Mid Cheshire Hospitals NHS
NHS Foundation Trust

Commissioning for Quality and Innovation (CQUIN)

Quarter 3 Summary Report: October – December 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 £3,798,574.

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 was agreed 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 3 (October - December 2015).

Performance Summary

Quarter 3 (October - December 2015)

Goal No.	Goal Name	Description of Goal	Financial Value of goal (£)	RAG Status Quarter 3
1.	Acute Kidney Injury (AKI)	Diagnose AKI and provide follow up information to GP's on discharge	370,333.17	✓
2.	Sepsis: Part 1: Screening	Ensure appropriate sepsis screening tool in place and utilised	185,166.59	✓
	Part 2: Antibiotic administration	Initiation of intravenous antibiotics within one hour of presentation for those patients with suspected severe sepsis or septic shock	185,166.59	✓
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	222,199.90	✓
	Part 2: Staff training	Appropriate training is available to staff	37,033.32	✓
	Part 3: Supporting carers	Ensure carers feel supported	111,099.95	✓
4	Urgent and Emergency Care	Improving the recording of diagnoses in the emergency department of patients with mental health needs	370,333.17	✓
5	Advancing Quality (AQ): Acute Myocardial Infarction	Implement the AQ care pathway for Acute Myocardial Infarction	15,000	☹
6	Advancing Quality (AQ): Heart Failure	Implement the AQ care pathway for Heart Failure	15,000	✓
7	Advancing Quality (AQ): Hip and Knee Replacement	Implement the AQ care pathway for Hip and Knee Replacement	15,000	✓

8	Advancing Quality (AQ): Pneumonia	Implement the AQ care pathway for Pneumonia	15,000	
9	Advancing Quality (AQ): Chronic Obstructive Pulmonary Disease (COPD)	Implement the AQ care pathway for COPD	15,000	
10	Advancing Quality (AQ): Hip Fracture	Implement the AQ care pathway for Hip Fracture	15,000	
11	Advancing Quality (AQ): Sepsis	Implement the AQ care pathway for Sepsis	15,000	
12	Advancing Quality (AQ): Acute Kidney Injury	Implement the AQ care pathway for Acute Kidney Injury	15,000	
13	Advancing Quality (AQ): Diabetes	Implement the AQ care pathway for Diabetes.	15,000	
14	Advancing Quality (AQ): Alcoholic Liver Disease	Implement the AQ care pathway for Alcoholic Liver Disease	15,000	
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	 188,364 188,364 188,364	  
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	188,364	
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	188,364	

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	188,364	✓
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	 188,364 188,364 188,364 188,364	 ✓ ✓ ✓ ✓
20	Integrated care record	Implementation of the integrated digital care record	188,364	✓
21	Neonatal Specialised Commissioning: Neonatal Admissions	Improve learning from avoidable term admissions (≥ 37 week gestation) into neonatal units	47,621	✓
22	Neonatal Specialised Commissioning: Neonatal Critical Care	Reduce clinical variation and identify service improvements by ensuring data completeness in the audit questions identified	47,621	✓

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

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 three, an improvement target of 60% was agreed with the Commissioners. The results below confirm that this target was met during the quarter, achieving 62% overall.

Month	Target	Percentage Achieved
July	10%	50%
August	10%	51%
September	10%	57%
October	60%	83%
November	60%	45%
December	60%	57%

To help improve the quality of AKI information within the discharge letter and make the process easier for those producing the summaries, the AKI leads met in November to discuss revising the layout of the AKI information within the discharge summary. Slight amendments have been made and the new format went live on1 December 2015.

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	50%	75%
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	40%	48%
Quarter 4	90%	

For quarter 3, the results show a percentage compliance of antibiotic administration within one hour of arrival of 48%.

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 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 were amended to include the specific information highlighted above. This ensures GPs receive the required information and the updated system went live from 1 July 2015.

During quarter three, 92% 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. 22 were referred in October, 10 in November and 14 in December.

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.

For staff who have completed the initial e-learning module, there will be a “refresher” e-learning package to complete on a 2-3 year basis. The Lead Nurse for Dementia is currently devising the package which will be available from April 2016.

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 next Dementia Link Nurse meeting will take place in March and “communication” will be the core theme.

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

The study day looking at oral care at end of life for people with dementia has held in November and was a great success. Over 40 members of staff attended who are now able to share their learning with their local teams.

Numbers trained so far during quarter three:

The figures for dementia awareness training are calculated as a percentage on a rolling programme. During quarter 3, the Trust achieved dementia training for 90% of clinical staff and 88% of non-clinical staff. This equates to a total of 90% for all Trust staff.

The number of staff who have completed the e-learning modules or have completed or are undertaking the workbook has continued to increase during quarter 3.

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.

Clinical staff refer carers to the dementia service for clinical and personal support as needed. Dementia information boards are evident throughout the hospital as a resource for staff, patients and visitors. Carers are provided with written information about dementia and support available both within the hospital and local community.

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 early identification of individuals who may require additional support.

Throughout this quarter, positive feedback has been received from carers about the knowledge, care, compassion and commitment shown by staff and the benefits of open visiting. The use of the dementia care bundle facilitates partnership working by involving carers from the outset. Their help in completing a personal support plan for the individual enables staff to be more person-centred in their approaches to care.

Feedback from carers during this quarter has identified the following areas for improved outcomes: carer involvement in discharge planning, being kept regularly informed about treatment/ progress, offering additional emotional support for carers and avoiding duplication of information.

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 concerns raised by carers 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.

Audits undertaken during quarter 3 continue to show that all patients with mental health needs were coded to one of the mental health codes identified above. None of these patients were coded under the category of “other” or “diagnosis unclassifiable”. There are no “unknown” categories on the Trust ED record.

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 3. The data below shows performance for September 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
CLA-53	Evaluation of LV function	11	11	100
CLA-54	Statins prescribed	10	12	90.9
CLA-55	Referral made	10	12	83.3
NHS-1	Antiplatelet prescribed within 24 hours before or after arrival, or start of symptoms	10	11	90.9
NHS-2	Antiplatelet prescribed at discharge	7	7	100
NHS-3	ACEI Or ARB	10	11	90.9
NHS-4	Smoking cessation advice/counselling	4	4	100
NHS-5	Beta-blocker at discharge	12	12	100

Data completeness for this focus area is 100%. The appropriate care score achieved for September is 66.7% with a year to date to score of **88.7%**

Planned actions:

• As this measure was previously achieving, an exception review will be undertaken by the Quality Matron to review the patients that are not achieving all measures.

• An electronic referral form is being developed to support the referral process to cardiac rehabilitation.

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 3. The data below shows performance for September 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
CLA-63	Beta-blocker at discharge	4	4	100
CLA-64	Specialist review	5	5	100
NHS-24	LV function evaluation	12	12	100
NHS-25	ACEI or ARB at discharge	4	4	100
NHS-26	Discharge instructions	8	10	80
NHS-27	Adult smoking cessation advice/counselling	2	2	100

Data completeness for this focus area is 98%.

The appropriate care score achieved for September is 83.3% with a year to date to score of **83.5%**

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 3. The data below shows performance for September 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
CLA-51	Appropriate Duration	17	18	94.4
NHS-45	Antibiotics one hour prior to surgery	19	19	100
NHS-46	Antibiotics recommended by local guidelines	19	19	100
NHS-47	Antibiotics discontinued within 24 hours	19	19	100
NHS-48	VTE prophylaxis ordered	12	12	100
NHS-49	VTE prophylaxis given within 12 hours after surgery	11	12	91.7

Data completeness for this focus area is 100%

The appropriate care score achieved for September is 89.5 % with a year to date to score of **93.6 %**

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 3. The data below shows performance for September 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
NHS-33	Oxygenation assessment	15	15	100
NHS-34	Initial antibiotic selection for CAP in immunocompetent patients	7	9	77.8
NHS-38	Initial antibiotic received within 6 hours of arrival	5	10	50
NHS-39	Adult smoking cessation advice/counselling	1	3	33.3
NHS-50	CURB-65 score	9	13	69.2

Data completeness for this focus area is 96%

The appropriate care score achieved for September is 40% with a year to date to score of **55.7%**

Planned actions:

• The Quality Matron has met with the clinical lead and advanced nurse practitioner. They are promoting the use of the pneumonia pathway.

• The Quality Matron is attending the AQ collaborative in February to share ideas with Trusts that are doing well in this focus area.

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 3. The data below shows performance for September 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
COPD-A12	Arrange appropriate follow-up within 72 hours of discharge: Hospital Community Primary Care Team	4	17	23.5
COPD-A1	Pulse oximetry performed and targeted oxygen administered within 4 hours of hospital arrival	5	5	100
COPD-A10	Arrange referral for spirometry if appropriate	0	10	0
COPD-A11	Patient requiring Non-Invasive Ventilation (NIV) should have documented evidence about their ceiling of care options	2	2	100
COPD-A2	Corticosteriods administered appropriately within 4 hours of hospital arrival	11	14	78.6
COPD-A3	Bronchodilators administered appropriately within 4 hours of hospital arrival	13	17	76.5
COPD-A4	Antibiotics administered appropriately with 4 hours of hospital arrival	6	7	85.7
COPD-A5	Offer smoking cessation report	2	4	50
COPD-A6	Offer pulmonary rehab referral	2	17	11.8
COPD-A7	Review inhaler technique	0	15	0
COPD-A8	Provide written self – management plan, including use of rescue medications and contact numbers	0	17	0
COPD-A9	If the patient oxygen saturations is 92% or less arrange referral for home oxygen therapy assessment	1	1	100

Data completeness for this focus area is 98%. The appropriate care score achieved for September is 0% with a year to date to score of **0%.**

Planned actions:

• There is a COPD AQ collaborative in January which the ward manager and matron for respiratory are attending to share ideas with Trusts that are achieving in this focus area.

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 3. The data below shows performance for September 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
HFR-01	Validated pain score assessment and analgesia within 60 minutes of arrival	17	20	85
HFR-02	Admission to an appropriate Orthopaedic or Orthogeriatric ward within four hours of arrival	15	24	62.5
HFR-03	Jointly agreed protocol commenced within six hours of arrival	17	24	70.8
HFR-04	Pressure ulcer assessment within 6 hours of arrival	19	24	79.2
HFR-05	Consultant / senior clinician supervision during surgery	20	24	83.3
HFR-06	Documentation in the post-operative notes that the patient should fully weight bear	24	24	100
HFR-07	Physiotherapy assessment within 24 hours of surgery	16	24	66.7
HFR-08	Nutritional screen within 24 hours of arrival	14	24	58.3

Data completeness for this focus area is 100%. The appropriate care score achieved for September is 8.3% with a year to date to score of **8.2%**

Actions / areas of concern:

• There is currently no weekend physiotherapy service. This will prevent compliance with physiotherapy assessment within 24 hours of surgery for some patients.

• The care elements require a consultant / senior clinician to supervise during surgery. On occasions, the Trust may have a staff grade / senior fellow or speciality doctor present which means this measure is not met. It is not felt that quality of care is compromised by this action and issues relating to this care element have been escalated to the AQ lead with other Trusts who have similar concerns.

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 3. The data below shows performance for September 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
SEP S-10	Severity of sepsis documented	22	22	100
SEP S-11	Antibiotic review within 72hrs of therapy commencing	14	22	63.6
SEP S-01	EWS recorded within 60 minutes of hospital arrival	36	43	83.7
SEP S-02	Evidence of 2 or more SIRS and documentation of suspected sepsis source within 2 hours of hospital arrival	20	28	71.4
SEP S-03	Blood cultures taken within 3 hours of hospital arrival	2	27	7.4
SEP S-04	Antibiotics administered within 3 hours of hospital arrival	13	28	46.4
SEP S-05	Serum lactate taken within 3 hours of hospital arrival	15	27	55.6
SEP S-06	Second litre of IV fluids commenced within 4 hours of hospital arrival	3	10	30.0
SEP S-07	Oxygen therapy administered within 4 hours of hospital arrival	3	9	33.3
SEP S-08	Fluid balance chart commenced within 4 hours of hospital arrival	4	21	19.0
SEP S-09	Senior review or assessment by Critical Care within 4 hours of hospital arrival	1	11	9.1

Data completeness for this focus area is 94%. The appropriate care score achieved for September is 34.9% with a year to date to score of **35.3%**

Planned actions:

• A sepsis strategy has been developed and is reviewed monthly at the sepsis committee

• A sepsis trolley is due to be trialled in the emergency department. If this is successful, it will be rolled out to the assessment areas

• A training booklet about sepsis is being developed for the link nurses to disseminate in their ward areas.

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 3. 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 for September 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
AKI-07	Pharmacist medication review within 24 hours of 1st AKI alert	4	15	26.7
AKI-01	Urine dipstick within 24hours of 1st AKI alert	3	13	23.1
AKI-02	Stop ACE inhibitors and ARB's within 24hours of 1st AKI alert	8	10	80
AKI-03	Serum Creatine test repeated within 24 hours of 1st AKI alert	8	14	57.1
AKI-04	Ultrasound scan of urinary tract within 24 hours of 1st AKI alert	2	14	14.3
AKI-05	Specialist renal or Critical Care decision within 24 hours of 1st AKI 3 alert	3	16	18.8
AKI-06	Written self-management information prior to discharge	5	12	41.7

Data completeness for this focus area is 73%. The appropriate care score achieved for September is 11.1% with a year to date to score of **5.5%**

Planned actions:

• A Nurse Consultant and Consultant Anaesthetist are leading on this focus area and reviewing all case notes for audit.

• The aim is to establish an alert system with pathology to allow for 'real time' data capture by the outreach team.

• The Director of Pharmacy is reviewing the prescription chart to incorporate AKI alerts and the time of medication review.

• Pharmacy staff will receive training in January on AKI measures.

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 3. The data below shows for September 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
DIAB-01	Blood glucose within 30 minutes of hospital arrival	18	22	81.8
DIAB-02	Foot inspection within 24 hours of hospital arrival	19	22	86.4
DKA-01	EWS and GCS carried out at recommended intervals	0	5	0
DKA-02	Blood and urine tests at recommended intervals	0	5	0
DKA-03	IV fluids commenced within 60 minutes of DKA detection	4	4	100
DKA-04	Fixed rate IV insulin commenced within 60 minutes of DKA detection	1	4	25
DKA-05	Senior review	5	5	100
FOOT-01	Foot ulcer description within 4 hours of detection	1	1	100
FOOT-02	Antibiotics administered within 6 hours of foot ulcer detection	1	1	100
FOOT-03	Referred to hospital foot care team within 24 hours	1	1	100
FOOT-04	Seen by hospital foot care team within 72 hours of referral	0	1	100
FOOT-05	Outpatient appointment booked before discharge	0	0	0
HYPO-01	Quick acting carbohydrates administered within 15 minutes of hypoglycaemia detection	3	3	100
HYPO-02	Blood glucose monitored after carbohydrate administration	0	3	0

HYPO-03	Care escalated if BG<4mmol/l at 45 minutes after carbohydrate administration	0	0	0
HYPO-04	Cause of hypoglycaemia discussed with patient before discharge	2	3	66.7

Data completeness for this focus area is 97%. The appropriate care score achieved for September is 40.9% with a year to date to score of **23.9%.** There has been an overall improvement on the progress of achieving the measures for diabetes.

Planned actions:

• The division of Medicine & Emergency Care are advertising for a diabetic specialist nurse who will support the delivery of the AQ measures.

• The AQ leads are reviewing all measures in January 2016 to reduce the number of measures that need to be achieved.

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 3. The data below shows performance for September 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
ARLD-09	Risk of alcohol withdrawal assessed within 4 hours of hospital arrival.	0	11	0
ARLD-10	Care bundle commenced within 4 hours of hospital arrival	4	14	28.6
ARLD-11	Serum lactate taken within 3 hours of hospital arrival	4	14	28.6
ARLD-01	Early Warning score recorded within 60 minutes of hospital arrival	8	14	57.1
ARLD-02	Alcohol misuse screening within 4 hours of hospital arrival	9	14	64.3
ARLD-03	Antibiotics and Terlipressin within 4 hours of suspected variceal bleed	0	1	0
ARLD-04	IV Pabrinex within 6 hours of hospital arrival	6	14	42.9
ARLD-05	Blood test results available within 4 hours of hospital arrival	12	14	85.7
ARLD-06	Ascitic tap performed within 8 hours of hospital arrival	1	4	25
ARLD-07	Gastroenterology or Hepatology ward admission or specialist review within 48 hours or hospital arrival	6	12	50
ARLD-08	Patient seen by or referred to alcohol services prior to discharge	7	10	70

Data completeness for this focus area is 96%. The appropriate care score achieved for September is 0% with a year to date to score of **3.1%**

Planned actions:

• The pathway for alcoholic liver disease is to be reviewed by the Medical Director, Director of Nursing and Quality and Lead Nurse for Medicine and Emergency Care.

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 three, the aim was to standardise the support and advice that is provided during the follow up telephone call, based on patient feedback.

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 had not been 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.

Following these visits, the 48 hour post discharge phone call proforma has been further developed to include key aspects that patients said they would like to discuss. These were:

1. Pain management after discharge from hospital
2. Wound care after discharge from hospital
3. More information on what to do if there is leg swelling

Patients who participated in the pilot have been written to by the Manager of ward 9 to advise them of the key themes.

Nursing and therapy staff have reviewed the proforma and added specific questions which relate to the physiotherapy and occupational therapy the patient received.

Guidance for staff on appropriate actions to be taken if patients raise any concerns has been developed. Briefing sessions for staff on undertaking the post discharge phone call and how to give the most appropriate advice and deal with any concerns are taking place.

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 three, the aim was to analyse the survey results undertaken for patients who have experienced heart failure and who are being discharged from the service to identify areas of good practice or improvement.

Progress Report

There have been 24 responses to the questionnaire for quarter three. From the responses:

85.42% felt that the heart failure service met their expectations.

81.25% felt that heart failure had been fully explained and understood it.

69% felt that the heart failure service telephone support was adequate.

Specific comments included “Could not have been explained any better” and “Made to feel comfortable about my illness, kept me informed”

Following on from the questionnaire results, the heart failure nurses will ensure that the telephone support service is more clearly explained when they deliver discharge advice and instructions.

The intention is to continue giving out questionnaires to all patients discharged from the heart failure service so that its effectiveness can continue to be monitored.

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

Progress Report

Patient Background

A 78 year old patient was admitted to the Trust in November 2015 at 16:10. The patient was an emergency admission with increased confusion and a raised temperature.

The patient had a presenting history of increased lethargy, pyrexia, reduced mobility and reduced fluid intake. On admission the patient's Early Warning Score (EWS) was 3.

A working diagnosis of a urinary tract infection (UTI) and sepsis was made.

The patient's sepsis and UTI were successfully treated with antibiotics and the patient was discharged ten days later.

Areas for improvement / lessons to be learned

- **The patient was not screened for sepsis on admission to the Emergency Department, even though the patient had a EWS of 3.**
- **Although the patient was diagnosed and treated for sepsis, the sepsis screening tool and sepsis pathway were not completed.**
- **The patient did not receive intravenous antibiotics within one hour of arrival at hospital. The first dose of antibiotics was administered two hours after arrival.**

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 for quarter three was to pilot the 'Ready, Steady, Go' transition programme and to implement service improvements.

Progress Report

In September 2015, six young people due to commence transition were contacted to commence a pilot of the 'Ready, Steady, Go' transition programme from NHS Diabetes England.

Verbal feedback from the young people identified that they liked the structure of the programme. It was also noted that it complemented the current structured education programme and worked well alongside it.

The diabetes nurses identified it allowed a framework for the diabetes patients to follow to ensure all the key principles of transition were addressed. The implementation of the 'Ready, Steady, Go' programme will commence in April 2016. This follows a change in the documentation since NHS Diabetes England has now changed to NHS England with amended documents so they can be used for all medical specialities. The new documents are awaited.

Young people with learning disabilities will also follow the programme with support from their parent/carer. It is recognised that some of the transition principles will not be achievable; however, the programme will be adjusted accordingly to meet their individual needs.

Engagement with adult services has progressed and an adult key worker has now been identified for transition. Dates for formal handover sessions are awaited. The 'Ready, Steady, Go' programme now incorporates a 'Hello' transition plan which is to be implemented once the young person has transitioned to the Adult Key Worker.

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 three was to implement a referral pathway of self-care for the ongoing management of patients diagnosed with cancer of unknown primary.

The intention was also to complete a holistic needs assessment and identify a key worker for all patients with cancer of unknown primary.

An individualised care plan was also to be provided to help individuals self-manage their care.

Progress Report

A referral pathway and model of patient centred care for ongoing management of patients with a ‘cancer of unknown primary / malignancy of unknown origin’ has been written and approved for use within the Trust.

All patients presenting with cancer of unknown primary / malignancy of unknown origin have an identified keyworker. An holistic needs assessment and care plan are completed if appropriate to do so.

Staff training is incorporated within the acute oncology rolling program of education.

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 three, the aim was to undertake a baseline audit of categorisation utilising data from 2014/15.

The intention was also to train healthcare professionals in the use of the risk stratification tool.

Progress Report

Progress continues to be made in relation to this CQUIN which requires cross organisational collaboration with the Christie to ensure optimum support for cancer survivorship.

A draft risk stratification has been developed by one of the Trust's Consultant breast surgeons which has been approved.

Agreement from the Christie in relation to arrangements for long term follow up for patients who are ending acute treatment for cancer is pending.

A meeting has been arranged with the breast team to agree the risk stratification across surgical and oncology follow up.

Status

Goal 19: Discharge

Part 1: Patient Experience

Aim

Understand patients' and carers' views of the discharge process

During quarter three, the aim was to develop an action plan based on the results of the questionnaire used to establish patient satisfaction with the discharge process.

Progress Report

A discharge survey was completed 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.

Status

Goal 19: Discharge

Part 2: Discharge Documentation

Aim

Review and develop existing documentation used in discharge planning

During quarter three, the aim was to launch the new discharge documentation.

Progress Report

The division of medicine and emergency care has further developed the short stay nursing documentation which was piloted successfully on the Primary Assessment Area for 4 months.

The short stay nursing documentation now includes a section which records the discharge arrangements for the patient. This will be completed from the point the patient is identified as medically fit for discharge to the day the patient leaves the trust.

The discharge section includes a tear off copy for the patient/relative/carer to ensure that this information is both shared during the inpatient stay and confirmed as the patient leaves the ward.

This short stay nursing documentation is also integrated with a revised medical proforma with the arrangement that multi-professionals will evaluate patient reviews/care in one place. This should support improved communication between professionals to ensure that each patient receives timely and appropriate care.

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 three, 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

To help maintain a high level of completion on the acute medical assessment area, all of the e-discharges are checked by a Consultant. There have been no incident report forms or GP concerns raised in relation to gaps in e-discharge letters.

In relation to completion of the e-discharged correspondence, an audit of 148 sets of notes across the medical wards has been undertaken to review compliance. The majority of letters were fully completed but it was highlighted that there was room for improvement. To help improve the compliance:

An e-discharge policy will be introduced

The introduction of location specific discharge letters for the planned investigation unit, the treatment centre, the primary assessment area and nurse led clinics will be considered.

Multi professional input to e-discharge from Pharmacist and Advanced Nurse Practitioners will be progressed.

The mandatory fields will be reviewed to ensure all are still relevant and some non-mandatory fields will be made mandatory in line with updated care pathways

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.

Progress Report

The patient is a 42 year old lady who was independent, active and worked full time. She is married and has a young family.

She was admitted in November 2015 after experiencing sudden immobility overnight. She was diagnosed with Multiple Sclerosis (M.S.). Although she responded to steroid treatment, her mobility remained poor and she now had a life changing diagnosis which required input from multiple agencies.

The original plan was for the patient to see a neurologist as an outpatient after Christmas for a definitive diagnosis and treatment plan. This was causing the patient some concerns as she was unsure about her future and she was unable to access an MS nurse to support her without first seeing a neurologist. The IDT nurse liaised with the neurologist and arranged an inpatient consultation. Once the Neurologist saw the patient, she was then able to access the MS specialist nurse who arranged to see her as an urgent home visit.

Social services worked alongside the IDT and assessed the patient as benefiting from a reablement package of care while she was still in an acute phase of her condition. This involved carers helping with personal care and meal preparation to encourage independence. She also had walking practise 1 hour a day at lunch time to build up her stamina.

Red Cross were asked to support daily with any cleaning and shopping tasks. The social worker arranged for a disability badge to help with parking as her mobility and tiredness remained an issue.

The Social Worker also worked closely with children's services, advising them of the current situation.

The patient was discharged mid December with the above services in place. Children's Services are in touch with the family and provide psychological input for the children on a weekly basis, but due to priority of the case, they not provided with any practical support for the children. The hospital social worker continued to meet with the patient once a week and phoned every week to ensure that the discharge was a success and that all other external agencies to provide ongoing support.

The outcomes have been summarised as follows:

- ✓ the ward referred the patient early on during her admission to the integrated discharge team (IDT), allowing them to alert social care to the complexity of the case
- ✓ Joint work between health and social care to support discharge planning
- ✓ IDT listened to the patient and worked with neurological team to get an earlier consultation
- ✓ The GP was contacted before discharge and able to support with home visits and telephone appointments
- ✓ Social care accessed all available resource for the patient including 3rd sector support.

Learning points to be discussed between the commissioners and Trust staff:

- There was limited access to specialist multiple sclerosis (MS) nurses at the point of diagnosis
- Although well supported, the patient felt isolated at times due to her new MS diagnosis and staff knowledge and experience.
- There is limited practical support available in the community for patients to care for their children when they have life changing events.

Status

Goal 20: Integrated Care Record

Aim

Implement the integrated care record.

During quarter three, the aim was to complete the project initiation documentation to identify all technical work stream requirements, produce relevant project plans and identify the information governance requirements of the project.

It was also the intention that 90% of project board meetings and programme boards should be attended – either by the nominated attendee or their deputy.

Progress Report

The Data Sharing Agreement is due to be signed by the end of January 2016. It is expected that test data flows will commence in February 2016.

All agreed milestones are being achieved and the project initiation documentation has been completed.

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.

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 and it has taken a little time to formalise the review process. For quarter 3, the review process is now fully established and compliance has improved accordingly.

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%
August	18	15	83%
September	13	12	92%
October	24	24	100%
November	9	9	100%
December	14	14	100%

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
Q1 April to June 15	3	3	100%
Q2 July to Sep 15	4	4	100%
Q3 Oct to Dec 15	2	2	100%

Quarter	Eligible Babies	Data completeness of retinopathy screening	% Achieved
Q1 April to June 15	4	4	100%
Q2 July to Sep 15	7	7	100%
Q3 Oct to Dec 15	5	5	100%

Quarter	Eligible Babies	Data completeness of mothers milk at discharge	% Achieved
Q1 April to June 15	4	4	100%
Q2 July to Sep 15	5	5	100%
Q3 Oct to Dec 15	8	8	100%

Quarter	Eligible Babies	Data completeness of parental consultation	% Achieved
Q1 April to June 15	77	77	100%
Q2 July to Sep 15	67	67	100%
Q3 Oct to Dec 15	66	64*	97%

*Single Mother of twins was too poorly to accompany them as they were ex utero transfer from Birmingham. Telephone updates were provided to mother by nursing staff to midwives who then spoke to mother in Birmingham

Status