Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

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31 July 2013
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Goal 17: Prognostication and advance care planning
Goal 18: Medicines management
Goal 19: Improving inhaler technique
Goal 20: Advice line for GPs
Goal 21: Retinopathy screening
Goal 22: Total parenteral nutrition administration
Introduction

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes.

These schemes require the development of clear plans and goals through agreement between providers and commissioners.

The goals have a proportion of the provider’s contract income linked to them which is earned by the provider upon achievement of the goals.

The overall financial value of CQUIN schemes is currently 2.5% of the provider’s contract value.

For MCHFT, the expected financial value of the 2013/14 CQUIN scheme is £3,725,482.

For 2012/13, there are four national CQUIN goals which focus on the NHS Safety Thermometer (goal one), Dementia Care (goal two), Venous thromboembolism (VTE) (goal three) and the Friends and Family Test (goal four).

MCHFT and the Clinical Commissioning Groups (CCGs) have agreed a further sixteen goals (goals five to twenty).

The North West Specialised Commissioning Group (SCG) has negotiated two goals in relation to the neonatal services provided at MCHFT (goals twenty one and twenty two).

This paper summarises progress against the CQUIN goals for quarter 1 (April – June 2013).

Please note that the final allocation of CQUIN funding for the goals agreed with the CCG’s has yet to be finalised. In addition, the detail of two goals have yet to be agreed (goal 19: improving inhaler technique and goal 20: advice lines for GP’s).
## Performance Summary
### Quarter 1 (April - June 2013)

<table>
<thead>
<tr>
<th>Goal No.</th>
<th>Goal Name</th>
<th>Description of Goal</th>
<th>Goal Weighting as %</th>
<th>Expected Financial Value of goal (£)</th>
<th>RAG Status Quarter 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>NHS Safety Thermometer</td>
<td>To collect data in relation to pressure ulcers, falls, urinary tract infection and VTE</td>
<td>5.0%</td>
<td>186,274</td>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td>Dementia Part 1: Assess and refer</td>
<td>The proportion of patients aged 75 and over to whom the case finding question is applied following emergency admission; the proportion of those identified as potentially having dementia who are appropriately assessed and the number referred on to GP services.</td>
<td>3.0%</td>
<td>111,765</td>
<td>😞</td>
</tr>
<tr>
<td></td>
<td>Part 2: Training</td>
<td>Named lead clinician for dementia and appropriate training for staff.</td>
<td>0.5%</td>
<td>18,627</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 3: Supporting carers</td>
<td>Ensuring carers feel supported.</td>
<td>1.5%</td>
<td>55,882</td>
<td>✓</td>
</tr>
<tr>
<td>3.</td>
<td>Venous Thromboembolism (VTE) Part 1: Risk assessment</td>
<td>% of all adult inpatients who have had a VTE risk assessment on admission to hospital.</td>
<td>2.5%</td>
<td>93,137</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 2: Root cause analysis</td>
<td>The number of root cause analyses carried out on cases of hospital associated thrombosis.</td>
<td>2.5%</td>
<td>93,137</td>
<td>✓</td>
</tr>
<tr>
<td>4.</td>
<td>Friends and Family Test Part 1: Phased expansion</td>
<td>Roll out the friends and family test to maternity services.</td>
<td>1.5%</td>
<td>55,882</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 2: response rate and improvement</td>
<td>Increased response rate.</td>
<td>2.0%</td>
<td>74,510</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 3: improvement on staff survey results</td>
<td>Improved performance on the staff friends and family test.</td>
<td>1.5%</td>
<td>55,882</td>
<td>✓</td>
</tr>
<tr>
<td>5.</td>
<td>Advancing Quality (AQ): Acute Myocardial Infarction</td>
<td>Implement the AQ care pathway for Acute Myocardial Infarction</td>
<td>0.4%</td>
<td>14,902</td>
<td>✓</td>
</tr>
<tr>
<td>6.</td>
<td>Advancing Quality (AQ): Heart Failure</td>
<td>Implement the AQ care pathway for Heart Failure</td>
<td>0.4%</td>
<td>14,902</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Project Description</td>
<td>Percentage</td>
<td>Total</td>
<td>Status</td>
<td></td>
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<tr>
<td>7</td>
<td>Advancing Quality (AQ): Hip and Knee Replacement</td>
<td>0.4%</td>
<td>14,902</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Advancing Quality (AQ): Pneumonia</td>
<td>0.4%</td>
<td>14,902</td>
<td></td>
<td></td>
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<tr>
<td>9</td>
<td>Advancing Quality: Stroke</td>
<td>0.4%</td>
<td>14,902</td>
<td></td>
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<tr>
<td>10</td>
<td>Co-ordinated electronic patient records (EPR)</td>
<td>3.0%</td>
<td>111,765</td>
<td></td>
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<tr>
<td>11</td>
<td>Alcohol assessment</td>
<td>4.8%</td>
<td>178,823</td>
<td></td>
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<tr>
<td>12</td>
<td>Readmissions</td>
<td>12.0%</td>
<td>447,058</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Cancellations</td>
<td>12.0%</td>
<td>447,058</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Patient/carer focus groups (glaucoma, head &amp; neck cancer, stroke)</td>
<td>4.0%</td>
<td>149,019</td>
<td></td>
<td></td>
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<tr>
<td>15</td>
<td>Staff Engagement</td>
<td>4.0%</td>
<td>149,019</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 1: Care rounds</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Part 2: Staff focus groups (glaucoma, head &amp; neck cancer, stroke)</td>
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<td></td>
<td>Part 3: Shared decision making in outpatient services: (cardiac rehabilitation, women on high risk pathway, acne services)</td>
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- **Glaucoma**
- **Stroke**
- **Head & Neck**
- **Cardiac rehab**
- **Antenatal pathway**
- **Acne**
|   | 16 | Pressure ulcers: Part 1: Training | Increase the number of eligible clinical staff in post who have attended training for pressure ulcer prevention, assessment and management. | 6.2% | 230,980 | ✓ |
|   |   | Part 2: Assessment and management | Ensure all patients receive an initial risk assessment on admission and appropriate plan of care. Reduce the incidence of preventable hospital acquired pressure ulcers by 10%. | 4.0% | 149,019 | ✓ |
|   | 17 | Prognostication and advance care planning | Identify and support patients in their last 12 months of life. | 4.0% | 149,019 | ✓ |
|   | 18 | Medicines management | Reduce harm from omitted and delayed medicines in hospital. | 6.0% | 223,529 | ✓ |
|   | 19 | Improving inhaler technique | Measure and improve inhaler technique for inpatients. | 6.0% | 223,529 | Not agreed |
|   | 20 | Advice line for GPs | Provide dedicated time where consultants are available on a regular basis to discuss patients’ management with GPs. | 12.0% | 447,058 | Not agreed |
|   | 21 | Retinopathy screening | Achieve 95% screening rate for retinopathy of prematurity (RoP) |   |   | ✓ |
|   | 22 | Total parenteral nutrition administration | Timely administration of total parenteral nutrition (TPN) for preterm infants |   |   | ✓ |

RAG status:

On track ✓

Off track but recoverable 😞

Off track and unlikely to recover ❌
Goal 1: NHS Safety Thermometer

Aim
To ensure all patients are surveyed monthly to collect data on pressure ulcers, falls, urinary tract infections and VTE.

Payment of the CQUIN is based on quarterly submissions of monthly survey data to the information centre. Each quarterly submission qualifies the Trust for 25% of the value of the CQUIN goal.

Progress Report
Between April and June 2013, 100% of applicable patients were included in the NHS Safety Thermometer data collection process and this data was submitted to the NHS Information Centre.

Status
✓
Goal 2: Dementia
Part 1: Assess and refer

Aim
To ask the dementia case finding question to relevant patients aged 75 and above.
To undertake a dementia diagnostic assessment on those patients who responded positively to the dementia case finding question.
To refer those patients whose diagnostic assessment was either positive or inconclusive to their GP for follow up.
Payment of the CQUIN is based upon achievement of 90% in each of the elements of the indicator each month for the quarter.

Progress Report
The case finding question was asked of approximately 45% of relevant patients during quarter 1, which does not meet the target of 90%. Not achieving the first part of this process renders the remaining two elements immaterial from the perspective of the CQUIN payment. However, from a quality perspective, it is important that patients who respond positively to the case finding question are referred to their GP for follow up if required. This was achieved in the majority of cases, but not all.
To improve results in this area, a dementia support assistant will be appointed to commence work in July to support processes on the wards and data collection of the results.

Status
😀 😊
Goal 2: Dementia  
Part 2: Training

Aim
To identify a named lead clinician and implement a planned training programme for dementia.

Payment of the CQUIN will be made at the end of the year provided the training programme has been undertaken.

Progress Report
A named clinician has been identified to lead on dementia care in the Trust.

A training programme has been developed and implemented to ensure all staff receive training about dementia on induction and as part of their mandatory training programme.

Status
✓
Goal 2: Dementia
Part 3: Supporting Carers

Aim
To support carers of people with dementia. A monthly audit must be undertaken to test whether carers feel supported. The results should be reported to the Board.

Progress Report
A monthly audit to determine how supported carers feel who care for people with dementia has been commenced.

Currently, only small numbers of the survey have been returned for review. The results to date show:

83% of carers felt fully supported and 17% felt partly supported.

All carers were encouraged to visit the ward’s outside of visiting hours if they wanted to do this.

All carers felt involved in the discharge planning process and all carers were able to find someone to discuss their worries and fears if they needed to.

All carers felt staff on the ward had an understanding of dementia, but 17% felt some staff only had a little understanding of dementia.

These results will continue to be reviewed by the patient experience action group, chaired by the divisional lead nurse for the diagnostics and clinical support services division.

Status

✅
Goal 3: Venous Thrombo Embolism (VTE)
Part 1: Risk Assessment

Aim
To ensure at least 95% of adult inpatients have had a VTE risk assessment on admission to hospital.

Progress Report
The Trust has achieved above 95% for the first three months of the year.

April 2013  97.6%
May 2013  95.1%
June 2013  97.7%

Status
✓
Goal 3: Venous Thrombo Embolism (VTE)
Part 2: Root Cause Analysis

Aim
All hospital associated thrombosis must have a root cause analysis undertaken.

Progress Report
All hospital acquired VTE’s undergo a level 1 root cause analysis. There have been three confirmed hospital acquired VTEs in the first quarter of 2013/2014.

There are a further two suspected VTE’s which are currently being investigated. If required, a root cause analysis will be undertaken and reported in the next quarterly report.

April 2013  No reported hospital associated thrombosis
May 2013  Two hospital associated thrombosis were reported. Both are undergoing level 1 root cause analysis investigations.
June 2013  One hospital associated thrombosis was reported which is currently undergoing a level 1 root cause analysis investigation.

Status
Goal 4: Friends and Family Test
Part 1: Phased expansion

Aim
The Friends and Family Test must be rolled out for maternity services by October 2013.

Progress Report
Discussions have taken place between the Head of Midwifery and the Patient Experience Manager to commence preparations for the roll out of the Friends and Family Test in October 2013. A pilot of the process will commence in August 2013.

Status
✔️
Goal 4: Friends and Family Test
Part 2: Response Rate and Improvement

Aim
The Trust must achieve a response rate of at least 15% in quarter 1.
By quarter 4, the Trust must achieve a response rate that improves on quarter 1 and is 20% or over.

Progress Report
The Trust has achieved above 15% for the first three months of the year.

April 2013  17.4%
May 2013   21.2%
June 2013  21.4%

Status
✅
Goal 4: Friends and Family Test
Part 3: Improvement on Staff Survey Results

Aim
The Trust must improve on its performance of the Friends and Family Test results from the 2012/13 annual staff survey when the 2013/14 staff survey results are published in February 2014.

Progress Report
Staff focus groups took place in June where staff were asked

   a. Would they recommend the Trust as a place to work
   b. Would they recommend the Trust as a place to receive treatment.

The response from staff was overwhelming yes to both questions. Where the answer was ‘No’ to question b, the reason for this response related mainly to waiting time and poor communication issues.

The 2013 staff survey will go out to 850 staff in September 13.

Status

✓
Goal 5: AQ: Acute Myocardial Infarction (AMI)

Aim
To ensure patients who have had an acute myocardial infarction receive the appropriate care pathway which includes:

1. Aspirin at arrival
2. Aspirin prescribed at discharge
3. ACEI or ARB for LVSD*  
4. Smoking cessation advice/counselling
5. Beta blocker on discharge
6. Evaluation of left ventricular function (new measure)
7. Statin prescribed (new measure)
8. Referral made for cardiac rehabilitation (new measure)

Progress Report
This financial year, the Trust will be measured using an appropriate care score (ACS). To meet the target, 93% of patients will have to receive all the care elements. With changes to clinical practice that were introduced over the last year, it is anticipated that the Trust will meet these targets. The graph below summarises performance last year against this year’s target.

*ACEI – Angiotensin Converting Enzyme Inhibitor
ARB – Angiotensin Receptor Blocker
LVSD – Left Ventricular Systolic Dysfunction

Status
Goal 6: AQ: Heart Failure

Aim
To ensure patients who have heart failure receive the appropriate care pathway which includes:

1. Left Ventricular Systolic (LVS) assessment
2. Detailed discharge instructions
3. ACEI or ARB for LSVD
4. Smoking cessation advice/counselling
5. Beta blocker at discharge (new measure)
6. Specialist review (new measure)

Progress Report

This financial year, the Trust will be measured using an appropriate care score (ACS). To meet the target, 78% of patients will have to receive all the care elements. With changes to clinical practice that were introduced over the last year, together with planned service developments, it is anticipated that the Trust will meet these targets. The graph below summarises performance last year against this year's target.

Status
Goal 7: AQ: Hip and Knee Replacement

Aim
To ensure patients who undergo hip or knee replacement surgery receive the appropriate care pathway which includes:

1. Prophylactic antibiotic received within one hour prior to surgical incision
2. Prophylactic antibiotic selection for surgical patients
3. Prophylactic antibiotics discontinued within 24 hours after surgery end time
4. Recommended Venous Thromboembolism prophylaxis ordered
5. Appropriate and timely Venous Thromboembolism prophylaxis
6. VTE appropriate duration (new measure)

Progress Report
This financial year, the Trust will be measured using an appropriate care score (ACS). To meet the target, 82% of patients will have to receive all the care elements. Recent changes in the policy for VTE prophylaxis is expected to ensure that the Trust meets this target. The graph below summarises performance last year against this year’s target.

Status

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The graph below summarises performance last year against this year’s target.

**Hip and Knee**

The graph below summarises performance last year against this year’s target.

**Status**

![Checkmark]
Goal 8: AQ: Pneumonia

Aim
To ensure patient who have pneumonia receive the appropriate care pathway which includes:

1. Oxygenation assessment within 24 hours prior to or after hospital arrival
2. Initial antibiotic selection
3. First dose of antibiotics within six hours after hospital arrival
4. Smoking cessation advice/counselling
5. CURB-65 assessment

Progress Report

The Trust did not achieve the required result in this area over the last financial year. Challenges have been data capture (patients could be on a number of wards throughout the Trust), documentation of interventions and inconsistency in practice.

This financial year, the Trust will be measured using an appropriate care score (ACS). To meet the target, 61% of patients will have to receive all the care elements. Projected performance suggests the Trust is just below the required standard. This area remains of some concern.
Goal 9: AQ: Stroke

Aim
To ensure patients who have a stroke receive the appropriate care pathway which includes:

1. Direct admission to a stroke unit within 4 hours of hospital arrival
2. Screened for swallowing disorders within 24 hours of admission
3. Brain scan within 24 hours of admission
4. Aspirin within 24 hours of admission
5. Physiotherapy assessment within first 72 hours of admission
6. Assessment by an Occupational Therapist within first 72 hours of admission
7. Weighed at least once during admission

Progress Report
This financial year, the Trust will be measured using an appropriate care score (ACS). To meet the target, 64% of patients will have to receive all the care elements. Projected performance suggests that the Trust is below the required standard. Particular challenges are around the availability of acute stroke beds especially during winter pressure. Significant work continues in this area but it is possible that these targets will be achieved.

Status

📅
Goal 10: Co-ordinated Electronic Patient Record (EPR)

Aim
This is the second year of a 5 year plan to put in place hospital electronic patient records.

Quarters 1 and 2 require the implementation of work streams, with appropriate stakeholders, to produce roadmaps which detail the specific requirements of the EPR.

Progress Report

A lead from the clinical commissioning group (CCG) has been identified to be a member of the I.T. Strategy Steering Group. Operational representation on the EPR work stream will be filled by the CCG’s newly appointed Service Delivery Manager when they take up their post.

Soon after appointment of the Service Delivery Manger, it is envisaged that work will commence to identify stakeholders, specific requirements, costs and time scales to integrate the Trust’s future EPR solution with the CCG’s strategic partner system (Emis). This will then enable the road map to be produced ready for approval by the CCG and Trust Board.

Status

✔️
Goal 11: Alcohol Assessment

**Aim**
To implement an alcohol assessment tool (AUDIT – C), provide support as required and communicate the results to primary care.

Quarters 1 and 2 require the development of a pathway and processes to enable the alcohol assessments to be undertaken in the assessment areas and the outcomes to be communicated to primary care.

In addition, staff working in the assessment areas must be trained to complete the assessment and complete the pathway.

**Progress Report**

The alcohol assessment tool has been produced based on the AUDIT-C proforma.

The pathway for use of the tool is in place and training has commenced. The training is led by the hospital alcohol liaison service (HALS) who have secured regular sessions at induction, emergency care breakfast meetings and the emergency department meetings.

The process to collect data to share with the CCGs is scheduled to take place during quarter 2.

**Status**

✅
Goal 12: Readmissions

Aim
To reduce readmissions to the Trust within 30 days of discharge.

Quarter 1 requires a system to be developed whereby those patients who are readmitted are subsequently transferred to the Lead Consultant for their condition within 24 hours (Monday – Friday) and within 72 hours if admitted during the weekend.

The intention is also to work with the Commissioners to identify 3 clinical areas where readmissions are high and review the specific data for this activity. An action plan will then be developed and implemented.

Progress Report
A daily report now enables the divisions to proactively monitor 7 day readmissions and ensure appropriate action is taken.

The nominated matron leads for surgery and emergency care are working within four clinical specialties to focus on improving readmission rates in these areas through the development and implementation of local action plans.

The integrated discharge team (IDT) has a dedicated team member in place to focus on readmitted patients and work with partner organisations in the management of these patients. This will ensure plans and support are in place to prevent future readmissions.

The IDT are also carrying out daily follow up phone calls to patients at high risk of readmission 72 hours following discharge.

The divisions are reviewing all readmissions within 30 days on a daily basis and are setting up systems locally to ensure patients are managed within their specialties. They are establishing systems to collect information to demonstrate the effectiveness of these arrangements.

Status

✔️
Goal 13: Reducing Cancellations

Aim

To reduce cancellations for elective surgery and outpatient appointments, demonstrating a 10% reduction by quarter 4.

By quarter 1, a working group must be established, which includes commissioners, to review the pathway for booking patients’ appointments and managing cancellations.

Progress Report

The Trust has put forward a plan to implement a full partial booking system for follow up patients to reduce the number of clinic cancellations for outpatient appointments and implement a system for managing patient cancellations.

To progress the implementation of this system, a working group has been established which is led by the medical records team. A procedure has been written, detailing the roles and responsibilities of staff groups together with a proposed implementation schedule for all clinical specialities. The plan is currently being progressed in conjunction with commissioner involvement.

Status

☑️
Goal 14: Patient/Carer Focus Groups

Aim

To work with Commissioners and patients/carers from 3 specialities to determine their experiences of the service to inform the development of a service specification and a quality dashboard.

Quarter 1 requires Trust staff to work with the Commissioners to plan a focus group session for each of the three specialities (head and neck cancer, glaucoma and stroke).

Progress Report

**Head and neck cancer**
An initial meeting has taken place with the Commissioners with a follow up meeting scheduled for July for the Commissioners to attend the ear nose and throat (ENT) outpatients department to get a sense for the head and neck patient pathway. This will be followed by a further meeting to visit the inpatient ENT ward to see where patients are cared for. A patient focus group is planned for September 2013.

**Glaucoma**
An initial meeting has taken place between the matron for ophthalmology and the Commissioners with regard to the patient pathway for glaucoma and to establish the methodology for a patient focus group. The Commissioners have visited the eye care centre to observe the patient’s journey. The glaucoma leads are in the process of identifying patients who may wish to be involved in the focus group from recent attendance at the inaugural glaucoma support group meeting in March 2103. Relevant discussion topics have been identified to structure the focus groups.

**Stroke**
An initial meeting has taken place between the stroke team and Commissioners with regard to commencing a patient/carer focus group. Criteria have been discussed for the format of the meeting and staff, along with support from the Stroke Association, are identifying patients and carers who may wish to be involved.

Status

Head and Neck: ✓ Glaucoma: ✓ Stroke: ✓
Goal 15: Staff Engagement
Part 1: Care Rounds

Aim
To implement care rounds in all adult inpatient wards.

Quarter 1 requires the development of a plan to ensure this takes place.

Progress Report
Care rounds have been implemented in a number of wards and plans are in place to ensure the principle of care rounds is introduced into all ward areas. Feedback to date from ward staff has been very positive.

Status
✓
Aim
To establish staff focus groups in glaucoma, stroke and head and neck cancer for the Commissioners to meet staff to understand their perceptions of the patient pathway in these specialities. This will contribute to the development of service specifications and a quality dashboard.

By quarter 1, plans must be in place to enable the Commissioners to meet with the relevant staff groups.

Progress Report

Head and neck cancer
An initial meeting has taken place between the head and neck clinical nurse specialist and the Commissioners. The Commissioners will meet relevant staff in July as part of a visit to the inpatient and outpatient clinical areas. A staff focus group is planned for August 2013.

Glaucoma
An initial meeting has taken place between the matron for ophthalmology and the Commissioners with regard to establishing a staff focus group. Criteria have been discussed for the format of the meeting, which will link with knowledge gained from the patient focus group. Staff who are to be involved have been identified by the consultant lead for glaucoma and the matron.

Stroke
An initial meeting has taken place between the stroke team and Commissioners with regard to starting a staff focus group. This will combine with the work the stroke team is undertaking to develop a patient/carer focus group. Criteria have been discussed for the format the meeting should take and staff who are to be involved have been identified by the Ward manager and Senior therapist.

Status

Head and Neck: ✔ Glaucoma: ✔ Stroke: ✔
Goal 15: Staff Engagement
Part 3: Shared decision making in out patient services

Aim
The intention is to understand patients’ perceptions of their ability to share decision making whilst an outpatient.

The following patient groups will be surveyed once a process has been developed to implement the principles of shared decision making:

Cardiac rehabilitation
Women on the high risk pathway
Patients with acne

Quarter 1 requires the development of processes to undertake shared decision making and to develop patient experience measures to seek the views of patient’s.

Progress Report

Cardiac rehabilitation
Questionnaires have been developed to seek patients’ views of the cardiac rehabilitation service. Shared decision making will be evidenced via a flexible approach to service design and collaboration with the multi-disciplinary team.

Women on the high risk pathway
It has been agreed to use the knowledge gained from maternity participation in the AQUA (Advancing Quality Alliance) project and the “patient experiences of decision making form” provided by the project. The process for undertaking shared decision making has been discussed at the antenatal task and finish group including consideration as to which of the high risk pathways should be surveyed.

Patients with acne
On attending their first appointment, the dermatology specialist nurse discusses all treatment options to assist the patient make an informed decision about which treatment pathway they wish to commence. A questionnaire will be developed to evaluate patients’ perceptions of this service.

Status

Cardiac rehab: ✔️ High risk pathway: ✔️ Acne: ✔️
Aim
To demonstrate that a minimum of 50% of eligible staff working within all medical and surgical wards have undertaken pressure ulcer assessment, prevention and management training.

Quarter 1 requires the establishment of a baseline of undertaken training.

Progress Report
The baseline number of staff who have undertaken pressure ulcer training during quarter one is 214.

This equates to 33% of eligible staff working within the medical and surgical wards as there are 648 staff working in these areas.

Status
Goal 16: Pressure Ulcers  
Part 2: Assessment and Management

**Aim**
Ensure all patients receive an initial risk assessment on admission and appropriate plan of care.

In addition, the incidence of preventable hospital acquired pressure ulcers must be reduced by 10%.

Quarter 1 requires a baseline audit to be undertaken to determine the number of patients who have undergone a pressure ulcer assessment on admission.

**Progress Report**
In June 2013, 324 adult inpatient records were checked to see if pressure ulcer assessments had been undertaken.
99% of patients had had an assessment completed and 78% of these assessments were undertaken within 6 hours of admission.

**Status**

![Checkmark]
Goal 17: Prognostication and advance care planning

Aim
Prognostication of the last 12 months of life to ensure that advanced care planning (ACP) can commence in a timely and appropriate way.

Areas to be focussed upon include:
the implementation of electronic prognostication tools (ePAIGE),
introducing advance care planning discussion for patients with a non cancer diagnosis,
staff training in communication skills and the use of end of life care tools,
ensuring 40% of patients achieve their preferred place of death and referring patients to the gold standards register.

Progress Report

The Trust has now begun the process of implementing a new electronic prognostication tool (epaige). Computer services have been contacted and they are in the process of enabling the page on the Trust’s intranet site. Plans are in place for the Specialist palliative Care Team (SPCT) and the End of Life facilitators to commence rollout out education sessions about the epaige in September 2013.

Central & Eastern Cheshire Respiratory Team have received end of life care (EoLC) training via locally held workshops. Where appropriate, teams have ACP discussions with patients and distribute ‘Planning your Future Care’ booklet. All EoLC discussions / actions including referral to the gold standards register, ACP and do not resuscitate are recorded on a centrally held emis template.

Communication skills training is included in a variety of training which is accessed by clinical staff throughout the trust. The learning and development database demonstrates that over 80% of clinical facing staff have attended an appropriate level of communication skills training.

Training in end of life care is available to all clinical staff. Teaching and training is provided by the SPCT, the End of Life Service Model Facilitators and through the education partnership with Cheshire Hospices Education (CHE). All education provided by CHE to MCHFT is provided free of charge. The End of Life Service Model Facilitators are planning drop in teaching sessions in clinical areas throughout the coming year.

Status
✅
Goal 18: Medicines Management

**Aim**
To reduce harm from omitted and delayed medicines in hospital. Initially, critical medicines where timeliness of administration is crucial will be identified and changes to systems, including staff training, will be progressed.

An audit of omitted and delayed medicines will be undertaken to determine progress against the baseline audit undertaken in February 2013.

**Progress Report**
An audit was carried out in May 2013. All divisions had improved their compliance omitted and delayed medicines administration with an overall increase in the number of doses given of 0.9% in 3 months.

Incident reporting of omitted doses has improved by 18% in 3 months.

On-going mandatory medicines management training is continuing for nursing staff.

**Status**

✅
Goal 19: Improving inhaler technique

Aim
To measure and improve inhaler technique for inpatients.

The detail of this CQUIN has not yet been agreed.

Progress Report
Training for staff in relation to correct inhaler technique and the use of inspiratory flow has commenced. This includes pharmacists, pharmacy technicians, ward-based nursing staff and respiratory physiotherapists trained.

Status
Not known as content not yet agreed
Goal 20: Advice line for GPs

Aim
To provide dedicated time where Consultants are available, on a regular basis, to discuss patients’ management with GPs.

The detail of this CQUIN has not yet been determined / agreed.

Progress Report
A meeting to discuss the detail of this CQUIN between Trust Consultants and the Clinical Commissioners is scheduled to take place towards the end of July 2013.

Status
Not known as content not yet agreed
Goal 21: Retinopathy Screening

Aim
To achieve an increase of screening for a target of 95% of babies with a birth weight of < 1501g or a gestation of < 32+0 weeks who undergo a first retinopathy of prematurity (RoP) screening.

Quarter 1 requires the presentation of baseline data and an action plan to take forward actions to achieve 95%.

Progress Report

Baseline data 1st April 2012 to 31st December 2012

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of babies (excluding those transferred out) with a birth weight of &lt;1501g or a gestation of &lt;32+0 weeks.</th>
<th>Number of babies meeting the criteria for inclusion, screened prior to discharge.</th>
<th>Percentage achieved.</th>
</tr>
</thead>
<tbody>
<tr>
<td>April – June 2012</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>July – Sep 2012</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Oct – Dec 2012</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
</tbody>
</table>

Quarter 1 data 1st April 2013 to 30th June 2013

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of babies (excluding those transferred out) with a birth weight of &lt;1501g or a gestation of &lt;32+0 weeks.</th>
<th>Number of babies meeting the criteria for inclusion, screened prior to discharge.</th>
<th>Percentage achieved.</th>
</tr>
</thead>
<tbody>
<tr>
<td>April – June 2013</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
</tbody>
</table>

An action plan is not required to achieve a 95% screening rate for retinopathy of prematurity as this target has been achieved.

Status
Goal 22: Total Parenteral Nutrition (TPN) administration

Aim
To improve the proportion of preterm babies who start TPN by day 2 of life. This relates to babies with a birth weight of < 1500g or a gestation of < 30+0 weeks (excluding babies who undergo surgery on day 1 or 2 of life).
Quarter 1 requires the presentation of baseline data and an action plan for improvement.

Progress Report
The criteria for the national Neonatal Reporting System (Badger) has been amended to babies <29 weeks gestation and/or <1000g born or transferred in on day 1 of life. Therefore it has not been possible to obtain the number of babies in the original CQUIN criteria who have received TPN by day 2 of life. As a comparison, the number of babies eligible for TPN in the CQUIN criteria has been included in the tables.

Baseline data 1st April 2012 to 31st March 2013

<table>
<thead>
<tr>
<th></th>
<th>Number of babies &lt;29+0 weeks gestation and/or &lt;1000g born or transferred in on day 1 of life.</th>
<th>Number of babies &lt;29+0 weeks gestation and/or &lt;1000g born or transferred in on day 1 of life who start TPN by day 2 of life.</th>
<th>Percentage achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st April 2012 – 31st March 2013</td>
<td>10</td>
<td>9</td>
<td>90%</td>
</tr>
</tbody>
</table>

Babies eligible for TPN based on the CQUIN criteria: 22

Quarter 1 data 1st April 2013 to 30th June 2013

<table>
<thead>
<tr>
<th></th>
<th>Number of babies &lt;29+0 weeks gestation and/or &lt;1000g born or transferred in on day 1 of life.</th>
<th>Number of babies &lt;29+0 weeks gestation and/or &lt;1000g born or transferred in on day 1 of life who start TPN by day 2 of life.</th>
<th>Percentage achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2013</td>
<td>2</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>May 2013</td>
<td>5</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>June 2013</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>-----------</td>
<td>---</td>
<td>---</td>
<td>------</td>
</tr>
<tr>
<td>Babies eligible for TPN based on the CQUIN criteria: 11</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Baby 1 (April 2013) – did not receive TPN by day 2 due to standard TPN bag availability at the weekends (please see action plan below).

Baby 2 (May 2013) – did not receive TPN by day 2 on clinical grounds. The electrolyte status of the baby was not suitable for TPN and required plain 10% dextrose. This was a consultant decision not to start TPN which is clearly documented in the baby’s notes.

**Action plan**

- Leighton use bespoke TPN based on the individual baby’s blood test results. To implement the CQUIN standard, TPN bags have been implemented for babies starting TPN at the weekends.  
  
<table>
<thead>
<tr>
<th>Completed April 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deputy Director Nursing and Quality &amp; Commissioners to agree</td>
</tr>
</tbody>
</table>

- The national Badger system criterion has been amended. Confirmation is required from the commissioners whether this CQUIN will be amended in line with the national criteria.

**Status**

☑