Commissioning for Quality and Innovation (CQUIN)

Quarter 3 Report: October – December 2011

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

Jayne Hartley, Deputy Director of Nursing & Quality

Executive Lead: Julie Smith, Director of Nursing & Quality

16 February 2012
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</table>
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 1.5% of the provider’s contract value.

For MCHFT, the expected financial value of the 2011/12 CQUIN scheme is £2,049,000.

The NHS Institute for Innovation and Improvement has designed a standard template for CQUIN schemes to ensure each goal is clearly defined and able to be measured with a financial weighting attributed as a percentage.

For 2011/12, there are two national CQUIN goals which focus on the prevention of Venous Thrombo Embolism (VTE) (goal one) and Patient experience (goal two).

The SHA has negotiated 7 regional goals with commissioners which have been included within MCHFT’s CQUIN scheme. These relate to Advancing Quality (goals ten to fifteen) and TARN (goal sixteen).

MCHFT and the local commissioners have also agreed a further 7 local goals (goals three to nine).

This paper summarises progress against the CQUIN goals for quarter 3 (October – December 2011)
## Performance Summary
Quarter 3 (October – December 2011)

<table>
<thead>
<tr>
<th>Goal No.</th>
<th>Goal Name</th>
<th>Description of Goal</th>
<th>Goal Weighting</th>
<th>Expected Financial Value of goal</th>
<th>RAG Status Quarter 1 and 2</th>
<th>RAG Status Quarter 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>VTE prevention</td>
<td>Reduce avoidable death, disability and chronic ill health from VTE.</td>
<td>10%</td>
<td>£204,900</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>Patient experience – personal needs</td>
<td>Improve responsiveness to personal needs of patients</td>
<td>10%</td>
<td>£204,900</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>3</td>
<td>Admission Avoidance</td>
<td>Development of an emergency referral system for GPs that avoids admission to hospital</td>
<td>14%</td>
<td>£286,860</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>Patient passports for people who are frequent attendees at A&amp;E</td>
<td>Reduction in the number of people identified as frequent attendees to A&amp;E being admitted to hospital</td>
<td>13.33%</td>
<td>£273,132</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>Learning Disabilities</td>
<td>Improve the care of people with Learning Disabilities</td>
<td>10%</td>
<td>£204,900</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6</td>
<td>End of Life Care</td>
<td>Reduce the numbers of patients who die in hospital where their preferred place of care is not in hospital</td>
<td>12%</td>
<td>£245,880</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7</td>
<td>Paediatric Passport</td>
<td>Development and implementation of patient passport for children with complex health care needs</td>
<td>8%</td>
<td>£163,920</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8</td>
<td>Dementia Care</td>
<td>Improvement in the care of patients diagnosed with Dementia</td>
<td>8%</td>
<td>£163,920</td>
<td>✓</td>
<td>😞</td>
</tr>
<tr>
<td></td>
<td>Management of High Cost Drugs</td>
<td>To ensure high cost medicines and technologies are used, in a safe, effective and appropriate way within available funding</td>
<td>8%</td>
<td>£163,920</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>----------</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>10.</td>
<td>AQ Acute Myocardial Infarction</td>
<td>Implementation of AQ Care Pathway Acute Myocardial Infarction</td>
<td>0.67%</td>
<td>£13,660</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>11.</td>
<td>AQ Heart Failure</td>
<td>Implementation of AQ Care Pathway Heart Failure</td>
<td>0.67%</td>
<td>£13,660</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>12.</td>
<td>AQ Hip and Knee Replacement</td>
<td>Implementation of AQ Care Pathway Hip and Knee Replacement</td>
<td>0.67%</td>
<td>£13,660</td>
<td>😞</td>
<td>✔️</td>
</tr>
<tr>
<td>13.</td>
<td>AQ Pneumonia</td>
<td>Implementation of AQ Care Pathway Pneumonia</td>
<td>0.67%</td>
<td>£13,660</td>
<td>😞</td>
<td>☹️</td>
</tr>
<tr>
<td>14.</td>
<td>AQ Stroke</td>
<td>Implementation of AQ Care Pathway Stroke</td>
<td>0.67%</td>
<td>£13,660</td>
<td>✔️</td>
<td>😞</td>
</tr>
<tr>
<td>15.</td>
<td>AQ Patient Experience</td>
<td>All patients complete an AQ PEMs Survey</td>
<td>0.67%</td>
<td>£13,660</td>
<td>😞</td>
<td>😞</td>
</tr>
<tr>
<td>16.</td>
<td>TARN</td>
<td></td>
<td>2.67%</td>
<td>£54,640</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

RAG status: On track

Off track but recoverable

Off track and unlikely to recover
Goal 1: VTE Prevention

Aim

The aim is to ensure that 90% of adult inpatients have had a VTE risk assessment on admission to hospital. This must be achieved by March 2012.

Progress report

The Trust is making steady progress towards this goal. The VTE group is closely scrutinising areas of non compliance and action plans are in place and monitoring progress.

The Trust has made an overall increase in the numbers of patients assessed year to date.

<table>
<thead>
<tr>
<th>Month</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2011</td>
<td>70.1%</td>
</tr>
<tr>
<td>May 2011</td>
<td>71.1%</td>
</tr>
<tr>
<td>June 2011</td>
<td>78.6%</td>
</tr>
<tr>
<td>July 2011</td>
<td>84.3%</td>
</tr>
<tr>
<td>August 2011</td>
<td>85.1%</td>
</tr>
<tr>
<td>September 2011</td>
<td>90.5%</td>
</tr>
<tr>
<td>October 2011</td>
<td>89.4%</td>
</tr>
<tr>
<td>November 2011</td>
<td>91.4%</td>
</tr>
<tr>
<td>December 2011</td>
<td>89.6%</td>
</tr>
</tbody>
</table>

Status

On Track

[Green check mark]
Goal 2: Patient Experience: personal needs

Aim

The aim is to achieve a 5% increase in satisfaction ratings from the 2010/11 national inpatient survey in relation to the following questions (in addition to no % decrease in any of these questions):

1. Involvement in decision about treatment/care
2. Hospital staff being available to talk about worries/concerns
3. Privacy when discussing condition/treatment
4. Being informed about side effects of medication
5. Being informed who to contact if worried about condition after leaving hospital

Progress Report

The results below show variations in the scores from a reduction of 10% to an increase of 2% relating to these 5 questions over the past 3 years:

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>+ / - / =</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement in decision about</td>
<td>72%</td>
<td>68%</td>
<td>69%</td>
<td>69%</td>
<td>=</td>
</tr>
<tr>
<td>treatment/care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital staff being available</td>
<td>63%</td>
<td>63%</td>
<td>59%</td>
<td>62%</td>
<td>+</td>
</tr>
<tr>
<td>about worries/concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privacy when discussing</td>
<td>78%</td>
<td>77%</td>
<td>79%</td>
<td>78%</td>
<td>-</td>
</tr>
<tr>
<td>conditions/treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being informed about side</td>
<td>53%</td>
<td>40%</td>
<td>41%</td>
<td>42%</td>
<td>+</td>
</tr>
<tr>
<td>effects of medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being informed who to contact</td>
<td>81%</td>
<td>71%</td>
<td>72%</td>
<td>73%</td>
<td>+</td>
</tr>
<tr>
<td>if worried about condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>after leaving hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results for 2011 have been confirmed and the CQUIN percentage score is 65% against a baseline figure of 64%. This equates to an overall increase of 1%. In addition, the percentage score for question 3 has fallen which means this CQUIN goal has not been achieved.

Status

Not achieved
Goal 3: Admission avoidance

Aim

The aim is to develop a process where all non elective admissions (including those in EAU) have a senior review which must be undertaken by a senior decision maker at grade ST4 or above.

Progress Report

The action for quarter 3 requires the following updates:

1 Update against action plan

A ‘perfect front door fortnight’ is planned for the end of February. This means the staff in the Emergency Department (ED) will work very closely with the staff from the Urgent Care Centre (UCC) to try and ‘streamline’ patients to the most appropriate place to receive their care. This will involve placement of a senior member of the medical team / decision maker at the front door to the department.

A meeting has been scheduled to develop a satisfaction questionnaire for patients. This includes an ED Consultant, Matron and Service Manager.

Electronic discharge letters for GPs are being reviewed in conjunction with representatives from the IT department.

The ED cards have been updated and evaluated and are now in use within the department.

2 Results and action plan of audit of number of patients who have had senior review

An audit of senior reviews for ED referrals for admission was undertaken by the Service Manager and an ED Consultant. On the audit day, 43 patients were audited. Seven of these patients had been incorrectly coded on ICS as they were GP admissions. The receptionists have been reminded to ensure accurate data entry on ICS.

Of the 36 patients admitted from ED, 24 (56%) were seen by an SHO and the remaining 12 (28%) patients were reviewed by a middle grade or Consultant.

The audit identified that 29 admissions were appropriate. Of the 7 remaining patients, admission could have been avoided had the following been in place:

- Observation ward in ED: 2
- Cardiac panel machine in ED: 1
- Paediatric observation area: 1
- Care in community / social support: 2 (subsequent LoS of 15 and 25 days)
- Post op complications admitted direct to surgery: 1

Recommendations from the audit have been developed and are being taken forwards within the emergency care division.

Status

On Track
Goal 4: Patient passports for people who are frequent attendees at A&E

Aim

The aim is to develop and implement patient passports for use by adults who are frequent attendees at A&E.

Progress Report

The action for quarter 3 requires the following updates:

1 Update against action plan

The Trust passport has been agreed between mental health and alcohol services and will also be used at East Cheshire NHS Trust.

The Emergency Department Matron met with Mental Health in November 2011 and Alcohol Services in January 2012. Regular meetings will commence with all at the end of January 2012.

As care plans are developed, the Emergency Department Matron will ensure a code is put onto ICS to highlight to staff that the patient has a passport. Codes will continue to be added for any new patients triggering. Emergency Department staff will be educated regarding the code and the need to check for the relevant passport.

Although patients are responsible for their own passport and bringing it with them when they attend the Emergency Department, staff are aware that, due to the complex issues some of these patients present with, there is a need for the department to hold a record. Once a patient books in to the department ICS will flag the patient as having a passport and staff will then ensure this is available to the doctor or practitioner responsible for the patients care. A file will be held in the department with patient passports for staff to access.

NWAS will also be informed of any patients that hold a passport to ensure they encourage the patient to bring it with them and also to assist them with their initial assessment of a patient. The Emergency Department Matron will ensure this is done and involve NWAS in any relevant meetings. This will be initiated when a passport is in place.

A report is available weekly on Rosetta showing patients that present more than 4 times with the same condition in a 60 day period. The Emergency Department Matron checks this report weekly and reviews any new patients that trigger. The data was last reviewed on the 26th December 2011. Three new patients have triggered and will be reviewed shortly.

Monthly meetings will be held with the relevant specialties to review frequent attenders and identify any gaps in service for example primary care, community, social or mental health.
The Rosetta report will be reviewed at this meeting and new patients will be passed over to the relevant specialities for development of the passport/care plan. Existing patient’s who hold a passport will also be reviewed every time they re attend and passports will be updated as appropriate. The first of these meetings are scheduled to take place in January 2012.

GP practices will be informed by letter of any patients who attend more than 4 times to the Emergency Department in a 60 day period with the same condition. This letter will be seeking support and review of these patients. This will involve us working more closely with primary care to prevent re attendance to the Emergency Department. This system will be tested once the first passport is in place.

2. Admission rate for cohort of patients

The original base line data was taken from November 2010 to August 2011. At this time a total of 9 patients had more than four attendances in a 60 day period with the same clinical condition presenting to the Emergency Department.

Of the 9 patients highlighted, one patient is deceased and one patient has had one attendance in August 2011. The other seven patients have not attended between August 2011 and December 2011. Three new patients have triggered during the four month period.

<table>
<thead>
<tr>
<th>Patient.</th>
<th>Presenting Complaint.</th>
<th>Number of attendances in a 60 day period. August 2011 – December 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>Respiratory</td>
<td>39 (Deceased)</td>
</tr>
<tr>
<td>Patient 2</td>
<td>Lacerations</td>
<td>29 (Attended in August 2011)</td>
</tr>
<tr>
<td>Patient 3</td>
<td>Overdose/ Poisoning</td>
<td>10 (Not Attended)</td>
</tr>
<tr>
<td>Patient 4</td>
<td>Respiratory</td>
<td>8 (Not Attended)</td>
</tr>
<tr>
<td>Patient 5</td>
<td>Mental Health</td>
<td>8 (Not Attended)</td>
</tr>
<tr>
<td>Patient 6</td>
<td>Overdose/Poisoning</td>
<td>8 (Not Triggered)</td>
</tr>
<tr>
<td>Patient 7</td>
<td>Other</td>
<td>6 (Not Attended)</td>
</tr>
<tr>
<td>Patient 8</td>
<td>Respiratory/Asthma</td>
<td>5 (Not Attended)</td>
</tr>
<tr>
<td>Patient 9</td>
<td>Overdose/Poisoning</td>
<td>5 (Not Triggered)</td>
</tr>
</tbody>
</table>

Status

On Track
Goal 5: Learning Disabilities (LD)

Aim

The aim is to improve the care of people with learning disabilities by developing and implementing a patient passport and ensuring patients with a learning disability have a reasonable adjustment risk assessment if the criteria is met.

Progress Report

The action for quarter 3 requires the following updates:

1 *Implementation of the awareness training programme*

- Over 130 members of staff have attended LD Awareness Training from April to November 2011.
- The training programme includes sessions delivered by service users and carers.
- Bespoke training continues.
- Paediatric LD Awareness training is planned for early 2012.

2 *Implementation of the patient passport*

- Patient passports have been implemented.
- An audit of patients with LD within the Emergency Care Division was undertaken in December 2011. All relevant patients had a passport.

3. *Percentage of patients who fulfilled the criteria who have had a reasonable adjustment (RA) assessment within 48 hours of admission:*

- 8 have been completed to date by the Privacy and Dignity Matron
- Currently rolling out RA care plan / risk assessment across the Trust.
- The plan is to audit RA care plans once these have been rolled out. This will take place in Feb / March 2012.
- The RA care plan is available to download from the intranet under Learning Disability Guidelines

Feedback from carers who have been involved with the use of the reasonable adjustment care plan has been really positive. Examples of comments received include:

‘The Matron made reasonable adjustments not only for the patient but also for the carer’

‘I feel every effort was made to communicate information – by phone, text and letter. An outstanding example of patients and carers feeling valued. This enhances trust in hospital systems’
'I now feel much more confident when my son is admitted to hospital and not as anxious as I used to be. He is much more relaxed and happy'

I am so grateful for the changes already made. Previously a hospital stay could be quite an ordeal. Now I feel well supported and that the staff care. They speak directly to my son and not just to me. A side room is now made available with an adjustable bed, air mattress and hoist. Staff now offer support.'

**Status**

On Track
Goal 6: End of Life Care

Aim

The aim is to reduce the number of patients who die in hospital where their preferred place of care is not in hospital.

Progress Report

The action for quarter 3 requires the following updates:

1. **Implement the care of the dying pathway for all patients identified as end of life.** Target is 70% of patients by end of quarter 4

   The audit carried out in April 2011 shows 60% of all anticipated deaths were commenced on the care of the dying pathway. The same audit was repeated in November 2011 and the results are pending. However, preliminary results indicate that 71% of patients experiencing an anticipated death are on the care of the dying pathway.

2. **End of life patients who are on the gold standard framework (GSF) register and have a preferred place of care (PPC) recorded on their admission letter must have this recorded on hospital records.**

   This information is recorded for all palliative care patients. Work is ongoing with the PCT to capture more patients on a Trust wide basis.

3. **70% of patients known to the Specialist Palliative care team with a PPC are dying in their preferred place of care.**

   Audit data shows that 70% of patients known to the Specialist Palliative care team are dying in their preferred place of care.

4. **Audit the percentage of anticipated deaths who have a PPC documented and audit the percentage of those anticipated deaths with a PPC documented who do not achieve their PPC.**

   Once the data from the November 2011 audit has been fully analysed, this information will provide a baseline for the number of patients who have an anticipated death and a PPC recorded in their notes.

5. **70% of inpatients with a PPC and the place of care is not hospital have the rapid discharge pathway implemented for them when they have a sudden deterioration in their condition.**

   The bi-annual audit shows that over 70% of patients known the Macmillan nurses who have a PPC have the rapid discharge pathway implemented if their condition deteriorates rapidly.
6. Improvement in the scores of 10 (by at least one in each) out of the 16 indicators of the acute EOL quality marker.

There has been an improvement by one in 10 out of the 16 indicators of the acute end of life quality marker.

7. 80% of specialist palliative care staff will have completed the appropriate level of advanced communication skills training.

100% of specialist palliative care staff have completed advanced communication skills training.

8. Generic staff will have commenced either intermediate or basic level training in communication skills in-year.

The communication skills training for generic staff has commenced and is being offered to staff.

Status

On Track
### Goal 7: Paediatric Passport

#### Aim

The aim is to develop and implement patient passports for children who have complex health and social care needs.

#### Progress Report

The action for quarter 3 requires an audit of the implementation of the paediatric patient passport which has been undertaken – the results are awaiting analysis.

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
<th>When</th>
<th>Action</th>
<th>Outcome</th>
<th>Progress/Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Bev Walley</td>
<td>24.02.12</td>
<td>Complete documentation audit.</td>
<td>Results of documentation audit.</td>
<td>Due to the complexities of the patients participating in this project only 6 passports have been returned despite sending out to a further 3 families. Two patients have died, three patients were unable to complete due to their children being unwell and two parents chose not to complete as they felt their child’s medical needs changed too often. The documentation audit is now complete and is awaiting analysis. The final report will be available for February 2012 in line with agreed timescales.</td>
</tr>
<tr>
<td>2.</td>
<td>Bev Walley</td>
<td>24.02.12</td>
<td>Complete child/carer feedback survey.</td>
<td>Results of feedback survey and action plan.</td>
<td>The child/ carer feedback survey has now been distributed to the families who returned the patient passports. The families of the two patients who died have not been included; however,</td>
</tr>
</tbody>
</table>
### 3. Results of the documentation audit reported

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bev Walley</td>
<td>31.03.12</td>
<td>Present documentation audit at Divisional audit meeting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The final passport document will be completed following the analysis of the documentation audit and feedback survey results. Following this the communication plan will be commenced to ensure stakeholders are aware of the launch of the passport in March 2012.</td>
</tr>
</tbody>
</table>

### 4th Quarter

<table>
<thead>
<tr>
<th>Ensure plan is in place to roll out passport to all applicable children from 1st April 2012</th>
<th>Bev Walley</th>
<th>31.03.12</th>
<th>Communicate plan to roll out passport to key stakeholders. Prepare on line resource and paper copies of document.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Coordinate contacting families to roll out passport to all applicable children/young people eligible for the passport.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>End March 2012.</td>
</tr>
</tbody>
</table>

### Status

On Track

![Green Checkmark]
Goal 8: Dementia Care

Aim

The aim is to improve the care of people provided for patients diagnosed with dementia through staff training, the development and implementation of a patient passport and ensuring 90% of patients admitted with a diagnosis of dementia received a full clinical review of their medications.

Progress Report

The action for quarter 3 requires a report which includes:

1 Number of staff who have undergone training:

- Training is currently delivered by a variety of methods

<table>
<thead>
<tr>
<th>Training</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction Day 1</td>
<td>284</td>
</tr>
<tr>
<td>Biennial Mandatory Update</td>
<td>915</td>
</tr>
<tr>
<td>Customer Care Training</td>
<td>41</td>
</tr>
<tr>
<td>Mental Health Capacity Act</td>
<td>46</td>
</tr>
<tr>
<td>Respect Course</td>
<td>3</td>
</tr>
<tr>
<td>Dementia Training</td>
<td>14</td>
</tr>
<tr>
<td>Junior Doctor Induction</td>
<td>90</td>
</tr>
<tr>
<td>Conflict Resolution Training (Since Sept 2011)</td>
<td>276</td>
</tr>
<tr>
<td>Dementia Training – Pharmacy</td>
<td>32</td>
</tr>
<tr>
<td>WoW ward training</td>
<td>32</td>
</tr>
</tbody>
</table>

All of the above courses contain some form of dementia training.

Total numbers: 1713 between April and November 2011.

2 Number of patients who have a patient passport:

- A snapshot audit was undertaken in December 2011 within the Emergency Care Division.

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients with a diagnosis of dementia</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Number of those with a patient passport</td>
<td>6</td>
<td>32%</td>
</tr>
<tr>
<td>Number of passports awaiting relatives in order to complete</td>
<td>9</td>
<td>47%</td>
</tr>
<tr>
<td>Total number not completed</td>
<td>4</td>
<td>21%</td>
</tr>
</tbody>
</table>
Progress against the 90% target for patients admitted to hospital who have had a full clinical review of their medication regime.

- Audits are carried out by pharmacy every 3 months to ascertain the number of adults admitted who had a medication history performed by pharmacy within 48 hours of admission. Results to date are as follows:

  May 2011 59%  (62% for medical patients)
  August 2011 67%  (70% for medical patients)

Status

Off track but recoverable 😞
Goal 9: Management of High Cost Drugs

Aim
The aim is to ensure high cost medicines and technologies are used in safe, effective and appropriate way within available funding.

Progress Report
During month 7 (October) 69% of MM1 forms (high cost drug forms) were initially completed.

During month 8 (November) 67% of MM1 forms were initially completed.

Whenever the PCT find a missing MM1 form, they contact the divisional pharmacists and they organise one. This means, each month any missing MM1 forms are resolved.

Status
On Track
Goal 10: AQ – Acute Myocardial Infarction (AMI)

Aim

The aim is to ensure that the clinical process measures for AMI are implemented for all patients admitted following an acute myocardial infarction.

Progress Report

Information relating to progress with the Advancing Quality targets is published via the North West Advancing Quality Alliance (AQUA).

The data processing schedule means that the results, when reported, are usually 4 months behind. The following graph shows the progress of MCHFT for April to August 2011.

![AMI - Composite Scores 2011/12](chart.png)

Status

On Track
Goal 11: AQ – Heart Failure

Aim

The aim is to ensure that the clinical process measures for heart failure are implemented for all patients admitted following a diagnosis of heart failure.

Progress Report

Information relating to progress with the Advancing Quality targets is published via the North West Advancing Quality Alliance (AQUA).

The data processing schedule means that the results, when reported, are usually 4 months behind. The following graph shows the progress of MCHFT for April to August 2011.

![Heart Failure Composite Scores 2011/12]

Status

On Track
Goal 12: AQ – Hip and Knee Replacement

Aim

The aim is to ensure that the clinical process measures for hip and knee replacements are implemented for all patients admitted this type of orthopaedic surgery.

Progress Report

Information relating to progress with the Advancing Quality targets is published via the North West Advancing Quality Alliance (AQUA).

The data processing schedule means that the results, when reported, are usually 4 months behind. The following graph shows the progress of MCHFT for April to August 2011.

The graph shows that improvements have been made and the target was achieved in August. The main areas of concern relate to poor documentation regarding the administration of antibiotics within 1 hour of surgery (surgical incision) – the actual time of the administration of the antibiotics is often not recorded in the medical record.

These results have been discussed with the orthopaedic surgeons and anaesthetic team and escalated within the surgery and cancer division.

Status

On Track
Goal 13: AQ – Pneumonia

Aim

The aim is to ensure that the clinical process measures for pneumonia are implemented for all patients admitted following a diagnosis of pneumonia.

Progress Report

Information relating to progress with the Advancing Quality targets is published via the North West Advancing Quality Alliance (AQUA).

The data processing schedule means that the results, when reported, are usually 4 months behind. The following graph shows the progress of MCHFT for April to August 2011.

The failure to record the CURB-65 assessment continues to reduce compliance scores. The CURB-65 is a clinical prediction tool that has been validated for predicting the severity of and mortality in pneumonia. The score is an acronym for each of the risk factors measured: Confusion of new onset, Urea greater than 7 mmol/l, Respiratory rate of 30 breaths per minute or greater, Blood pressure less than 90 mmHg systolic or diastolic blood pressure 60 mmHg or less and age 65 or older.

These results have been discussed with the respiratory consultants and escalated within the emergency care division.

The regional AQ results for 2010/2011 have been published and show that MCHFT failed the pneumonia CQUIN score of 81.48% with a score of 80.79%

Status     Off track and unlikely to recover
Goal 14: AQ – Stroke

Aim

The aim is to ensure that the clinical process measures for stroke care are implemented for all patients admitted following a stroke.

Progress Report

Information relating to progress with the Advancing Quality targets is published via the North West Advancing Quality Alliance (AQUA).

The data processing schedule means that the results, when reported, are usually 4 months behind. The following graph shows the progress of MCHFT for April to August 2011.

The composite quality score (CQS) relates to the total number of measures that have been achieved.

The appropriate care score (ACS) relates to the total number of patients who receive all eligible measures.

Both scores must be achieved as part of the CQUIN schedule.

The graph shows that the composite quality score for stroke has fallen by approximately 2% in the past two months. This has been due to an increase in the number of admissions during June, July and August with high numbers of admissions taking place on the same day on at least 21 days during this time.

Although the composite quality score is falling, the appropriate care score is still achieving the target which means many patients are still receiving all of the required care all of the time.

The Trust is working to improve both scores and early indications suggest that improvements are being made.

Status

Off track but recoverable 😞
Goal 15: AQ – Patient Experience

Aim

The aim is to ensure that patients who are admitted for treatment relating to AMI, heart failure, hip or knee replacement surgery, pneumonia or stroke complete an AQ patient experience survey.

Progress Report

Information relating to progress with the Advancing Quality targets is published via the North West Advancing Quality Alliance (AQUA).

The data processing schedule means that the results, when reported, are usually 2 - 3 months behind. The following table shows the progress of MCHFT for April to October 2011.

MCHFT has not reached the target of 20% for Quarter 2. The main reason why the Trust is failing to achieve the target is related to the actual identification of the AQ populations. AQ and Commissioning for Business Services (CBS) are currently reviewing the data to incorporate patients who are unable to complete a survey prior to discharge or who are deceased. This return rate may increase in future reports

Status

Off track but recoverable
Goal 16: TARN

Aim

The aim is to ensure that the number of patients who meet TARN inclusion are submitted to TARN and that the data submitted is as complete as possible.

Measurement against this goal is as follows:

1 tick (0-20% of expected no. of cases received) in 10/11 requires an increase to 2 ticks (21-40% of expected no. of cases received) in 11/12.

2 ticks (21-40% of expected no. of cases received) in 10/11 requires an increase to 3 ticks (41-64% of expected no. of cases received) in 11/12.

3 ticks (41-64% of expected no. of cases received) in 10/11 requires an increase to 4 ticks (>65% of expected no. of cases received) in 11/12.

4 ticks (>65% of expected no. of cases received) in 10/11 requires maintenance at 4 ticks in 11/12. For those Trusts who have achieved 4 ticks for their Completeness of Data, they will need to maintain the 4 ticks as stated above, improve on their data accreditation by at least 0.5% if there is room for improvement, have at least 2 trauma meetings (months in the year to be decided by the commissioner and the provider) where their results from TARN are discussed and an action plan drawn up (a copy of the action plan needs to be submitted to the Commissioner and progress reported at the relevant quality contract meeting) and must also demonstrate improvement in care in 2011/12 for the more severely injured patients.

Progress Report

The requirements for maintenance of 4 ticks are being included within the evidence portfolio which is being prepared for submission for the Trauma Unit assessment which takes place on March 1st 2012.

Status

On Track