SEPS-05	Serum lactate taken within 3 hours of hospital arrival	79	58	47	98	48.0%
SEPS-06	Second litre of IV fluids commenced within 4 hours of hospital arrival	149	55	11	31	35.5%
SEPS-07	Oxygen therapy administered within 4 hours of hospital arrival	149	54	11	32	34.4%
SEPS-08	Fluid balance chart commenced within 4 hours of hospital arrival	95	55	26	85	30.6%
SEPS-09	Senior review or assessment by Critical Care within 4 hours of hospital arrival	143	54	5	38	13.2%

The clinical focus area population for sepsis between April and July 2015 is 235 patients.

Data completeness for this focus area is 75.3%.

The appropriate care score achieved is currently 37.3%

In Quarter 2, the sepsis committee commenced work to produce a sepsis strategy and action plan to improve the recognition and subsequent timely management of sepsis in the Emergency Department and Acute Admission Areas. This will support best practise and promote the focus areas in the AQ measures.

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.

Progress Report

Data collection for AQ runs approximately 10 weeks behind the current date. This means available results do not demonstrate an accurate reflection of Quarter 2. In addition, due to a delay in implementing the national algorithm for AKI, data collection did not commence until May 2015. The data below demonstrates performance from May 2015 up to and including July 2015.

Care elements:

		MCHFT				
	Measure	**Excluded**	**Missing Data**	**Numerator**	**Denominator**	**Rate**
AKI-07	Pharmacist medication review within 24 hours of 1st AKI alert	14	38	14	44	31.8%
AKI-01	Urine dipstick within 24hours of 1st AKI alert	14	38	5	44	11.4%
AKI-02	Stop ACE inhibitors and ARB's within 24hours of 1st AKI alert	32	38	18	26	69.2%
AKI-03	Serum Creatine test repeated within 24 hours of 1st AKI alert	15	38	30	43	69.8%
AKI-04	Ultrasound scan of urinary tract within 24 hours of 1st AKI alert	19	38	4	39	10.3%
AKI-05	Specialist renal or Critical Care decision within 24 hours of 1st AKI 3 alert	17	38	6	41	14.6%
AKI-06	Written self-management information prior to discharge	19	38	0	39	0

The clinical focus area population for AKI is 96 patients between April and July 2015.

Data completeness for this focus area is 60.4%.

The appropriate care score achieved is currently 4.0%

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.

Progress Report

Data collection for AQ runs approximately 10 weeks behind the current date. This means available results do not demonstrate an accurate reflection of Quarter 2. The data below shows performance from April 2015 up to and including July 2015.

Care elements**:**

		MCHFT				
	Measure	**Excluded**	**Missing Data**	**Numerator**	**Denominator**	**Rate**
DIAB-01	Blood glucose within 30 minutes of hospital arrival	0	18	52	79	65.8%
DIAB-02	Foot inspection within 24 hours of hospital arrival	1	18	53	78	67.9%
DKA-01	EWS and GCS carried out at recommended intervals	63	16	0	18	0
DKA-02	Blood and urine tests at recommended intervals	63	16	0	18	0
DKA-03	IV fluids commenced within 60 minutes of DKA detection	71	16	6	10	60%
DKA-04	Fixed rate IV insulin commenced within 60 minutes of DKA detection	66	16	9	15	60%
DKA-05	Senior review	63	16	13	18	72.2%
FOOT-01	Foot ulcer description within 4 hours of detection	78	15	4	4	100%
FOOT-02	Antibiotics administered within 6 hours of foot ulcer detection	75	16	1	6	16.7%
FOOT-03	Referred to hospital foot care team within 24 hours	73	16	1	8	12.5%

FOOT-04	Seen by hospital foot care team within 72 hours of referral	73	16	1	8	12.5%
FOOT-05	Outpatient appointment booked before discharge	76	16	2	5	40.0%
HYPO-01	Quick acting carbohydrates administered within 15 minutes of hypoglycaemia detection	66	15	3	16	18.8%
HYPO-02	Blood glucose monitored after carbohydrate administration	66	15	4	16	25.0%
HYPO-03	Care escalated if BG<4mmol/l at 45 minutes after carbohydrate administration	81	15	1	1	100%
HYPO-04	Cause of hypoglycaemia discussed with patient before discharge	67	15	6	15	40.0%

The clinical focus area population for diabetes between April and July 2015 is 97 patients.

Data completeness for this focus area is 81.4%.

The appropriate care score achieved is currently 21.5%

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.

Progress Report

Data collection for AQ runs approximately 10 weeks behind the current date. This means available results do not demonstrate an accurate reflection of Quarter 2. The data below shows performance from April 2015 up to and including July 2015.

Care elements:

		MCHFT				
	Measure	**Excluded**	**Missing Data**	**Numerator**	**Denominator**	**Rate**
ARLD-09	Risk of alcohol withdrawal assessed within 4 hours of hospital arrival.	19	2	8	22	36.4%
ARLD-10	Care bundle commenced within 4 hours of hospital arrival	1	2	36	40	90%
ARLD-11	Serum lactate taken within 3 hours of hospital arrival	1	2	9	40	22.5%
ARLD-01	Early Warning score recorded within 60 minutes of hospital arrival	0	2	31	41	75.6%
ARLD-02	Alcohol misuse screening within 4 hours of hospital arrival	4	2	28	37	75.7%
ARLD-03	Antibiotics and Terlipressin within 4 hours of suspected variceal bleed	34	2	3	7	42.9%
ARLD-04	IV Pabrinex within 6 hours of hospital arrival	9	2	10	32	31.3%
ARLD-05	Blood test results available within 4 hours of hospital arrival	1	2	28	40	70.0%
ARLD-06	Ascitic tap performed within 8 hours of hospital arrival	25	2	6	16	37.5%
ARLD-07	Gastroenterology or Hepatology ward admission or specialist review within 48 hours or hospital arrival	13	2	20	29	69.0%
ARLD-08	Patient seen by or referred to alcohol services prior to discharge	26	2	7	15	46.7%

The clinical focus area population for ARLD between April and July 2015 is 43 patients.

Data completeness for this focus area is 95.3%.

The appropriate care score achieved is currently 2.4%

In Quarter 2, the care bundle for alcohol related liver disease was reviewed to ensure all elements of the measures in this focus area are included to promote best practice. The referral process to the alcohol liaison service is also being reviewed to capture appropriate documentation of the referral system for patients.

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 two, the aim was to analyse feedback from the face to face interviews and use this feedback to develop the follow up telephone call proforma.

Progress Report

A standard set of questions was developed by the orthopaedic senior nursing team covering the main aspects of a patient's pre-operative assessment preparation and admission to hospital. This was to establish the patient's views on their preparation for surgery, their admission to hospital and how well prepared they felt for their discharge home. Patients were also asked if there were any other issues they would like to discuss in a post discharge phone call that we had not suggested.

Patients were identified during their admission as suitable for a home visit and, with their agreement, a convenient time for the visit was arranged. The orthopaedic ward manager and ward sister visited 10 patients who had either a total hip replacement or total knee replacement. The visits took place within a week of the patient's discharge from hospital. Patients were informed at the time of the visit that they would receive a letter from the orthopaedic sisters with the key themes that patients had identified

Key themes that the 10 patients identified were collated. A standard letter has been produced for the patients that participated to thank them for their participation and to inform them of the key themes that patients wanted to discuss in a 48 hours post discharge phone call.

The first draft of the proforma has been completed and nursing staff are in the process of liaising with therapy staff to include specific questions related to the patients' therapy regime.

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 two, the aim was to analyse the results from an exit survey undertaken for patients who have experienced heart failure and who are being discharged from the service to identify potential areas for improvement.

Progress Report

A patient survey was commenced on 20 July for patients discharged from the heart failure clinic with heart failure. Over 30 surveys have been given out with a pre-paid envelope and patients have been asked to return the questionnaires by post or hand to the heart failure nurses.

Unfortunately, there has been a very poor response rate to the questionnaires. Therefore, the heart failure nurses are now encouraging patients to complete the survey prior to leaving their appointment. These results will be reported in Quarter 3.

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 two, the aim was to progress a patient story for a patient cared for on the sepsis pathway, identify learning from their stay and share positive experiences and areas for improvement with staff through an episode of care flyer

Progress Report

Patient Background

A patient was admitted to the trust in August at 17.15. The patient was a General Practitioner admission with potential pneumonia.

The patient had a presenting history of feeling weak, cold, shivery, short of breath and tired. The patient reported having 'cold' symptoms for the past week. On admission, the patient had a pyrexia of 39.8^{0}c and a tachycardia of 107. Their early warning score (EWS) was 3.

A working diagnosis of sepsis and a lower respiratory tract infection was made. The patient's sepsis and pneumonia were successfully treated with antibiotics and physiotherapy and the patient was discharged 8 days later

What was done well during the admission?

- **The sepsis pathway was commenced within 45 minutes of arrival at hospital.**
- **A fluid balance chart was commenced on admission.**
- **The community acquired pneumonia MDT management plan was commenced on admission.**

What we didn't do well during the admission

- **Although the sepsis pathway was commenced the 'Sepsis Management Guidelines' section was not fully completed and not completed within one hour.**
- **Blood cultures were not taken within the timeframe specified in the sepsis pathway. Blood cultures were not taken until the following day at 09:00.**
- **Blood gases were not checked within the timeframe specified in the sepsis pathway. Blood gases were checked at 20:54.**
- **Serum lactate was not taken within the timeframe specified in the sepsis pathway. Serum lactate was taken at 20:54.**
- **The patient did not receive intravenous antibiotics within one hour of arrival at hospital. The first dose of antibiotics was given at 19:40.**

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 two was to produce the results, analysis and action plan based on the experience of surveys of carers and young people that addresses the principles of transition.

Progress Report

There were responses received from 20 carers/parents and from 30 young people.

Overall, the responses highlighted very positive feedback and praised the support provided from all members of the diabetes team regarding the transition to adult services.

Specific feedback included comments such as:

‘I would like to say that I am glad I got the support and help I needed from the diabetic nurses and my paediatrician. I would like to thank them all. They are really lovely’

‘Everything explained clearly - great service of the nurses from Children's Diabetes Team’

The next steps are to progress formal transition documentation and to pilot ‘Ready, Steady, Go’ transition patient hand held records.

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 two was to develop a pathway of self care for the ongoing support of patients diagnosed with cancer of unknown primary.

The intention was also to develop a standard operating procedure to support the ongoing management of patients with cancer of unknown primary.

An information pack was also to be developed to help individuals self manage their care.

Progress Report

A model of self-care (incorporating holistic needs assessment, individualised personal care plan and education around self-management) for the ongoing support of patients with an established diagnosis of 'cancer of unknown primary / malignancy of unknown origin' has been developed. This, along with an accompanying standard operating procedure, has been forwarded to the Trust's cancer governance committee for approval in October 2015.

An information resource library has been established in collaboration with the Trust's Macmillan information and support manager to ensure appropriate information is offered and provided to patients, enabling them to self-manage their care.

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 two, the aim was to develop a risk stratification tool in line with the National Cancer Institute risk stratified pathway.

Progress Report

Quarter 2
The milestones for this CQUIN were developed and finalised during quarter 2.

The Breast Care Team has reviewed a number of models to stratify patients and divide them into three distinct groups. This tool will be forwarded for approval at the Trust's cancer governance committee in December 2015.

Status

Goal 19: Discharge

Part 1: Patient Experience

Aim

Understand patients' and carers' views of the discharge process

During quarter two, the aim was to develop a questionnaire to establish patient satisfaction with the discharge process.

The intention was also to review feedback from the friends and family test and complaints / issues raised in relation to experiences of discharge.

Progress Report

A discharge survey was completed during quarter two with 102 respondents completing the survey (62% response rate). Key highlights from respondents reported :

- 100% felt they were treated with privacy and dignity
- 94% felt they were involved with planning their discharge from hospital.
- 95% of patients were supplied with the necessary medications.

An action plan has been developed with the following targets. Progress will be monitored by the Action Group for Patient Experience.

Standard/Process/Issue/Gap Identified	**Action Required**
49% reported a delay in their discharge due to waiting for medications	Early identification by ward staff of patients for discharge and prompt action of medication prescribing.
25% of patients were not given a copy of the discharge checklist.	Ward staff to ensure that patients are given a copy of the discharge checklist to read.
39% of patients had the opportunity to read the bedside folder. A decrease since last audit.	Ward staff to ensure that each bed space has a folder and that patients are encouraged to read it.

During the next quarter, it has been proposed that Governors may undertake interviews with patients waiting in the discharge lounge to gain additional views.

In relation to the friends and family test, comments from patients have been reviewed for issues relating to the discharge process.

In the first two quarters, there were six negative comments about delays to discharge due to medication and there were nine positive comments highlighting a smooth transition on discharge.

Examples of comments made include:

“My father was looked after exceptionally well. My estimation of Leighton has increased after the care given and the well planned and smooth discharge. Keep up the good work.”

“Staff enabled a quick and effective discharge”

In relation to formal and informal concerns, there were 4 issues raised in quarter two, mainly relating to appropriateness and fitness for discharge. There were 18 informal concerns raised and resolved. Issues related to medication, appropriateness of discharge and correct documentation.

Status

Goal 19: Discharge

Part 2: Discharge Documentation

Aim

Review and develop existing documentation used in discharge planning

During quarter two, the aim was to review existing discharge documentation used by clinical staff and undertake an audit of the current discharge checklist.

Progress Report

The review of current nursing and medical documentation has taken place and a new integrated nursing and medical assessment document has been developed. This is currently with the printers and will be trialed in the medical assessment areas in November 2015.

This document includes a new discharge checklist, which records the intended date of discharge of the patient, who made this decision and with whom this decision has been shared. It is the expectation that the patient and/or carers are made aware of the intended date of discharge and this information is shared with other disciplines, including residential/nursing home, social workers or care providers, community matrons to ensure that preparation for discharge is seamless.

Discharge arrangements are recorded with the details of medication advice, transport arrangements, wound care instructions, equipment for discharge, information given to patient/carer and a section is also included which enables the nurse to record who to contact if further support is required.

This document will be signed by the member of staff and patient/carer and a copy given to the patient/carer to take home. It is the intention that the new discharge check list will ensure that the patient and carers are fully involved in the discharge process and have the right information to ensure that the discharge process is effective.

An audit of the current discharge checklist was undertaken by the integrated discharge team during quarter 2. The results will be reviewed during quarter 3 and used to facilitate the introduction of the new discharge checklist.

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 two, the aim was to review incident report forms and GP concerns about gaps in e-discharge letters and take actions to address these.

Progress Report

During quarter two, there have been very few issues raised via the incident reporting system and GPs in relation to gaps in e-discharge letters.

This situation was reported by the service manager for the emergency department and asessment areas to the Commissioners during quarter 2 at the joint quality and safety meeting.

There has been an increase in the number of advanced nurse practitoners (ANP's) working in the assessment areas. The ANP's have responsibility for overseeing the production of e-discharge letters. This has led to improvements in the quality and provision of e-discharge letters.

In addition, the acute medical areas have introduced a 'golden rule' that patients cannot be discharged without a letter. This has also seen an improvement in the provision of correct e-discharge letters.

Status

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 two, the aim was to follow the journeys of 2 patients to understand their experience of complex discharge arrangements by reviewing:

1. the experiences of a patient with complex needs who was being discharged to a care home

And

2. the experiences of a patient with complex needs who required a fast track discharge at the end of their life.

Progress Report

The integrated discharge team (IDT) have reviewed the journey of two patients.

The first patient was a gentleman with a diagnosis of dementia who now required 24 hour mental health and nursing care. The outcomes have been summarised as follows in relation to what could have been managed differently and what worked well:

- There was evidence of deterioration in cognition in the weeks leading up to admission
- Community services were contacted on a number of occasions prior to admission.

- The Trust's mental health team were not advised of the patient's admission
- The patient was in the wrong setting on an acute medical ward for an extended period of time before accessing the most appropriate service.

- ✓ A Deprivation of Liberty order was initiated appropriately
- ✓ Appropriate one to one support was initiated rapidly following mental health review and advice
- ✓ Shared access to mental health records supported the discharge process
- ✓ The patient's behaviour was managed appropriately and supported by the mental health team.

The second patient's story was about a married couple who both required fast track applications for end of life care. The outcomes have been summarised as follows in relation to what could have been managed differently and what worked well:

- There was an 18 day delay during which Mrs B progressed through the social care route prior to her diagnosis being known. Following diagnosis, the exit route changed to health which allowed for more flexibility
- Should staff have considered co-locating both patients on the same ward?

✓ One IDT nurse and one social worker was allocated to the couple for consistency
✓ Expert knowledge and support from the IDT navigated the family through a tragic period
✓ Despite the complexity of both cases, both their health and social care needs were met jointly
✓ Joint work with social care and the care home provided the ultimate exit route
✓ Both patients were discharged within 7 days of their prognosis to their preferred place of care together.

These stories will be shared in more detail with the staff on the wards. In addition, they will also be shared with social services and other relevant agencies so that lessons can be learned for future care.

Status

Goal 20: Integrated Care Record

Aim

Implement the integrated care record.

During quarters one and two, the aim was to meet with the Commissioners to agree the milestones for this element of the CQUIN. In addition, a project initiation document was required to identify the technical work stream requirements.

Progress Report

Further meetings have taken place with the Comisisoners to agree the milestone requirements for this element of the CQUIN.

The first milestone to develop the project initiation document has been achieved. The remaining milestones have also been agreed.

Status

Goal 21: Neonatal Admissions

Aim

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

During each quarter, 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 within one month of the baby's admission.

Progress Report

A weekly multi-disciplinary meeting involving neonatal and maternity services undertakes 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.

Month	Term Admissions	Clinical Review achieved within 1 month	% Clinical Review achieved within 1 month
April	10	0	0
May	13	0	0
June	26	23	88%
July	21	15	71%
Aug	18	15	83%
Sep	13	12	92%

Total percentage achieved for both quarters = 64%

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

Quarter	Eligible Babies	Data completeness of temperature taken within 1 hour	% Achieved
April to June 15	3	3	100%
July to Sep 15	4	4	100%

Quarter	Eligible Babies	Data completeness of retinopathy screening	% Achieved
April to June 15	4	4	100%
July to Sep 15	7	7	100%

Quarter	Eligible Babies	Data completeness of mothers milk at discharge	% Achieved
April to June 15	4	4	100%
July to Sep 15	5	5	100%

Quarter	Eligible Babies	Data completeness of parental consultation	% Achieved
April to June 15	77	77	100%
July to Sep 15	67	67	100%

Status