Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

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4 May 2012
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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 quarter 4 (January – March 2012)
## Performance Summary
Quarter 4 (January – March 2012)

<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 Quarters 1 and 2</th>
<th>RAG Status Quarter 3</th>
<th>RAG Status Quarter 4</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>
<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>
<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>
<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>
<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>
<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>
<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>
<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>
<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>
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</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>
<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>
<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>
<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>
<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>
<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>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>TARN</td>
<td></td>
<td>2.67%</td>
<td>£54,640</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

RAG status:

On track / **Quarter 4 = Achieved**

Off track but recoverable / **Quarter 4 = Applicable to AQ results only**

Off track and unlikely to recover / **Quarter 4 = Not Achieved**
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>
<tr>
<td>January 2012</td>
<td>94.6%</td>
</tr>
<tr>
<td>February 2012</td>
<td>96.3%</td>
</tr>
<tr>
<td>March 2012</td>
<td>95.7%</td>
</tr>
</tbody>
</table>

Status

Achieved

Achieving this CQUIN has been challenging. It has required drive and motivation with a clinical and corporate input on a daily, weekly and monthly basis to ensure the Trust has achieved compliance. It is rewarding to note that the Trust has not had a Hospital Acquired VTE since June 2011 which is a positive patient safety improvement.
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 to</td>
<td>63%</td>
<td>63%</td>
<td>59%</td>
<td>62%</td>
<td>+</td>
</tr>
<tr>
<td>talk about worries/concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privacy when discussing conditions</td>
<td>78%</td>
<td>77%</td>
<td>79%</td>
<td>78%</td>
<td>-</td>
</tr>
<tr>
<td>treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being informed about side effects</td>
<td>53%</td>
<td>40%</td>
<td>41%</td>
<td>42%</td>
<td>+</td>
</tr>
<tr>
<td>of medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being informed who to contact if</td>
<td>81%</td>
<td>71%</td>
<td>72%</td>
<td>73%</td>
<td>+</td>
</tr>
<tr>
<td>worried about condition after</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>leaving hospital</td>
<td></td>
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</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

The national inpatient survey steering group which is led by the divisional lead nurses has commenced 5 workstreams to address the issues raised within this element of the CQUIN and the Trust is confident that the increase of 1% will be improved upon over the next financial year.
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 4 requires the following updates:

1 Results of patient survey with action plan
A patient survey is currently taking place within the Emergency Department to analyse the patient feedback following the ‘perfect front door’ fortnight. Operational pressures have led to a short delay in the processing of this survey.

2 Evaluation of outcomes
Pending the outcome of the above audit

Status
Achieved
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 4 requires the following updates:

1. Results of patient experience survey
Since January 2012 four new patients have triggered more than four attendances in a 60 day period. However, since January 2012, two of these patients have not reattended and no longer require a passport. One patient is known to the discharge team and has been referred to the Community Matrons who are waiting for a suitable moment to undertake a patient experience interview. The fourth patient is currently an inpatient and will have a passport completed on this admission.

2. Demonstrate a reduction in attendances for this cohort of patients
Since the start of the financial year, there have been 16 patients attending on more than four occasions and nine of these no longer attend the A&E department.

3. Demonstrate a reduction in admissions for this cohort of patients
Most of the patients that have been reviewed were generally in a period of crisis requiring mental health and alcohol liaison services and have not triggered again once this period settled.

Status

Achieved

Whilst reviewing the patients as part of this CQUIN, it became evident that not all the regular attenders were being identified because the CQUIN specified that patients must present with the same condition. A new report has been requested which shows all patients who have more than four attendances in a 90 day period to the Emergency Department, irrespective of their presenting condition.

This has shown there are currently 15 patients who regularly attend the Emergency Department more than four times in a 90 day period. These patients will all now be reviewed.
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 4 requires the following updates:

1. **Number of staff who have achieved awareness training**
   - Over 200 members of staff have attended LD awareness training from April 2011 to March 2012.
   - Bespoke training continues.
   - Further training of medical staff continues.
   - LD awareness training always receives excellent evaluations.

2. **Percentage of patients / carers who are using a patient passport**
   - Because the patient passport can be downloaded from any pc within the Trust as well as the partnership Trust, it is impossible to obtain an accurate percentage of exactly how many people are using them. However, audits identify that patients in the hospital with a learning disability do have a patient passport and evaluation of their content has been very positive.
   - Complex care plans for particular patients continue to be developed with patients and their carers. The “I Am’s” are flagged on the computer system and a copy kept in patient’s notes.
   - Patients have been referred for an “I Am” by GP’s and other Health Care Professionals.

3. **Audit of the outcomes of the use of the reasonable adjustments risk assessment (RA) tool**
   - Questionnaires were sent out to patients and carers where the RA assessment tool was used. 50% were returned and the feedback was excellent. Suggestions were made in respect of improvements that could be included such as a section for specialised equipment needed and a section for risk assessing care interventions.
   - Other positive comments included:
     
     “A side room is available where possible, an adjustable bed and an air mattress. Staff now offer support. A hoist is made available”
     
     “We had extra visits prior to treatment, we had visits at home”.
“A photographic journey was provided from leaving home and returning home again, a favourite toy was also in each photo and it was waiting on my child’s bed when she came into hospital”.

4. Results of documentation audit for the patient passport and reasonable adjustments risk assessment tool

- All RA risk assessment tools have been completed to a high standard.
- Reasonable adjustments stated were met.
- Patient passports were completed with the help of carers and relatives.
- All the relevant details were included.

5. Results of the patient / carer survey

- The Privacy & Dignity Matron has sent out questionnaires entitled “Your Visit to Hospital”. The questionnaires have been developed by the North West Regional Health Equality Group and The Clear Communication People Ltd.
- The questionnaires have also been sent to other service users who have visited MCHFT via Andy Worth, Health Facilitator, Karen Somers, CAHMS and Allison Budden, LD Community Nurse.
- Of those received so far, comments have included the following:

  “The staff touched me when talking to me as requested in my patient passport as I cannot see”.

  “All the staff now speak to my son and not just me. They include him in as much as possible since he had his patient passport”.

  “Matron liaised with ward staff and theatre staff which helped”.

  “Next time I need to visit with my daughter I feel confident that we will have plenty of support”.

Status

Achieved

The work undertaken over the year culminated in the Trust being the winners of the “Enhancing Patient Dignity” Category at the 2011 Nursing Times Awards
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 4 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 showed 60% of all anticipated deaths were commenced on the care of the dying pathway. The audit was repeated in November 2011 and the results demonstrated that 71% of patients experiencing an anticipated death are now cared for on the care of the dying pathway thereby achieving the CQUIN target.

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 Commissioners 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 73% 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.

The data from the latest care of the dying pathway audit showed that 13% of patients who died within the hospital had a PPC recorded in their notes. (94% of patients known to the SPC team had a PPC recorded).

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**

Achieved

The use of the care of the dying pathway is well established within the Trust but the challenge with this CQUIN is to maintain its use. This has been achieved with collaborative working with the End of Life facilitator to provide ongoing education regarding end of life tools across the Trust.

The challenge with achieving PPC is that it is dependent on factors outside of the Trust’s control. For example, sometimes the patients’ families are not able to support the patient’s decision to go home to die for a variety of reasons and also on occasion it has not been possible for community staff to provide the care package required on discharge to support a safe discharge.
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 4 requires evidence of a plan to roll out the passport to all applicable children from 1st April 2012.

<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>4th QUARTER</td>
<td>Ensure plan is in place to roll out passport to all applicable children from 1st April 2012</td>
<td>Bev Walley</td>
<td>31.03.12</td>
<td>Communicate plan to roll out passport to key stakeholders. Prepare on line resource and paper copies of document.</td>
<td>Coordinate contacting families to roll out passport to all applicable children/young people eligible for the passport.</td>
</tr>
</tbody>
</table>

Status

Achieved

To help progress goals which include patient documentation, it would be useful to develop a flow chart to clarify the approval process for such documentation. This would help reduce unnecessary delays.
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 4 requires a report which includes:

1 Results of patient / carer survey with action plan

- Following a survey where patients and carers were interviewed about their admission to hospital, the main area for development appears to be involving patients in decision making. To address this the following actions are being undertaken:
  - Dementia link nurses on all wards and departments to champion dementia care
  - Mental Capacity Act / Deprivation of Liberty Safeguarding training
  - Dementia Awareness training is now mandatory
  - Links to Cheshire Hospices’ Education to enable staff to develop communication skills, particularly around rest of life conversations
  - All staff have now received information around dementia care in the hospital, mental capacity assessments and best interest decision making.
  - Easy read information leaflets / picture pathways in development.

2 Percentage of patients who have a patient passport:

- A snapshot audit was undertaken in March 2012 within the Emergency Care Division.
  - % of patients with a passport completed 21.5%
  - % of patients with a passport pending completion 50%
  - % of patients without a passport 28.5%

Of the patients who did not have a passport, two were waiting review by the Dementia Nurse from the IDAT team and two were on the care of the dying pathway which meant that a patient passport was inappropriate.
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 acute admissions)
  August 2011 67%  (70% for acute admissions)
  January 2012 71%  (73% for acute admissions)

It can therefore be seen that progress is being made toward the 90% target as required by the CQUIN goal.

Status

Achieved

The target for next year is 70% of newly admitted patients to be seen by the pharmacy team within 48 hours of admission and 100% of patients taking high risk drugs (including anticoagulants, insulin and anticonvulsants medication).
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

During month 12 (March) 100% 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

Achieved

This CQUIN has been very time intensive for the divisional pharmacists who have been responsible for collecting the MM1 forms, inputting the data into the database, faxing the forms to primary care and casing up any missing forms. However, it is believed that this work has given the primary care trust the assurance that high cost medicines are used appropriately throughout the Trust.
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 November 2011.

Status

On track pending final results
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 November 2011.

Status

On track pending final results
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 November 2011.

The graph shows that improvements have been made and the target was achieved in August, September and October but the Composite Quality Score reduced in November. Early indicators suggest from December results that the score will be greater than the CQUIN target.

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

Status

On track pending final results
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

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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 November 2011.

![Pneumonia Composite Scores 2011/12](image)

The failure to record the CURB-65 assessment and the administration times for antibiotics has reduced compliance scores.

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

At present only 6 Trusts within the North West will achieve their CQUIN target. This is predominantly due to the introduction of the CURB-65 metric.

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

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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 December 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 Trust has continued to improve the care delivery to patients who have been diagnosed with a Stroke. The Trust has achieved the CQUIN target for the last three consecutive months.

Status

On track pending final results
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 following table shows the progress of MCHFT for April 2011 to March 2012.

The Trust has not yet reached the target of 25% of Advancing Quality (AQ) patients to complete a questionnaire. The main factor for Trust not achieving this target has been matching the completed questionnaires to the AQ population.

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

On Monday 16 April 2012, the Trust was officially accredited and designated as a ‘Major Trauma Receiving Unit’, which will allow the local population to access improved emergency care.

Across the country, changes are being made to the way in which patients with major trauma are treated, following evidence that Major Trauma Systems can save 20% more lives every year. The University Hospital of North Staffordshire (UHNS) has been designated as the area’s local Major Trauma Centre, and will be supported by Leighton Hospital as a Major Trauma Unit. Major trauma patients require round-the-clock emergency access to a wide range of clinical services and expertise, and by becoming an accredited Major Trauma Unit, the Trust will be able to save more lives and significantly improve peoples’ chances of making full recoveries.

Status Achieved
