Commissioning for Quality and Innovation (CQUIN)

Quarter 1 Report: April – June 2011
and
Quarter 2 Report: July – September 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

18 October 2011
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<td>28</td>
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<td>Advancing Quality (AQ): Patient experience</td>
<td>29</td>
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<tr>
<td>Submission to the Trauma Audit &amp; Research Network (TARN)</td>
<td>30</td>
</tr>
</tbody>
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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 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 quarters 1 and 2 (April – September 2011)
## Performance Summary

**Quarters 1 and 2 (April – September 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</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>
</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>
</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>
</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>
</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>
</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>
</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>
</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>
</tr>
<tr>
<td></td>
<td><strong>Management of High Cost Drugs</strong></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>
</tr>
<tr>
<td>---</td>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td><strong>AQ Acute Myocardial Infarction</strong></td>
<td>Implementation of AQ Care Pathway Acute Myocardial Infarction</td>
<td>0.67%</td>
<td>£13,660</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td><strong>AQ Heart Failure</strong></td>
<td>Implementation of AQ Care Pathway Heart Failure</td>
<td>0.67%</td>
<td>£13,660</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td><strong>AQ Hip and Knee Replacement</strong></td>
<td>Implementation of AQ Care Pathway Hip and Knee Replacement</td>
<td>0.67%</td>
<td>£13,660</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td><strong>AQ Pneumonia</strong></td>
<td>Implementation of AQ Care Pathway Pneumonia</td>
<td>0.67%</td>
<td>£13,660</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td><strong>AQ Stroke</strong></td>
<td>Implementation of AQ Care Pathway Stroke</td>
<td>0.67%</td>
<td>£13,660</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td><strong>AQ Patient Experience</strong></td>
<td>All patients complete an AQ PEMs Survey</td>
<td>0.67%</td>
<td>£13,660</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td><strong>TARN</strong></td>
<td></td>
<td>2.67%</td>
<td>£54,640</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 increase in the numbers of patients assessed month on month.

April 2011  70.1%
May 2011  71.1%
June 2011  78.6%
July 2011  84.3%
August 2011  85.1%
September 2011  90.5%

Status

On Track  

✓
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

In August 2011, 644 adult patients were telephoned post discharge to ask about their recent inpatient experiences. Any issues that were raised were managed by the staff making the telephone call (less than 10% of respondents raised queries).

The results from this survey are as follows:

<table>
<thead>
<tr>
<th>Questions asked:</th>
<th>N=110</th>
<th>Percentage Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you feel that the ward staff did everything they could do to manage your pain?</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>Was there anyone on the ward that you could talk to about your worries or fears?</td>
<td></td>
<td>82</td>
</tr>
<tr>
<td>Were there any delays in receiving your medication on discharge?</td>
<td></td>
<td>57</td>
</tr>
<tr>
<td>Were you kept informed about your condition or treatment?</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>Did you find it noisy at night?</td>
<td></td>
<td>62</td>
</tr>
<tr>
<td>Were you informed who to contact after your discharge if you had a problem?</td>
<td></td>
<td>74</td>
</tr>
<tr>
<td>Q - Did you have confidence and trust in the doctor examining and treating you?</td>
<td>N=28</td>
<td>100%</td>
</tr>
</tbody>
</table>
Emergency Care Division – summary
July - August 2011

<table>
<thead>
<tr>
<th>Ward</th>
<th>No. of interviews</th>
<th>Positive response</th>
<th>Concerns to be resolved</th>
<th>Satisfaction level</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>12</td>
<td>11</td>
<td>1</td>
<td>92%</td>
</tr>
<tr>
<td>EAU</td>
<td>55</td>
<td>45</td>
<td>10</td>
<td>82%</td>
</tr>
<tr>
<td>Ward 1</td>
<td>81</td>
<td>77</td>
<td>4</td>
<td>95%</td>
</tr>
<tr>
<td>Ward 2</td>
<td>64</td>
<td>58</td>
<td>6</td>
<td>91%</td>
</tr>
<tr>
<td>Ward 4</td>
<td>41</td>
<td>39</td>
<td>2</td>
<td>95%</td>
</tr>
<tr>
<td>Ward 5</td>
<td>83</td>
<td>63</td>
<td>20</td>
<td>76%</td>
</tr>
<tr>
<td>Ward 6</td>
<td>15</td>
<td>14</td>
<td>1</td>
<td>93%</td>
</tr>
<tr>
<td>Ward 6A</td>
<td>21</td>
<td>19</td>
<td>2</td>
<td>90%</td>
</tr>
<tr>
<td>Ward 14</td>
<td>44</td>
<td>37</td>
<td>7</td>
<td>84%</td>
</tr>
<tr>
<td>Ward 11</td>
<td>27</td>
<td>26</td>
<td>1</td>
<td>96%</td>
</tr>
<tr>
<td>Ward 18</td>
<td>81</td>
<td>75</td>
<td>6</td>
<td>93%</td>
</tr>
<tr>
<td>Ward 19</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>15</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>SAU</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>534</td>
<td>474</td>
<td>60</td>
<td>89%</td>
</tr>
</tbody>
</table>

Emergency Care
- Staff were excellent
- The care was excellent
- Everything went really well
- Good care and happy with everything
- Nursing staff were fantastic
- Happy with all aspects of discharge
- No problems, very happy
- Excellent care, no issues
- Excellent care and information given
- Everything was first class
- Staff were lovely and made you feel very welcome

Surgery and Cancer
- Patient described being very scared about operation due to worries about anaesthetic and was reassured completely by the Consultant
- Staff were marvellous, I had great care and they responded to all my needs
- Everybody was very professional
- Absolutely brilliant, more impressed with Leighton than the South Cheshire
- Fantastic – nothing was too much troubled.
- Absolutely excellent.
The Trust’s individual 2011 survey results will be made available in January / February 2012.

It is always precarious to attempt to predict the results and subsequent benchmarking position with regard to the inpatient survey.

The results which are shown overleaf from previous years show variations in the scores relating to these 5 questions between a reduction of 10% to an increase of 2%:
<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement in decision about treatment/care</td>
<td>72%</td>
<td>68%</td>
<td>69%</td>
</tr>
<tr>
<td>Hospital staff being available to talk about worries/concerns</td>
<td>63%</td>
<td>63%</td>
<td>59%</td>
</tr>
<tr>
<td>Privacy when discussing conditions/treatment</td>
<td>78%</td>
<td>77%</td>
<td>79%</td>
</tr>
<tr>
<td>Being informed about side effects of medication</td>
<td>53%</td>
<td>40%</td>
<td>41%</td>
</tr>
<tr>
<td>Being informed who to contact if worried about condition after leaving hospital</td>
<td>81%</td>
<td>71%</td>
<td>72%</td>
</tr>
</tbody>
</table>

These scores relate to the mean rating scores from the Care Quality Commission’s benchmark report. The report containing the 2011 inpatient survey results will be published around June 2012.

Assuming the results from the 2011 survey follow a similar pattern then it is unlikely that this CQUIN goal will be achieved.

A reduced payment is more likely based as follows:

- Payment at 90% for a 4% increase
- Payment at 80% for a 3% increase
- Payment at 70% for a 2% increase
- Zero payment for no increase

**Status**

Unknown but probably
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 2 requires the development of an action plan which includes

1 Baseline data for each speciality that accepts non-elective admissions.

Baseline data for non-elective admissions to Medicine and split between GP and ED referrals is being collected.

2 Communication plan for engaging with GPs and community clinical staff to promote services.

Communication plan includes:
- working closely with the Urgent Care Centre and piloting a joint working initiative for two weeks, which was very successful.
- regular meetings with representatives from Out-of Hours
- designated Consultant in ED is GP Link and attends commissioning meetings with PBC.

3 Outline plans for patient experience surveys after 6 months following implementation of senior clinical decision maker early stage input.

Patient Survey in place for patients admitted via EAU.

Plans are in place for the development of a patient survey for ED patients.

4 Plans for audit

An audit of Emergency Department referrals for admission has been undertaken.

The development of an EAU database is in progress – this will allow the division to confirm that patients on EAU are always assessed by a senior decision maker (ST4 or above)
5 Action plan detailing processes for discharge communication to be sent to GP within 24 hours. Letter to include reason (listed in a drop down box) admission (diagnosis, observation, investigation, active treatment, management plan or awaiting senior review) with free text box to give more detail around reason listed.

<table>
<thead>
<tr>
<th>Action</th>
<th>By Whom</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly turnaround statistics shared at Consultant and divisional IG Committee</td>
<td>Service Manager</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Action takes on under-performing areas (e.g Cardio/Gastro – individual doctors allocated/extra hours)</td>
<td>Service manager</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Bereavement Officer completes E-discharge for RIP patients</td>
<td>Bereavement Officer</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Review of GP letters from ED</td>
<td>ED Consultants</td>
<td>December 2011</td>
</tr>
<tr>
<td>IT setting up process for ED letters to be sent electronically to GPs</td>
<td>IT</td>
<td>December 2011</td>
</tr>
</tbody>
</table>

**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 2 requires the development of an action plan which includes

1 Baseline data to include attendance rate for cohort of patients

The base line data was taken from November 2010 to August 2011. During this time there were a total of 9 patients who had more than four attendances in a 60 day period, with the same clinical condition presenting to the Emergency Department (ED). Details are shown below;

<table>
<thead>
<tr>
<th>Patient.</th>
<th>Presenting Complaint.</th>
<th>Number of attendances in a 60 day period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>Respiratory</td>
<td>39</td>
</tr>
<tr>
<td>Patient 2</td>
<td>Lacerations</td>
<td>29</td>
</tr>
<tr>
<td>Patient 3</td>
<td>Overdose/ Poisoning</td>
<td>10</td>
</tr>
<tr>
<td>Patient 4</td>
<td>Respiratory</td>
<td>8</td>
</tr>
<tr>
<td>Patient 5</td>
<td>Mental Health</td>
<td>8</td>
</tr>
<tr>
<td>Patient 6</td>
<td>Overdose/Poisoning</td>
<td>8</td>
</tr>
<tr>
<td>Patient 7</td>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td>Patient 8</td>
<td>Respiratory/Asthma</td>
<td>5</td>
</tr>
<tr>
<td>Patient 9</td>
<td>Overdose/Poisoning</td>
<td>5</td>
</tr>
</tbody>
</table>

2 Communications plan for developing and implementing patient passports with key stakeholders

Develop a Trust passport / care plan that can be used for all types of patients presenting to the Emergency Department. Reviewing the baseline data, this will initially be agreed between mental health and the community matrons as these are the main areas for initial focus. However it is envisaged that other key stakeholders will be involved as and when required.

The Emergency Department Matron will meet monthly with the relevant specialties (mental health and community matrons) to review progress and implementation of the passport / care plan.

Once a care plan is developed the ED Matron will ensure a code is put onto ICS to highlight to staff that the patient has a passport. ED staff will be educated regarding the code and the need to check for the relevant passport. Although the intention would be that patients should be responsible for their own passport and bringing it...
with them when they attend the Emergency Department, staff are fully aware that due to the complex issues some of these patients present with e.g. mental health, there will be 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.

NWAS will 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 to help prevent admission at the first point of contact. The ED Matron will ensure this is done and involve NWAS in any relevant meetings.

A report will be available weekly on Rosetta showing patients that present more than 4 times with the same condition in a 60 day period. The ED Matron will review this report weekly initially and review any new patients that trigger.

A monthly meeting will be held with the relevant specialties to review frequent attendees 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 specialties for development of the passport/care plan. Existing patients who hold a passport will also be reviewed every time they re-attend and passports will be updated as appropriate.

GP practices will be informed by letter of any patients who attend more than 4 times to the ED 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.

3 Outline plans for a patient experience survey after 6 months following implementation of passport

A patient survey will be developed by the ED Matron and sent to all patients who have a patient passport 6 months after implementation.

Results will be reviewed at the monthly meeting and feedback to the relevant specialties/ key stakeholders will be provided.

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 2 requires the development of an action plan which includes

1 Plan for a training programme to highlight the needs of patients with a learning disability

LD awareness training forms part of the in-house Health Care Assistant training programme.
Bespoke LD awareness training exists for all wards and departments.
LD awareness training programme developed for medical staff and ambulance service staff.
LD awareness is covered in Customer Care training programme.
LD awareness is covered in Privacy and Dignity training.

2 Development of a reasonable adjustments risk assessment tool in collaboration with Learning Disabilities Lead in Cheshire and Wirral Partnership (CWP)

MCHFT has developed a reasonable adjustment risk assessment tool in collaboration with the LD Lead from CWP.
The tool has been developed and is in use, although currently only by Privacy and Dignity Matron.

Criteria for use:
   a. Patient has a moderate → profound learning disability and may well lack capacity.
   b. Patient may well need additional support whilst in hospital due to being at risk.
   c. Reasonable adjustments are required to support the patient on the ward.
   d. Reasonable adjustment will be required to minimise risk and increase the likelihood of the patients accessing diagnostics and treatment.

3 Plan for training of staff in the use of the reasonable adjustments risk assessment tool.

The reasonable adjustments risk assessment tool will be included as part of LD awareness training.
The Privacy and Dignity Matron will present the tool at Divisional Ward Manager’s meetings, who will then cascade the training to their individual ward/departmental staff.
The tool will be included as part of Customer Care training programme and as part of Privacy and Dignity training.
4 Plan for implementation of the tool

The tool is available to download from the LD Guidelines on the hospital intranet.

IT have been requested to enable staff who download the tool to register they have done so for monitoring/audit purposes. Staff will be able to log that they have used the tool and the medical record number of the patient they have used it on.

Staff will contact the Privacy and Dignity Matron for advice, guidance and support.

Information Governance are to develop a code for the ICS (RA) to identify from admission those patients who have an assessment tool in place. This will prompt staff to look for the tool once the notes have been obtained.

The Privacy and Dignity Matron will check to determine if staff can access the ICS coding systems so that development of the tool can be added at ward/departmental level.

5 Plans for the development and implementation of a patient passport for patients with a learning disability in collaboration with key stakeholders. This will include a communication strategy for patients/carers and health care professionals involved in the care of patients with a learning disability

A patient passport for patients with a learning disability has been developed and implemented in collaboration with key stakeholders.
A communication strategy has been developed.

6 Plans in place for a documentation audit of patient passports and use of reasonable adjustment assessment

An audit of patient passports will be undertaken by the Privacy and Dignity Matron in November 2011.
An audit of the use of reasonable adjustment assessments where the criteria is met will take place in January 2012 by the Privacy and Dignity Matron.

7 Plans for a patient/carer survey after implementation

A patient/carer survey will be sent out to patients admitted in November and December 2011 to MCHFT with a learning disability. The survey will be devised in collaboration with key stakeholders at the LD Development Group.
The survey will be made available in easy read format.

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 2 requires the results from an audit on end of life care:

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 audit is due to be repeated in November 2011.

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.

This data is being collected via the bi-annual audit.

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 now 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 2 requires the development of an action plan to address the design, implementation and audit of the patient passport as follows:

<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>1st QUARTER</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1. Baseline data detailing the number of children eligible to have a patient passport.</td>
<td>Bev Walley</td>
<td>30.06.11</td>
<td>Collect data from Children and Young peoples Home Care Team of children who are eligible for the passport.</td>
<td>Data for number of patients to be included in the project.</td>
<td>Number of patients identified eligible for a patient passport as of June 2011 = 63. June 2011.</td>
</tr>
<tr>
<td>2. Children’s passport designed for undertaking pilot scheme.</td>
<td>Bev Walley</td>
<td>30.06.11</td>
<td>Design patient passport.</td>
<td>Draft copy of patient passport.</td>
<td>Following consultation with a service user, a documentation review from the Child and Adolescent unit and a Children’s Hospice the paediatric passport has been completed and is now available in draft format. June 2011.</td>
</tr>
<tr>
<td>3. Written guidelines agreed for</td>
<td>Bev Walley</td>
<td>31.07.11</td>
<td>Production of guidelines for patients eligible.</td>
<td>Data sheet showing details of patients to be</td>
<td>Guidelines for implementation developed, as well as</td>
</tr>
</tbody>
</table>

It should be noted that there is also an additional page at the end of the document which includes information regarding useful organisations for families via the internet.
<table>
<thead>
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</thead>
<tbody>
<tr>
<td>5. Communication plan for developing and implementing patient passports with Key stakeholders (parents, GP's, other health care providers)</td>
<td>Bev Walley</td>
<td>31.08.11</td>
<td>Develop a communication plan to roll out the patient passport within the PCT locality.</td>
<td>Communication Plan completed for key stakeholders.</td>
<td>Progress report as above (points 1 – 3). July 2011.</td>
</tr>
<tr>
<td>2ND QUARTER</td>
<td>Bev Walley</td>
<td>30.09.11</td>
<td>Develop a child/carer experience survey in collaboration with the MCHFT Patient Experience Team.</td>
<td>Child/carer feedback questionnaire compiled.</td>
<td>Communication plan developed. The process to compile this included a meeting with the Trusts Communication Manager, to gain wide ranging and appropriate support. Signed off by Divisional General Manager - August 2011</td>
</tr>
<tr>
<td>1. Outline plans for a child/carer experience survey after 3 months following implementation of passport</td>
<td>Bev Walley</td>
<td>30.09.11</td>
<td>Audit proforma to identify results from draft documentation.</td>
<td>Audit results of draft proforma.</td>
<td>Meeting undertaken with Patient Experience team member to develop child / carer feedback questionnaire. Questionnaire developed and submitted to the Trust Matrons group for feedback on 29th September 2011.</td>
</tr>
<tr>
<td>2. Documentation audit of the passport designed including outline plan as to how this will be</td>
<td>Bev Walley</td>
<td>30.09.11</td>
<td></td>
<td></td>
<td>Draft proforma developed – September 2011. Awaiting meeting with clinical audit team to verify process and proforma approval.</td>
</tr>
<tr>
<td>Undertaken</td>
<td>Bev Walley</td>
<td>30.09.11</td>
<td>Produce 2nd quarterly report for the project.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. Agreement as to which children to be included in the pilot and roll out pilot to include a maximum of 10 children</td>
<td>31.10.11</td>
<td>Consent from families agreeing for their child/young person to be included in pilot phase.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Progress report for Quarter 2.</td>
<td></td>
<td></td>
<td>Quarterly report</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Quarterly action plan completed as above in points 1 – 3.</td>
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</tbody>
</table>

**Status**

On Track
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 2 requires the development of an action plan which includes

1 Plan for training of staff in care of a patient with a diagnosis of Dementia

Dementia care training became part of mandatory training as from 1 September 2011.
Dementia care training is covered in the Customer Care training programme and Privacy & Dignity training
Two training dates booked: one for 12 September 2011 and another early 2012 (date to be confirmed) for Health Care Assistant training with the Alzheimer’s Society.
There is an active Dementia Care link nurse group – ‘Dedicated to dementia (Double D’s) who receive regular training
WOW Wards programme to commence October 2011.
MCHFT successful in their bid to become a pilot site for the Elder Friendly Care Wards – quality mark, with the RCP. Due to commence October/November 2011.
Privacy & Dignity Matron attends new Doctor Induction Programmes from August 2011.
Privacy & Dignity Matron plus Psychiatric Liaison Service to provide training for staff from the Emergency Care Division.

2 Plan for collaboration with all key stakeholders to develop and implement a patient passport

MCHFT, in collaboration with key stakeholders, has already devised a patient passport.
The patient passport refers to the following:
   a. This Is Me document produced by the Alzheimer’s Society
   b. Information about ME to help You document, produced by MCHFT via the Dementia Care Pathway Group. This can be downloaded from the electronic dementia care guidelines on the hospital intranet.
   c. Hospital Passport developed by MCHFT and CWP as part of the work undertaken by the Learning Disabilities Development Group

3 Plan patient experience survey of Patients with a diagnosis of Dementia/carer 6 months after implementation.

This will be a qualitative audit interviewing patients with dementia and their carers in respect of their experience in hospital.
Support will be provided in undertaking this audit by the Alzheimer’s Society.

4 Ensure 90% patients with a diagnosis of Dementia have a full clinical review of their medications to look at medications which may cause falls, antipsychotic drugs, any history of cardiac disease, anti-Dementia drugs and the clinical need for medication (Review can be carried out by a pharmacist or an appropriately trained pharmacy technician who has had additional training sufficient to accept the delegated responsibility and clear lines of referral to a pharmacist are evident)

A medication review is to be carried out on all patients with a diagnosis of dementia – emergency and elective admissions.
Emergency patient medication reviews will be carried out on the Emergency Assessment Unit and the Surgical Assessment Unit.
Elective admissions will have a medication check performed by the Po-Ac Sister at the Pre-op assessment clinic, and a full clinical medication review will take place once the patients is admitted to an in-patient ward.

The Privacy and Dignity Matron will audit the notes of patients with dementia to ascertain the numbers who have had a full clinical review of their medication.

**Status**

On Track
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
At month 5 the current cumulative position is;
78% of monoclonal antibodies dispensed have had an MM1 form completed
68% of spend on monoclonal antibodies dispensed have had an MM1 form completed

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 and May 2011.

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 and May 2011.

![Graph showing 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 and May 2011.

For future reports, hip and knee replacement surgery will reported as a combined single score.

The main areas of concern relate to non administration of antibiotics within 1 hour of surgery (surgical incision) – on occasions this is administered outside this parameter or the time of antibiotic administration is not recorded. In addition, there are also issues relating to the timely administration of appropriate VTE prophylaxis within 24 hours prior to surgery.

These results have been discussed with the orthopaedic surgeons and orthopaedic nursing team and escalated within the surgery and cancer division.
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 and May 2011.

The main area of concern relates to failure to document the CURB-65 assessment which is a clinical prediction tool that has been validated for predicting 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.

Status: Off track but recoverable
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 and May 2011.

The composite care 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.

![Graph showing progress of MCHFT for April and May 2011]

Status

On Track

✅
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 tables show the progress of MCHFT for April, May and June 2011.

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>YTD Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Surveys received</td>
<td>30</td>
<td>29</td>
<td>69</td>
<td>125</td>
</tr>
<tr>
<td>Number of Surveys that could be matched to SLS P&amp;R</td>
<td>0</td>
<td>30</td>
<td>62</td>
<td>92</td>
</tr>
<tr>
<td>Of the Surveys that could be matched to SLS P&amp;R: Number who could be matched to the AQ Patient Population</td>
<td>0.0%</td>
<td>107.1%</td>
<td>93.5%</td>
<td>69.2%</td>
</tr>
<tr>
<td>Number of AQ spells in SLS P&amp;R</td>
<td>177</td>
<td>166</td>
<td>194</td>
<td>557</td>
</tr>
<tr>
<td>% Return Rate</td>
<td>6.8%</td>
<td>4.3%</td>
<td>13.0%</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

Answers to the Question: "On reflection did you get the care that mattered to you?" (Note: This is for all Surveys regardless of whether they were matched to P&R or the AQ population)

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>YTD Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Never</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1 - Rarely</td>
<td>0.0%</td>
<td>0.9%</td>
<td>0.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2 - Sometimes</td>
<td>0.0%</td>
<td>0.9%</td>
<td>2.6%</td>
<td>1.4%</td>
</tr>
<tr>
<td>3 - Most of the time</td>
<td>0.0%</td>
<td>0.9%</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>4 - At all times</td>
<td>14.0%</td>
<td>15.8%</td>
<td>15.1%</td>
<td>16.0%</td>
</tr>
<tr>
<td>I do not wish to answer</td>
<td>79.1%</td>
<td>51.3%</td>
<td>75.7%</td>
<td>70.9%</td>
</tr>
</tbody>
</table>

MCHFT has not reached the target of 10% for the first quarter. 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. 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

MCHFT scored 4 ticks in quarters 1 and 2 of 2011/12

Status

On Track  

32