Commissioning for Quality and Innovation (CQUIN)

Quarter 2 Report: July - September 2013

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

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Executive Lead: Julie Smith, Director of Nursing & Quality

October 2013
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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 2.5% of the provider’s contract value.

For MCHFT, the 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 2 (July – September 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 2 (July – September 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>
<th>RAG Status Quarter 2</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>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td>Dementia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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>
<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>
<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>
<td>✓</td>
</tr>
<tr>
<td>3.</td>
<td>Venous Thromboembolism (VTE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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>
<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>
<td>✓</td>
</tr>
<tr>
<td>4.</td>
<td>Friends and Family Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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>
<td>✓</td>
</tr>
<tr>
<td>Part 2: response rate and improvement</td>
<td>Increased response rate.</td>
<td>2.0%</td>
<td>74,510</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<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>
<td>✓</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>
<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>
<td>😞</td>
</tr>
<tr>
<td>7</td>
<td>Advancing Quality (AQ): Hip and Knee Replacement</td>
<td>Implement the AQ care pathway for 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>Implement the AQ care pathway for Pneumonia</td>
<td>0.4%</td>
<td>14,902</td>
<td>😞</td>
<td>😞</td>
</tr>
<tr>
<td>9</td>
<td>Advancing Quality: Stroke</td>
<td>Implement the AQ care pathway for Stroke</td>
<td>0.4%</td>
<td>14,902</td>
<td>😞</td>
<td>😞</td>
</tr>
<tr>
<td>10</td>
<td>Co-ordinated electronic patient records (EPR)</td>
<td>Implement a rolling 5 year plan with involvement from the CCGs to put in place hospital electronic patient records.</td>
<td>3.0%</td>
<td>111,765</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>11</td>
<td>Alcohol assessment</td>
<td>Implementation of a systematic assessment of alcohol consumption, provision of support and communication with primary care on discharge.</td>
<td>3.0080%</td>
<td>112,063</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>12</td>
<td>Readmissions</td>
<td>Work with Commissioners to implement an action plan to reduce readmissions within 30 days of discharge.</td>
<td>6.8182%</td>
<td>254,010</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>13</td>
<td>Cancellations</td>
<td>Reduce cancellations for elective surgery and outpatients appointments.</td>
<td>6.8182%</td>
<td>254,010</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Patient/carer focus groups (glaucoma, head &amp; neck cancer, stroke)</td>
<td>Work with Commissioners and 3 patient focus groups (glaucoma, stroke, head and neck cancers) to develop service specifications and quality dashboards.</td>
<td>6.8182%</td>
<td>254,010 (84,670 each group)</td>
<td>✓ Glaucoma ✓ Stroke ✓ Head &amp; Neck ✓ Glaucoma ✓ Stroke ✓ Head &amp; Neck</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>14</td>
<td>Staff Engagement&lt;br&gt;Part 1: Care rounds</td>
<td>Implementation of care rounds.</td>
<td>10.6282%</td>
<td>395,950 (total) 131,984</td>
<td>✓ Glaucoma ✓ Stroke ✓ Head &amp; Neck ✓ Glaucoma ✓ Stroke ✓ Head &amp; Neck</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 2: Staff focus groups (glaucoma, head &amp; neck cancer, stroke)</td>
<td>Undertake three staff focus groups (glaucoma, head and neck cancers and stroke) to inform service specification and quality dashboards.</td>
<td></td>
<td>43,994 (each group)</td>
<td>✓ Glaucoma ✓ Stroke ✓ Head &amp; Neck ✓ Glaucoma ✓ Stroke ✓ Head &amp; Neck</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 3: Shared decision making in outpatient services: (cardiac rehabilitation, women on high risk pathway, acne services)</td>
<td>Measure and evaluate shared decision making in outpatients using the following services: cardiac rehabilitation, women on the high risk antenatal pathway, patients with acne.</td>
<td></td>
<td>43,994 (each group)</td>
<td>✓ Cardiac rehab ✓ Antenatal pathway ✓ Acne ✓ Cardiac rehab ✓ Antenatal pathway ✓ Acne</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Pressure ulcers: Part 1: Training</td>
<td>Increase the number of eligible clinical staff in post who have attended training for pressure ulcer prevention, assessment and management.</td>
<td>6.8182%</td>
<td>254,010</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 2: Assessment and management</td>
<td>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</td>
<td>6.8182%</td>
<td>254,010</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Prognostication and advance care planning</td>
<td>Identify and support patients in their last 12 months of life.</td>
<td>6.8182%</td>
<td>254,010</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Service Description</td>
<td>RAG status:</td>
<td>Percentage</td>
<td>Target</td>
<td>Agree or Disagree</td>
<td></td>
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<td>---</td>
<td>------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>18</td>
<td>Medicines management Reduce harm from omitted and delayed medicines in hospital.</td>
<td><img src="https://example.com/green-check" alt="Green Check" /> <img src="https://example.com/green-check" alt="Green Check" /></td>
<td>6.8182%</td>
<td>254,010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Improving inhaler technique Measure and improve inhaler technique for inpatients.</td>
<td><img src="https://example.com/not-agree" alt="Not Agree" /> <img src="https://example.com/not-agree" alt="Not Agree" /></td>
<td>6.8182%</td>
<td>254,100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Advice line for GPs Provide dedicated time where consultants are available on a regular basis to discuss patients' management with GPs.</td>
<td><img src="https://example.com/not-agree" alt="Not Agree" /> <img src="https://example.com/not-agree" alt="Not Agree" /></td>
<td>6.8182%</td>
<td>254,100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Retinopathy screening Achieve 95% screening rate for retinopathy of prematurity (RoP)</td>
<td><img src="https://example.com/green-check" alt="Green Check" /> <img src="https://example.com/green-check" alt="Green Check" /></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Total parenteral nutrition administration Timely administration of total parenteral nutrition (TPN) for preterm infants</td>
<td><img src="https://example.com/green-check" alt="Green Check" /> <img src="https://example.com/green-check" alt="Green Check" /></td>
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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 July and September 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 (stage 1).

To undertake a dementia diagnostic assessment on those patients who responded positively to the dementia case finding question (stage 2).

To refer those patients whose diagnostic assessment was either positive or inconclusive to their GP for follow up (stage 3).

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

As the Trust was not meeting the target of 90% during quarter 1, a dementia support assistant was appointed who commenced work in July to support processes on the wards and data collection of the results.

Response rates have improved greatly since the dementia support assistant started in post.

<table>
<thead>
<tr>
<th></th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2013</td>
<td>73%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>August 2013</td>
<td>91%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>September 2013</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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.

During Quarter 2, 403 people have been trained in dementia awareness on induction and mandatory training.

The awareness training is well evaluated and will soon contain the principals of the Mental Capacity Act as well as best interest decision making.

The new Dementia Liaison Nurse, who is working as part of the Integrated Discharge Team, will also be providing training to staff working on the wards. She will also assume responsibility for the dementia link nurse group. A study day for this group of staff is planned for 27 November 2013 at Cheshire Hospices Education.

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 continues to monitor support within the hospital for carers who care for people with dementia.

Responses to the audit have been poor over previous months, but in September 50% of surveys were returned.

A full time dementia link nurse has been appointed and has been in post since 29 July 2013.

September results showed that 86% of carers felt supported. The dementia link nurse is continuing to meet with in-patients, their carers and families to provide support and education.

The dementia link nurse has developed an information pack which is given to all in-patients and/or their carers on admission. The pack includes the ‘Information about me to help you’ documentation, the Alzheimer’s society ‘Dementia Guide’, the carer’s survey along with instructions for completing the paperwork and useful contact numbers. This was launched in mid-September.

September audit results show that 93% of carers reported that they had received the ‘Information about me to help you’ documentation compared with results of 33% in June 2013.

Again in September, 27% of carers stated that they had received written information about organisations representing people with dementia compared to results of 0% in June 2013.

74% of carers felt that the ward staff had an understanding of dementia. The dementia link nurse is currently working with the dignity matron to provide training for the ward staff looking after people with dementia. The dementia link nurse is also visiting all the ward areas daily (Monday – Friday) to offer support to staff as well as patients, carers and families.

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 five months of the year.

April 2013 97.5%
May 2013 95.1%
June 2013 97.7%
July 2013 97.2%
August 2013 96.4%

September 2013 Data will be available week commencing 21 October 2013.

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 five confirmed hospital acquired VTEs in the second quarter of 2013/2014.

There are a further five 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. These have undergone a level 1 root cause analysis investigation.
June 2013   Two hospital associated thrombosis were reported. These have undergone a level 1 root cause analysis investigation.
July 2013   Five hospital associated thrombosis were reported. These are undergoing a level 1 root cause analysis investigation.
August 2013  No reported hospital associated thrombosis to date
September 2013  No reported hospital associated thrombosis to date

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.

An agreement has been reached with Healthcare Communication to provide a texting service for the Maternity patients as the process requires each patient to be asked the friends and family test question four times during their pregnancy and delivery (antenatal, delivery, postnatal ward and postnatal community).

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 second quarter of the year.

<table>
<thead>
<tr>
<th>Month</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2013</td>
<td>17.4%</td>
</tr>
<tr>
<td>May 2013</td>
<td>21.2%</td>
</tr>
<tr>
<td>June 2013</td>
<td>21.4%</td>
</tr>
<tr>
<td>July 2013</td>
<td>20.3%</td>
</tr>
<tr>
<td>August 2013</td>
<td>18.3%</td>
</tr>
<tr>
<td>September 2013</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

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 was circulated to 850 staff in September 2013.

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 is being measured using an appropriate care score (ACS). To meet the target, 93% of patients will have to receive all the care elements. Current performance suggests we will meet this 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 is being measured using an appropriate care score (ACS). To meet the target, 78% of patients will have to receive all the care elements. The inconstancies that can be seen in the early part of this financial year should be resolved with the introduction of the new heart failure pathway.

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 (criteria for compliance has changed to within 12 hours)
6. VTE appropriate duration (new measure)

Progress Report
This financial year, the Trust is being 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 have coincided with a change in the AQ measure. The dip in performance reflects these two changes coming on line. Work is on-going in the division to address these two new requirements.

![Hip and Knee Chart]

Status
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 challenges faced by the trust in meeting this measure have not changed to date and practice remains inconsistent. This financial year, the Trust is being measured using an appropriate care score (ACS). To meet the target, 61% of patients will have to receive all the care elements. The Trust is just below the required standard.

This area remains of some concern. However, the recent appointments of advanced nurse practitioners in the medical assessment areas is anticipated to improve adherence to the pneumonia pathway as this has been highlighted as a priority area to address.

Pneumonia

Status

😊
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 is being measured using an appropriate care score (ACS). To meet the target, 64% of patients have to receive all the care elements. The graph below shows performance to date. The provision of a stroke bed within four hours remains the most challenging measure. Significant work continues in this area within the emergency department, stroke unit, rehabilitation unit and through regular liaison with the patient placement team.

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

The workstreams in relation to the Trust’s EPR strategy are now well established, and invites to sit on the workstream have been sent to the new Service Delivery Manager for the Clinical Commissioning Groups (CCG).

There has not been progress this quarter in terms of CCG / Trust EPR alignment with the CCG’s strategic partner, EMIS, as the Service Delivery Manager was only recently appointed and has yet to identify / provide the specific requirements for the CCG.

The new Service Delivery Manager has been invited to sit on the IT strategy group which next meets in November. In advance of the next steering group meeting, EMIS / Trust EPR road map meetings will be arranged.

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 has been agreed with both surgical and medical assessment areas. The alcohol assessment will be undertaken with all patients as part of their assessment process. All positive forms will be faxed through to the patient’s GP and be referred to the hospital alcohol liaison service (HALS).

All forms will be collated locally to evidence progress in relation to the CQUIN.

Staff 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. Cascade training is also underway for the staff working in the assessment areas.

Status

✅
Goal 12: Readmissions

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

Quarters 1 and 2 require 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.

Systems have been developed so that all patients that are readmitted to assessment areas are reviewed by the nurse co-ordinator to identify whether the readmission is for the same condition as their previous hospital stay. If this is the case that patient will be transferred to the appropriate ward under the lead clinician and records will be updated to indicate that this has been completed.

This data is currently under review by the lead matron to analyse for trends and key themes. Any themes identified will be highlighted to the clinical leads and plans put in place to address any issues going forward.

Status ✔️
Goal 13: Reducing Cancellations

Aim

To reduce cancellations for elective surgery and outpatient appointments, demonstrating a 10% reduction by quarter 4.
Quarters 2 and 3 require the joint Commissioner and Trust working group to introduce a pathway to reduce outpatient cancellations and pilot the pathway in three specialties.
Quarters 2 and 3 also require the development of a working group to review POAC processes and report on the elective surgery pathway

Progress Report

The Trust is currently implementing a full partial booking system for follow up patients to reduce the number of hospital initiated 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. To date there are 3 specialties that have implemented the partial booking system for follow up appointments with the fourth specialty planned to go live for November 2013.
Systems are in place to monitor the impact of implementing the partial booking system on reducing hospital initiated patient cancellations. It is anticipated that it will be approximately 3-6 months post implementation before a significant reduction in actual numbers will be seen.

A working group meets monthly to review and make improvements to preoperative assessment systems and processes. Members include clinicians and service managers from surgery and the womens and childrens’ divisions.
The scope of the group includes
ensuring that patients are effectively assessed for their fitness for anaesthesia and surgery and that this is the primary aim of preoperative assessment
exploring alternative ways of delivering preoperative assessment, e.g. telephone and online
improving the links between the anaesthetic department and the nurses undertaking preoperative assessments
improving the patient experience by reducing the number of required appointments and visits
considering and identifying the accommodation, IT, workforce and other requirements of a remodelled preoperative assessment service
An early outcome of this work has been the development of clear guidance for how and when nurses undertaking preoperative assessment should refer to the anaesthetic department.

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.

Quarters 1 and 2 require Trust staff to work with the Commissioners to plan and undertake a focus group session for each of the three specialities (head and neck cancer, glaucoma and stroke). An action plan is then required to inform the service specification and a quality / key performance indicator (KPI) dashboard for the service.

Progress Report

Head and neck cancer
The Commissioners attended the head and neck cancer support group with the clinical nurse specialist on 25 September 2013. Feedback has been reviewed from patients and carers in relation to their experiences throughout their cancer pathway. Themes are currently being reviewed which will lead to the development of an action plan.

Glaucoma
A focus group involving several patients and clinical staff from the eye care centre was facilitated by the Matron on 11 September 2013. Patients felt able to express and share their experiences with the group. Several suggestions were put forward relating to how we communicate with patients who have Glaucoma and these ideas will be shared with the staff focus group due to be held on 23 October 2013. In addition, the Quality Manager from the local Clinical Commissioning Group was in attendance to hear first-hand the patients’ experience. The next stage will be to develop a quality dashboard for Glaucoma in quarter 3.

Stroke
An initial meeting took place on 7 June 2013 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. The Stroke Association have also distributed ten patient surveys to former patients in the community. The feedback received is largely positive and two main themes for action were identified. These were that patients felt that they did not receive enough information from the multi-disciplinary team regarding their diagnosis and that they would like more information about how they could help to prevent any further recurrence of their stroke. These themes will be the focus for the group which is scheduled to meet on 28 October 2013.

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 2 requires the implementation of care rounds.

Progress Report

The emergency care division has identified a lead matron to standardise and implement care rounds effectively within the division. The proforma has been rolled out to pilot across the cardiology wards with full implementation planned for quarter 3 and review in quarter 4.

Care rounds have been implemented and embedded within the surgical division. Feedback to date from ward staff has been very positive.

Status

✓
Goal 15: Staff Engagement
Part 2: Staff Focus Groups

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.

Quarter 2 requires analysis of the results from the focus groups and the formulation of recommendations which will inform the service specification and a quality / KPI dashboard for the service.

Progress Report

Head and neck cancer
The Commissioners met with the clinical nurse specialist and staff from the ear nose and throat (ENT) outpatient department, dieticians, speech and language therapists and the lead clinician on 20 August 2013. All aspects of the patient pathway were discussed with view sought from all staff. These themes are being reviewed in line with feedback from the patient/carer focus group and will be developed into an action plan.

Glaucoma
A focus group with staff who are clinically involved in the care of patients with Glaucoma is set to take place on 23 October 2013. In addition, administrative staff from the Trust who manage the appointment system will also participate along with the Quality Manager from the Clinical Commissioning Groups. Feedback from the patient focus group held on 11 September 2013 will be shared at the staff focus group. The next stage will be to develop a quality dashboard for Glaucoma in quarter 3.

Stroke
An initial meeting on 7 June 2013 took place between the stroke team and the Commissioners with regard to starting a staff focus group. The staff focus group will combine with the work the stroke team is undertaking in the development of the patient/carer focus group. The format of the meeting has been discussed and staff who are to be involved have been identified by the ward manager and senior therapist. A staff questionnaire is currently being distributed to the ward staff. The aim of this is to gather information to ascertain if there are gaps in staff knowledge in relation to the delivery of holistic care to the stroke patient. The questionnaires are due to be returned by 21 October 2013. The results will be collated and discussed at the staff focus group meeting that is arranged for 31 October 2013. Actions will be formulated according to the responses obtained from the questionnaires and the discussions from the focus group.
**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 2 requires the implementation of shared decision making in the three services specified.

Progress Report

Cardiac rehabilitation (CR)
Patient questionnaires are distributed at the end of each patient’s phase 3 cycle of rehabilitation. Each patient’s view is collated and used to inform and develop the cardiac rehabilitation service. Members of the multi disciplinary team are actively engaged in the delivery and ongoing development of the CR service. This integrated yet flexible approach allows providers and users to influence pathway development through continuous feedback mechanisms.

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. There are three high risk pathways that have been identified to undertake shared decision making:
1. Increased risk of Downs’ Syndrome
2. Vaginal Birth after Caesarean Section (VBAC)
3. Pre-Labour Rupture of Membranes
Patient information and questionnaires have been developed and are now awaiting approval from the patient experience action group before distribution.

Patients with acne
A patient questionnaire has been developed to discover if patients feel they are involved in and have all the information required to make decisions about their treatment. The questionnaire will be given to all patients attending acne clinics in November and will include new patients and patients who have been on treatments for some time. It is anticipated that this will involve approximately 40 patients.

Status
Cardiac rehab: ✔️  High risk pathway: ✔️  Acne: ✔️
Goal 16: Pressure Ulcers
Part 1: Training

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 2 requires a report to show an increase in the number of staff undergoing pressure ulcer training.

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

In Quarter two, a further 103 staff received pressure ulcer training. This equates to 39% of eligible staff working within the medical and surgical wards as there are 817 staff working in these areas.

Status
✓
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%.

Quarters 1 and 2 require 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

✓
Goal 17: Prognostication and advance care planning

Aim

Prognostication of the last 12 months of life to ensure that advanced care planning can commence in a timely and appropriate way. This will provide our local population with quality and choice through their end of life pathways.

Progress Report

1 Electronic prognostication tools (epaige) to be implemented to i) support in decision making in the last 12 months of life for patients with cancer and heart failure ii) signpost to the appropriate advanced care planning tools iii) provision of the care of the dying documentation iv) communication to Primary.

The Trust has implemented and launched the electronic prognostication tool (epaige). This is now available as a direct link from the Trust's intranet site. Drop in education sessions are booked for all clinical areas provided by the specialist palliative care team (SPCT) and the end of life facilitators. These will run from early October to mid December.

2 A coding system must be used to identify patients that are in the last 12 months of life.

A code for the gold standard framework/register (GSF) has now been added to the current codes at the Trust. The SPCT is now awaiting GP practices to inform the Trust of patients currently on their GSF registers so that they will then be able to add the GSF code to the patient administration system (PAS).

3 Commence discussions with respiratory team to include advanced care planning for patients with COPD.

Central & Eastern Cheshire respiratory team have received end of life care (EoLC) training via locally held workshops. Where appropriate, teams have advance care planning (ACP) discussions with patients and distribute the ‘Planning your Future Care’ booklet. All EoLC discussions/actions including GSF referral and ACP are recorded on a centrally held EMIS template. It is planned for all band 6 team members to attend a connected communication course this year to assist with difficult conversations. The team feel well supported and will contact the SPCT if additional training is required.

4 80% of all clinical staff to have attended an appropriate level of communication skills training.

Communication skills training is included in a variety of training provided / accessed by clinical staff throughout the Trust. The learning and development database has been searched to ascertain the numbers of clinical staff who have attended an appropriate level of communication skills training. This database demonstrates that over 80% of clinical facing staff have attended an appropriate level of communication skills training.

5 Training in End of Life, including End of Life care tools and Palliative Care must be available for all clinical staff.

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 the Trust is free of charge. EoLC sessions have been provided in the postgraduate medical centre at the Friday clinical lecture programme and the medical breakfast meetings. The Trust also has a proactive palliative link nurse group who meet for 2 days a year and keep ward staff up to date with end of life issues.

6 Patients identified as being in the last 12 months of life will be offered the national booklet ‘Planning For Your Future Care. A Guide’.
Patients who are identified as being in their last 12 months of life are being offered the national booklet ‘Planning For Your Future Care: A Guide’. The SPC MDT form has been amended so that the SPCT can record which patients have been given the booklets and if not why not (e.g. not appropriate or refused).

7 Patients with dementia will have advanced care planning discussions and offered choices in their PPC. 40% of patients with dementia who die with a preferred place of care (PPC) will achieve their preferred place of death.
The Integrated Discharge Team (IDT) have now welcomed their Dementia Lead Discharge Nurse into post. This nurse is the point of contact for all patients and carers admitted to the hospital with a diagnosis of dementia, and will be pivotal in having end of life care planning discussions with appropriate patients. A meeting is being arranged in relation to PPC discussions and documentation between the end of life service model, SPCT and the dementia nurse.

8 The patient will be referred to the Gold Standards Register in Primary Care as soon as they are identified as being in their last 12 months of life. It is expected that there will be a 50% increase in the number of patients on the register from benchmark data collected on 01.03.13.
A GSF referral form has been developed and launched for use by the SPCT and disease specific specialist nurses who are keeping copies of GSF forms faxed out to GPs for auditing purposes. This information will be collated for the final quarter report.

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 of omitted and delayed medicines administration with an overall increase in the number of doses given of 0.9% in 3 months.

During quarter 2, incident reporting of omitted doses has improved by 18% in 3 months and on-going mandatory medicines management training is continuing for nursing staff.

The updated list of critical medicines is included in the Trust’s medicines policy which also includes guidance on the prescribing and administration of critical medicines.

All incidents related to omitted doses are discussed at the Trust’s Safe Medicines Practice Committee.

The emergency drugs room stock list is available on the intranet and has been reviewed to ensure critical medicines are available out of hours and patients have at least 14 days supply of all medicines (including critical medicines) on discharge.

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.

A pilot is being developed which will commence on the respiratory ward. This will involve the assessment of a patient’s inhaler technique, patient counselling and ensuring patients have been prescribed the correct device.

Status
Not known as content not yet agreed
Goal 20: Advice & Guidance Service for GPs

Aim
To provide a dedicated service for paediatrics and gynaecology where Consultants are available, on a regular basis, to discuss patients’ management with GPs.

To assist GP’s to make appropriate referral decisions to secondary care.

Progress Report
A meeting to discuss the detail of this CQUIN between Trust Consultants and the Clinical Commissioners took place at the end of July 2013. The outline service model has been further developed into:

a. advice & guidance service to be trialled in Paediatrics and Gynaecology.
b. GPs to request advice & guidance via e-mail.
c. A letter / e-mail will be sent back to the GP confirming the advice and guidance from the Consultant.
d. If possible, the Consultant will use the GP e-mail as a referral letter if an admission or urgent outpatient appointment is required.
e. Referral criteria will not be specific and the guiding principal will be that the service is for any GP concerns or queries that require a secondary care Consultant input.
f. The advice & guidance service within Paediatrics will form part of a service remodelling to try and reduce the number of children who come into hospital.

NHS.net e-mail accounts have been set up for the two advice & guidance services with access to them for Consultants and their administrative support. A draft advice & guidance template has been devised and needs to be agreed with GP colleagues before a go-live date on 1st January 2014. Quarter 3 will be used to communicate the availability of this service to GPs. The CQUIN trial will last for three months after which it will be evaluated at the end of quarter 4.

Status
Not known as content not yet agreed

45
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.

Each quarter requires the presentation of results 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>

Quarterly data 1st April 2013 to 30th September 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>
<tr>
<td>July – Sep 2013</td>
<td>9</td>
<td>9</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).
Each quarter requires the presentation of results 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>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>
</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>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>
</tr>
<tr>
<td>May 2013</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>
Babies eligible for TPN based on the CQUIN criteria: 11

Quarter 2 data 1st July 2013 – 30th September 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>July 2013</td>
<td>0</td>
<td>0</td>
<td>100%</td>
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<tr>
<td>August 2013</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>September 2013</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
</tbody>
</table>

Babies eligible for TPN based on the CQUIN criteria: 10

Action plan

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.

Commissioners to confirm revised wording for CQUIN.

Status

✅