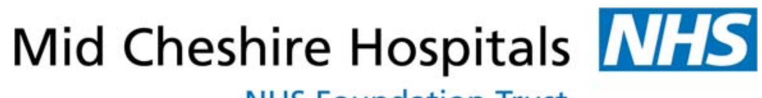

Commissioning for Quality and Innovation (CQUIN)

Quarter 4 Summary Report: January – March 2016

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

Jayne Hartley, Deputy Director of Nursing & Quality

Executive Lead: Alison Lynch, Director of Nursing & Quality

11 May 2016

Contents Page

Introduction			4
Performance summary			5
Goal 1:	Acute Kidney Injury (AKI)		8
Goal 2:	Sepsis		
	Part 1: Screening		9
	Part 2: Antibiotic administration		10
Goal 3:	Dementia:		
	Part 1: Find, assess, investigate, refer and inform (FAIRI)		11
	Part 2: Staff training		12
	Part 3: Supporting carers		13
Goal 4:	Urgent and Emergency Care: Improving recording of diagnoses in the emergency department of patients with mental health needs		14
Goal 5:	Advancing Quality (AQ):	Acute Myocardial Infarction	15
Goal 6:	Advancing Quality (AQ):	Heart Failure	16
Goal 7:	Advancing Quality (AQ):	Hip and Knee Replacement	17
Goal 8:	Advancing Quality (AQ):	Pneumonia	18
Goal 9:	Advancing Quality (AQ):	Chronic Obstructive Pulmonary Disease (COPD)	19
Goal 10:	Advancing Quality (AQ):	Hip Fracture	20
Goal 11:	Advancing Quality (AQ):	Sepsis	21
Goal 12:	Advancing Quality (AQ):	Acute Kidney Injury	22
Goal 13:	Advancing Quality (AQ):	Diabetes	23
Goal 14:	Advancing Quality (AQ):	Alcoholic Liver Disease	25
Goal 15:	Advancing Quality (AQ):	Patient Experience	
	Part 1: Hip and Knee Replacement		26
	Part 2: Heart Failure		27
	Part 3: Sepsis		28
Goal 16:	Transition for young people with Diabetes		29
Goal 17:	Person centred care for patients who have a diagnosis of cancer of unknown primary (CUP)		30

Goal 18: Cancer survivorship risk stratification 31

Goal 19: Discharge
Part 1: Patient Experience 32
Part 2: Discharge Documentation 34
Part 3: E-discharge Correspondence 35
Part 4: Complex Discharge 37

Goal 20: Integrated care record 39

Goal 21: Neonatal Specialised Commissioning: neonatal admissions 40

Goal 22: Neonatal Specialised Commissioning: neonatal critical care 41

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 4 (January - March 2016).

Performance Summary

Quarter 4 (January - March 2016)

Goal No.	Goal Name	Description of Goal	Financial Value of goal (£)	RAG Status Quarter 4
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	Engage with patients to elicit their views about their experiences to inform the development of the service:		
	Part 1: Hip and Knee Replacement	Patients on the elective hip or knee pathway	188,364	
	Part 2: Heart Failure	Patients on the heart failure pathway	188,364	
	Part 3: Sepsis	Patients following the sepsis pathway	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	Understand patients' / carers' views of the discharge process	188,364	
	Part 2:Discharge Documentation	Review and develop existing documentation used in discharge planning	188,364	
	Part 3:E-discharge Correspondence	Improve the quality of correspondence between GPs and Acute Physicians	188,364	
	Part 4: Complex Discharge	Review the process of discharge of patients with complex care needs through the use of patient stories	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:

Achieved

Partially Achieved

Off track but recoverable
(relates to Advancing Quality CQUIN where data is delayed by four months)

Not achieved

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

To achieve the CQUIN for quarter 4, the target of 90% must be achieved.

The results below confirm that, despite achieving the targets for quarters 1, 2 and 3, the target was not met during quarter 4, achieving 62% overall.

Month	Target	Percentage Achieved
July	10% for the quarter	50%
August	10% for the quarter	51%
September	10% for the quarter	57%
October	60% for the quarter	83%
November	60% for the quarter	45%
December	60% for the quarter	57%
January	90% for the quarter	56%
February	90% for the quarter	72%
March	90% for the quarter	58%

To improve these results, the Trust has established a clinical care pathway group which is reviewing the AKI care pathway. In addition, education programmes are planned which will be led by the Deputy Medical Director to increase compliance with the completion of e-discharge letters.

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

The results below confirm that, despite achieving the targets for quarters 1, 2 and 3, the target was not met during quarter 4, achieving 50% overall.

Quarter	Target	Percentage Achieved
Quarter 1		14.3%
Quarter 2	15%	40%
Quarter 3	50%	75%
Quarter 4	90%	50%

To improve these results, the Trust has established a clinical care pathway group which is reviewing the sepsis care pathway. In addition, it has been agreed to recruit a full time specialist sepsis nurse whose role will be to educate and support staff in their care of patients with sepsis.

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

The results below confirm that, despite achieving the targets for quarters 1, 2 and 3, the target was not met during quarter 4, achieving 30% overall.

Quarter	Target	Percentage Achieved
Quarter 1		33%
Quarter 2		33.3%
Quarter 3	40%	48%
Quarter 4	90%	30%

To improve these results, the Trust has established a clinical care pathway group which is reviewing the sepsis care pathway. In addition, it has been agreed to recruit a full time specialist sepsis nurse whose role will be to educate and support staff in their care of patients with sepsis.

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 4, over 90% of relevant patients were asked the case finding question.

Of those who were identified as potentially having dementia, all were assessed and then referred onto GP services. 23 were referred in January, 18 in February and 27 in March.

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.

A Dementia Link Nurse meeting took place in March 2016 and centred around communicated. It was facilitated by the Dementia End of Life Practice Team based at Cheshire Hospices Education. The next meeting is scheduled for July 2016 and will concentrate on the Mental Capacity Act 2005. The Consultant Liaison Psychiatrist from Cheshire and Wirral Partnership Trust is also supporting us with delirium training sessions for medical and nursing staff.

Numbers trained so far during quarter three:

The figures for dementia awareness training are calculated as a percentage on a rolling programme. During quarter 4, the Trust achieved dementia training for 93% of clinical staff and 91% of non-clinical staff. This equates to a total of 92% 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 steadily during quarter 4.

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.

Dementia information boards are evident throughout the hospital as a resource for staff, patients and visitors. These include details of the dementia link staff for that area who have regular support sessions to equip them to act as in this role. In addition to this, carers are provided with written information about dementia and support available both within the hospital and local community. Clear information for carers/people living with dementia is also available on the Trust's website and Intranet.

All staff 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. Clinical staff will refer carers to the dementia service for advice and support as needed.

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.

Throughout this quarter, positive feedback has been received from carers about the knowledge, care, compassion and commitment shown by staff, access to relevant information and the benefits of open visiting.

Feedback from carers during this quarter has identified the following areas for improved outcomes: carer involvement in discharge planning including earlier access to a social worker; being kept regularly informed about treatment and progress; reduction of moves between wards and enabling a more dementia friendly environment. Work is in progress to address these issues.

The Alzheimer's Society has an information stand in the main outpatient department for use by all. Links have been established with the local Alzheimer's Society branches to encourage them to feedback any concerns raised by carers. User groups have been attended to open communication further, to explore ways of improving the service we provide. The Alzheimer's Society also offer a regular drop-in support group for hospital staff who are carers of people with dementia at home.

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 4 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 4. The data below shows performance for December 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
CLA-53	Evaluation of LV function	7	8	87.5
CLA-54	Statins prescribed	7	7	100
CLA-55	Referral made	8	8	100
NHS-1	Antiplatelet prescribed within 24 hours before or after arrival, or start of symptoms	9	9	100
NHS-2	Antiplatelet prescribed at discharge	4	4	100
NHS-3	ACEI Or ARB	7	8	87.5
NHS-4	Smoking cessation advice/counselling	1	2	50
NHS-5	Beta-blocker at discharge	8	8	100

Data completeness for this focus area is 97%. The appropriate care score achieved for December is 66.7% with a year to date to score of **86.3%**

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 4. The data below shows performance for December 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
HF-05	Beta-blocker at discharge	2	2	100
CLA-64	Specialist review	Retired September 2015		
HF-02	LV function evaluation	1	**1**	100
HF-04	ACEI or ARB at discharge	3	3	100
HF-03	Discharge instructions	4	4	100
HF-01	Heart failure specialist review <72 hours of heart failure documentation	4	4	100
HF-06	Referral for appropriate heart failure follow-up	4	4	100
NHS-27	Adult smoking cessation advice/counselling	Retired September 2015		

Data completeness for this focus area is 99.2%. The appropriate care score achieved for December is 100% with a year to date to score of **79.2%**

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 4. The data below shows performance for December 2015.

Care elements:

	Measure	**Numerator**	**Denominator**	**Rate (%)**
CLA-51	Appropriate Duration	21	22	95.5
NHS-45	Antibiotics one hour prior to surgery	25	25	100
NHS-46	Antibiotics recommended by local guidelines	25	25	100
NHS-47	Antibiotics discontinued within 24 hours	23	23	100
NHS-48	VTE prophylaxis ordered	14	14	100
NHS-49	VTE prophylaxis given within 12 hours after surgery	13	14	92.9

Data completeness for this focus area is 100%. The appropriate care score achieved for December is 92% with a year to date to score of **92.8%**

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 4. The data below shows performance for December 2015.

Care elements:

	Measure	**Numerator**	**Denominator**	**Rate (%)**
PN-01	Oxygenation assessment	13	14	92.9
PN-05	Initial antibiotic selection for CAP in immunocompetent patients	1	4	25
NHS-38	Initial antibiotic received within 6 hours of arrival	Retired September 2015		
NHS-39	Adult smoking cessation advice/counselling	Retired September 2015		
PN-04	CURB-65 score	7	9	77.8
PN-02	Chest x-ray within four hours of arrival	12	14	85.7
PN-03	Initial antibiotic received within four hours of hospital arrival	3	6	50

Data completeness for this focus area is 95.7%. The appropriate care score achieved for December is 50% with a year to date to score of **51.6%**

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 December 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
COPD-A12	Arrange appropriate follow-up within 72 hours of discharge: Hospital Community Primary Care Team	4	29	13.8
COPD-A1	Pulse oximetry performed and targeted oxygen administered within 4 hours of hospital arrival	6	7	85.7
COPD-A10	Arrange referral for spirometry if appropriate	0	9	0
COPD-A11	Patient requiring Non-Invasive Ventilation (NIV) should have documented evidence about their ceiling of care options	0	0	0
COPD-A2	Corticosteriods administered appropriately within 4 hours of hospital arrival	13	27	48.1
COPD-A3	Bronchodilators administered appropriately within 4 hours of hospital arrival	15	28	53.6
COPD-A4	Antibiotics administered appropriately with 4 hours of hospital arrival	6	15	40
COPD-A5	Offer smoking cessation report	3	6	50
COPD-A6	Offer pulmonary rehab referral	1	26	3.8
COPD-A7	Review inhaler technique	1	20	5
COPD-A8	Provide written self – management plan, including use of rescue medications and contact numbers	2	29	6.9
COPD-A9	If the patient oxygen saturations is 92% or less arrange referral for home oxygen therapy assessment	1	2	50

Data completeness for this focus area is 100%. The appropriate care score achieved for December is 3.4% with a year to date to score of **1.7%.**

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 4. The data below shows performance for December 2015.

Care elements:

	Measure	**Numerator**	**Denominator**	**Rate (%)**
HFR-01	Validated pain score assessment and analgesia within 60 minutes of arrival	17	24	70.8
HFR-02	Admission to an appropriate Orthopaedic or Orthogeriatric ward within four hours of arrival	19	25	76
HFR-03	Jointly agreed protocol commenced within six hours of arrival	18	27	66.7
HFR-04	Pressure ulcer assessment within 6 hours of arrival	22	27	81.5
HFR-05	Consultant / senior clinician supervision during surgery	22	26	84.6
HFR-06	Documentation in the post-operative notes that the patient should fully weight bear	26	26	100
HFR-07	Physiotherapy assessment within 24 hours of surgery	12	27	44.4
HFR-08	Nutritional screen within 24 hours of arrival	10	27	37

Data completeness for this focus area is 98.8%. The appropriate care score achieved for December is 11.1% with a year to date to score of **9.6%**

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 4. The data below shows performance for December 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
SEP S-10	Severity of sepsis documented	27	27	100
SEP S-11	Antibiotic review within 72hrs of therapy commencing	20	27	74.1
SEP S-01	EWS recorded within 60 minutes of hospital arrival	49	56	87.5
SEP S-02	Evidence of 2 or more SIRS and documentation of suspected sepsis source within 2 hours of hospital arrival	23	33	69.7
SEP S-03	Blood cultures taken within 3 hours of hospital arrival	9	31	29
SEP S-04	Antibiotics administered within 3 hours of hospital arrival	21	31	67.7
SEP S-05	Serum lactate taken within 3 hours of hospital arrival	15	31	48.4
SEP S-06	Second litre of IV fluids commenced within 4 hours of hospital arrival	2	16	12.5
SEP S-07	Oxygen therapy administered within 4 hours of hospital arrival	3	10	30
SEP S-08	Fluid balance chart commenced within 4 hours of hospital arrival	1	27	3.7
SEP S-09	Senior review or assessment by Critical Care within 4 hours of hospital arrival	4	15	26.7

Data completeness for this focus area is 98.6%. The appropriate care score achieved for December is 37.5% with a year to date to score of **35.1%**

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 4. 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 December 2015.

Care elements:

	Measure	Numerator	Denominator	Rate (%)
AKI-07	Pharmacist medication review within 24 hours of 1st AKI alert	10	29	34.5
AKI-01	Urine dipstick within 24hours of 1st AKI alert	9	27	33.3
AKI-02	Stop ACE inhibitors and ARB's within 24hours of 1st AKI alert	15	15	100
AKI-03	Serum Creatine test repeated within 24 hours of 1st AKI alert	23	29	79.3
AKI-04	Ultrasound scan of urinary tract within 24 hours of 1st AKI alert	4	19	21.1
AKI-05	Specialist renal or Critical Care decision within 24 hours of 1st AKI 3 alert	6	25	24
AKI-06	Written self-management information prior to discharge	6	13	46.2

Data completeness for this focus area is 91.1%. The appropriate care score achieved for December is 6.9% with a year to date to score of **7.9%**

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 4. The data below shows for December 2015.

Care elements**:**

	Measure	**Numerator**	**Denominator**	**Rate (%)**
DIAB-01	Blood glucose within 30 minutes of hospital arrival	27	41	65.9
DIAB-02	Foot inspection within 24 hours of hospital arrival	37	41	90.2
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	1	1	100
DKA-04	Fixed rate IV insulin commenced within 60 minutes of DKA detection	3	4	75
DKA-05	Senior review	5	5	100
FOOT-01	Foot ulcer description within 4 hours of detection	3	3	100
FOOT-02	Antibiotics administered within 6 hours of foot ulcer detection	2	3	66.7
FOOT-03	Referred to hospital foot care team within 24 hours	1	3	33.3
FOOT-04	Seen by hospital foot care team within 72 hours of referral	1	3	33.3
FOOT-05	Outpatient appointment booked before discharge	1	2	50
HYPO-01	Quick acting carbohydrates administered within 15 minutes of hypoglycaemia detection	4	6	66.7
HYPO-02	Blood glucose monitored after carbohydrate administration	0	6	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	0	6	0

Data completeness for this focus area is 96.3%. The appropriate care score achieved for December is 46.3% with a year to date to score of **34.6%.**

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 4. The data below shows performance for December 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 December 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 four, the aim was to review patient feedback and develop an action plan for any service changes that are required.

Progress Report

The 48 hour phone call proforma has been implemented.

Following a settling in period, further changes were needed to the wording of the questions so that concise accurate information could be obtained from the patients during the phone call.

Staff have been trained using the ‘guidance for staff’ advice sheet which ensures that all staff know the appropriate action to take if a patient expresses an area of concern relating to their recent orthopaedic admission. This robust system has been implemented for all new staff who will be undertaking the 48 hour phone call.

Feedback received from patients during the phone call will be used to review and improve the service that is offered to patients who are having arthroplasty surgery in the future.

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 four, the aim was to discuss the findings and feedback obtained and to develop an action plan for improvement.

Progress Report

During quarter 4, staff have continued to distribute discharge surveys to patients within the heart failure service. Unfortunately, the responses have been limited and there have only been 3 respondents.

The responses were directly from the patients, with one being looked after by the specialist heart failure nurse and two patients receiving shared care between consultant and the specialist nurse. No patients labelled the service as unsatisfactory. Two rated the service as 'good' and one felt it was 'satisfactory'.

No patients provided ideas as to how to improve the service.

Comments included:

"I was listened to and, although no treatment changes took place, I felt I could seek further advice if necessary."

"Clear explanations of my condition and how to improve it was provided. I was given regular appointments to discuss any concerns."

The heart failure service intends to continue to distribute surveys and, when enough responses are been obtained, the specialist nurses will re-evaluate the service to explore where changes and improvements can be made.

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 four, 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

An 89 year old female patient was admitted to the Trust on Wednesday 10 February 2016 during the afternoon. The patient was an emergency admission following a collapse at home.

On admission, the patient had an Early Warning Score of 6 due to and increased heart rate, respiratory rate and a high temperature (a normal Early Warning Score is 0). The patient was screened for sepsis in the emergency department

The patient was diagnosed as having sepsis of unknown origin.

The patient was successfully treated and they were discharge home.

Areas for improvement / lessons to be learned

- **Although the patient was diagnosed and treated for sepsis the sepsis pathway was only partially completed.**
- **The patient did not receive intravenous antibiotics within one hour of arrival at hospital. The first dose of antibiotics was not administered until 23:00.**
- **This episode of care has been shared with staff in the emergency department.**

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 four was to update progress against 'Ready, Steady Go'.

Progress Report

A keyworker has been identified in adult and paediatric diabetes services. Formal handover sessions have been agreed between the paediatric and adult diabetes teams. The first session took place in March 2016.

Joint adult and paediatric diabetes team meetings has been arranged for 6 meetings per year. The first meeting was in February 2016.

From April 2016, the paediatric diabetes team will be using the 'Ready Steady Go' transition documentation for all their patients from age 13 years until transfer to adult services.

Adult diabetes nurses will be given a plan to work with as the young person is transferred to adult services, which leads on from the 'Ready Steady Go' Transition Plan.

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 four was to evaluate the effectiveness of the referral pathway of self-care for the ongoing management of patients diagnosed with cancer of unknown primary. The evaluation was to include 5 interviews with patients/ relatives to ascertain if they found the additional education useful in managing their condition.
The intention was also to audit the number of completed holistic needs assessment and individualised care plans.
In addition, staff education was to be audited by an audit of the evaluation forms completed by staff plus interviewing 5 staff to ascertain their experiences of implementing the pathways.

Progress Report

It has proved difficult to conduct patient interviews in this group of very poorly patients and felt to be ethically inappropriate in most instances. One patient interview was conducted and very positive feedback was obtained. Other evidence received by patients and their families that highlights their positive experience of the CUP service include 4 thank you cards and 2 thank you emails.

100% of patients audited had holistic needs assessment completed.

A total of 240 healthcare professionals (including GP's, District Nurses, practice nurses, GP registrars in training, Hospital Registrars, ED Junior doctor training, and Hospital Link nurses who disseminate information to all ward staff) have received education on the CUP service. Evaluation from these events was generally very positive and healthcare professionals attending them are aware of the pathways and how to use them.

5 staff interviews have been completed. They are currently under evaluation but feedback has been positive. Staff interviewed demonstrated understanding and knowledge of using the pathways in practice.

Looking forward, further education sessions for healthcare professionals based on their area of practice will be developed, thus ensuring teaching is relevant and specific to them.

The clinical staff also plan to further review methods of obtaining feedback from this patient group, to ensure the service remains relevant and appropriate.

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 four, the aim was to commence delivery of the risk stratification tool and provide evidence of the initial implementation.

Progress Report

During quarter four, the surgical breast care team worked collaboratively with oncologist colleagues (Medical and Clinical Oncologists) from the Christie NHS Foundation Trust to agree and formalise the risk stratification of follow up across the complete patient pathway.

This collaboration has resulted in patients being stratified into the three different strands. The risk assessment is undertaken at the breast cancer multidisciplinary meeting where the risk stratification outcome is now recorded.

As a result of risk stratification, the breast care team is in the process of converting their clinic templates to enable low risk surgical patients to be discharged at one year and receive an extended appointment for an end of treatment summary which will be completed after an holistic needs assessment (to be taken forwards following discussions between the Trust and Commissioners at the end of April 2016).

Status

Goal 19: Discharge

Part 1: Patient Experience

Aim
Understand patients' and carers' views of the discharge process

During quarter four, the aim was to progress the delivery of the action plan.

In addition, the number of complaints / issues raised relating to experiences of discharge were to be reviewed, together with a review of feedback from the friends and family test.

Progress Report

During quarter four, progress against the action plan developed following the patient survey was monitored by the action group for patient experience. A group of four ward managers are leading on the action plan which includes the aim of continuing to improve delays on discharge.

The Trust has seen a significant improvement in patient satisfaction for patients feeling involved in decisions about discharge and for being advised about when they would be discharged.

Standard/Process/Issue/ Gap Identified	Action Update
Early identification by ward staff of patients for discharge with prompt medication prescribing for take home drugs.	There is a proactive approach by ward staff to ensuring plans are in place for a patient waiting to be discharged. Some wards are trialling the role of the discharge co-ordinator. The assessment wards have dedicated support from the pharmacy team which is improving dispensing medication for discharge. Results of a pharmacy audit demonstrate that prescriptions are completed within two hours of receipt by pharmacy.
Ward staff to ensure that patients are given a copy of the discharge checklist to read.	A discharge checklist has been made available to patients on admission. The checklist is currently being revised to improve communication of the discharge process.
Ward staff to ensure that each bed space has a folder and that patients are encouraged to read it.	The bedside folder has been revised, reprinted and delivered to ward areas by the ward managers' action group. Awareness has been raised with staff of the folder and the need to include on orientation of patients to the ward.

A review has also been undertaken of the number of complaints / issues raised relating to experiences of discharge, together with a review of feedback from the friends and family test.

Complaints and informal concerns:

- There has been a reduction in the number of formal complaints and informal concerns regarding discharge for 2015/2016 compared to the previous year.
- Individual cases, including issues relating to discharge, are reviewed by the complaints review group which is chaired by the Director of Nursing and has lay representatives as its members. Staff from the appropriate division attend to present complaints and actions taken / lessons learned.

- Examples of lessons learnt are now included in monthly "You Said, We Did" posters :

"On discharge of a patient, a document was not sent home with the patient when it should have been." It is now documented in the daily handover book to make sure that patients have all paperwork upon discharge or transfer. This has also been covered in monthly staff training and reminder correspondence has been sent to the Matrons and Ward Managers.

Example of comments from the Friends and Family Test:

"The discharge co-ordinator was fantastic"

"We cannot thank the ward enough for the care and commitments given to our wife and mother and the help we have had while she was an inpatient and with the discharge"

"Wonderful help and attention at all times. Couldn't be better. The Ward Sister was a tremendous help re: discharge"

"From first to last, took very good care of me and food very good. Let down by discharge time - 4 hours is too long to wait"

Status

Goal 19: Discharge

Part 2: Discharge Documentation

Aim
Review and develop existing documentation used in discharge planning

During quarter four, the aim was to implement an action plan in relation to the discharge documentation audit results.

Progress Report

The discharge documentation audit completed in February 2016 by the Integrated Discharge Team identified that the discharge checklist was not completed consistently by the ward staff.

The division of Medicine and Emergency Care commenced a pilot from February, 2016 of the new integrated nursing and medical assessment documentation. This incorporated a revised version of the short stay nursing documentation, which included a new discharge planning section with a revised medical proforma.

A staff feedback survey was completed in March 2016 to gather feedback from staff to ensure that the final version of the document supports effective assessment of patients on admission and enables good preparation for discharge. Overall, the feedback from staff regarding the pilot was very positive and it is intended that the new documentation will continue.

Following staff feedback, it is intended that the discharge section will be made available as a separate document which can be used in the multidisciplinary file and be easily available to all disciplines to ensure that discharge planning is accurately documented and shared with both patients and their families.

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 four, the aim was to review the contents of a sample of e-discharge letters and identify gaps and to implement the perfect week to highlight the importance of e-discharge letters.

Progress Report

Following the audit of e-discharge letters, which was carried out by the Deputy Medical Director, an action plan has been formulated. This will be led by the Medical Director and Deputy Medical Director and includes the following actions:

- **Improved education of medical staff**
  The importance of accurate completion of the discharge letters will be emphasised to all medical staff at each cohort of junior doctors joining the trust. e-discharge will also be part of the new Quality Initiative programme in the Postgraduate Medical Centre which takes place on Friday lunchtimes and includes multi-disciplinary staff.

  It is also planned that consultant medical staff randomly check a sample of e-discharge letters from their wards in future so as to check the accuracy and quality of content. This already happens in some specialties.

- **Advanced Nurse Practitioners (ANPs)**
  ANPs in every specialty will receive e-discharge training. This will reduce the risk of any delays in the process and ensure GPs receive correspondence in a timely manner.

- **Content of e-discharge letters**
  GPs had the opportunity to provide feedback about the quality and content of the e-discharge letters during a recent “Perfect Month” when they were invited to comment on letters received (this took place instead of the ‘perfect week’). This feedback will be used constructively to improve the content of the e-discharge letters.
  The Medical Director and Deputy Medical Director will meet with GPs to confirm what information is absolutely necessary within the discharge letter. This will form the template for all discharge letters produced by the Trust.
  The number of templates within the electronic discharge letter programme will be reduced so as to ensure consistent and effective communication.

- **Trust Prescription charts**
  Action will be taken to ensure that the Trust's prescription charts contain clear and easily identifiable data to confirm that each medication is either a new prescription or was already in place. This will be reflected in the changes to regular medication domain within the e-discharge letter

- **IT Strategy**
  The Trust's IT strategy / review will examine the possibilities of improving both the software and hardware available to produce the e-discharge letters. Auto-population of the discharge summary will be a core component of the Trust's electronic patient record strategy

- **Audit**
  A repeat audit of the quality of the e-discharge summaries will be performed after agreement about the new templates is reached.

Status

Goal 19: Discharge

Part 4: Complex Discharge

Aim

To provide evidence of lessons learned, actions required and changes in practice based on feedback from the patient stories described in the previous CQUIN quarterly reports.

Progress Report

Lessons	Current state/Changes in practise	Progress
Community information not readily available to hospital staff	The Integrated Discharge Team (IDT) have been nominated as the early adopters for the Cheshire care record. This will allow the staff to access the patients' shared care records and view vital community information such as mental health assessments, GP support and social care packages. This information will guide the hospital MDT with far more confidence for patients experiencing deteriorating mental health and social needs.	All staff trained, waiting set up of record due in summer 2016
Limited mental health involvement	IDT have set up an NHS.Net joint account with the Mental Health (MH) Liaison team, they receive a list of current complex patients who are in the Trust and the NHS system is used to communicate any changes or support required for patients requiring mental health services.	Daily liaison with MH services
Delayed Mental health referral/patient in wrong setting	IDT have met with lead consultants and social care to discuss appropriate referral to mental health services for inpatients. Consultants will support consultant to consultant referral for patients who are unable to be discharged into community EMI settings due to unmanageable behaviour.	Daily monitoring of all referred patients to ensure access to MH services

Lessons	Current state/Changes in practise	Progress
Delayed Length of stay (LOS)	LOS meetings have been set up internally between Trust senior managers to understand patient journeys and ensure robust medical plans are in place, providing challenge where necessary to escalate any delays, including multiple assessments.	Meet weekly or as requested to report progress
Early referral into IDT	IDT referrals are requested on admission from all ward areas and all referrals are reviewed within 24 hours. The patient's journey is followed through daily. Recent developments in electronic communications have allowed for ease of flow between services surrounding discharge planning.	IDT receive referrals 7 days a week and monitor caseload daily.
Diagnosis support for patients with Multiple Sclerosis (MS)	This particular case raised questions around access to a specialist nurse for patients newly diagnosed and in need of practical advice and support. There is a waiting list for the MS nurse. MS websites provide information around emotional and practical support and has a Crewe Branch support group.	IDT invite in 3rd sector support for cases requiring input.
Care Homes accepting on Fridays/weekends	Patients often remain in hospital for a further 2 days due to care home's reluctance to accept new admissions. This can be due to GP support, staffing levels at care homes etc. This remains a challenge for both hospital staff and commissioners to improve transfers at weekend.	Joint discharge group arranged to discuss role of a care home assessor in April 2016.

Status

Goal 20: Integrated Care Record

Aim

Implement the integrated care record.

During quarter four, the aim was to complete the training programme for appropriate clinical staff and to implement the data feeds.
It was also the intention that a report should be initiated which identifies the potential benefits realisation that will contribute to identifying local return on investment to feed into the overall 5 year benefits realisation plan.

Progress Report

The data sharing agreement was signed in February 2016.

All agreed milestones have been achieved.

Admission, discharge and transfer data is expected to commence being sent to the Cheshire care record once the two outstanding priority 1 data issues are resolved by Graphnet.

Train the trainer and system manager training took place on 24 March 2016.

User training for the Integrated Discharge Team took place week commencing 28 March 2016.

Work with the newly appointed Benefits Realisation Manager for the Cheshire Care Record has commenced.

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.

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%
January	15	15	100%
February	14	14	100%
March	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%
Q4 Jan to Mar 16	11	11	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%
Q4 Jan to Mar 16	9	9	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%
Q4 Jan to Mar 16	10	10	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%
Q4 Jan to Mar 16	59	59	100%

*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