Commissioning for Quality and Innovation (CQUIN)

Quarter 3 Report: October - December 2013

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

Jayne Hartley, Deputy Director of Nursing & Quality

Executive Lead: Julie Smith, Director of Nursing & Quality

7 January 2014
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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 thrombo embolism (VTE) (goal three) and the Friends and Family Test (goal four).

MCHFT and the Clinical Commissioning Groups (CCGs) for Vale Royal and South Cheshire 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 3 (October – December 2013).
## Performance Summary

**Quarter 3 (October – December 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>
<th>RAG Status Quarter 3</th>
</tr>
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<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>
<td>✓</td>
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<tr>
<td>2</td>
<td>Dementia</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 who are identified as potentially having dementia who are appropriately assessed and the number referred to GP services.</td>
<td>3.0%</td>
<td>111,765</td>
<td>🙁</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td></td>
<td>Part 1: Assess and refer</td>
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<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>
<td>✓</td>
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<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>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Venous Thromboembolism (VTE)</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>
<td>✓</td>
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<td></td>
<td>Part 1: Risk assessment</td>
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<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>
<td>✓</td>
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<td>4</td>
<td>Friends and Family Test</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>
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<td>Part 1: Phased expansion</td>
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<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>
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<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>
<td>✓</td>
<td>✓</td>
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<td></td>
<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>
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<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>
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<tr>
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<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>
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<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>
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<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>
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<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>
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<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>
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<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>
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<td>Cancellations</td>
<td>Reduce cancellations for elective surgery and outpatients appointments.</td>
<td>6.8182%</td>
<td>254,010</td>
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<td>14</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</td>
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<td>15</td>
<td>Staff Engagement</td>
<td>Implementation of care rounds.</td>
<td>10.6282%</td>
<td>395,950</td>
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<td>Part 1: Care rounds</td>
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<td>131,984</td>
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<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>
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<td>43,994</td>
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<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>10.6282%</td>
<td>43,994</td>
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<td>Acne</td>
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<td>16</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>
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<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 10%.</td>
<td>6.8182%</td>
<td>254,010</td>
<td></td>
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<tr>
<td></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>
<td>✓</td>
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<td>18</td>
<td>Medicines management</td>
<td>Reduce harm from omitted and delayed medicines in hospital.</td>
<td>6.8182%</td>
<td>254,010</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>19</td>
<td>Improving inhaler technique</td>
<td>Measure and improve inhaler technique for inpatients.</td>
<td>6.8182%</td>
<td>254,100</td>
<td>Not agreed</td>
<td>Not agreed</td>
<td>✓</td>
</tr>
<tr>
<td>20</td>
<td>Advice line for GPs</td>
<td>Provide dedicated time where consultants are available on a regular basis to discuss patients’ management with GPs.</td>
<td>6.8182%</td>
<td>254,100</td>
<td>Not agreed</td>
<td>Not agreed</td>
<td>✓</td>
</tr>
<tr>
<td>21</td>
<td>Retinopathy screening</td>
<td>Achieve 95% screening rate for retinopathy of prematurity (RoP)</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>22</td>
<td>Total parenteral nutrition administration</td>
<td>Timely administration of total parenteral nutrition (TPN) for preterm infants</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

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 October and December 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 and continue to achieve the required target.

<table>
<thead>
<tr>
<th></th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2013</td>
<td>50%</td>
<td>23%</td>
<td>22%</td>
</tr>
<tr>
<td>May 2013</td>
<td>60%</td>
<td>25%</td>
<td>22%</td>
</tr>
<tr>
<td>June 2013</td>
<td>59%</td>
<td>49%</td>
<td>46%</td>
</tr>
<tr>
<td>July 2013</td>
<td>75%</td>
<td>81%</td>
<td>62%</td>
</tr>
<tr>
<td>August 2013</td>
<td>93%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>September 2013</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>October 2013</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>November 2013</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>December 2013</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Status

✔️
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.

The awareness training continues to be well evaluated. The training now contains information for staff on the principals of the Mental Capacity Act (MCA) 2005, how to test for capacity, what is involved when a best interest decision needs to be made and when to involve advocacy.

The training also gives a brief description of the Deprivation of Liberty Safeguards and when they may apply in an acute hospital setting.

The dementia liaison nurse, who is working as part of the integrated discharge team, is also providing training to staff working on the wards. She will also assume responsibility for the dementia link nurse group. A study day for the dementia link nurses was held in November 2013 at Cheshire Hospices’ Education. This was very well evaluated, particularly the session looking at the MCA and case studies where it has been applied.

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 of people who have dementia. Responses to the audit have been low, but uptake of the dementia information pack has been good (averaging at least 50 packs given out monthly).

The audit results show that the majority of carers feel fully supported by the hospital during their relatives' journey. 90% of respondents report that they were able to find someone with whom to discuss any worries or concerns.

All respondents report receiving the “information about me to help you” document and find it helpful. It is planned to review and improve this document in line with developing a dementia care bundle to support the implementation of the dementia care pathway.

All carers also feel they are updated on the medical treatment/care that their relative is receiving, although the majority (67%) report that this is only when they make an enquiry. 58% of carers feel they are involved in discharge planning for their relative.

The dementia liaison nurse is working alongside ward staff to try to improve carers’ experiences surrounding information about progress and involvement in discharge planning. 75% of carers report they feel staff have a great deal of understanding/skill in their understanding of dementia. The dementia liaison nurse visits the wards daily (Monday-Friday) supporting ward staff with information about dementia and is working with the Dignity Matron to assess further training needs.

The majority of carers feel staff ask for their input during their relatives’ admission and all carers report that they are always able to visit outside normal visiting hours if they want to do this. Some wards are actively encouraging visiting outside normal hours, feeling it to be in the best interests of the patient as this can minimise their agitation and distress.

All carers state that they received written information about organisations representing people with dementia. The Alzheimer's Society “Dementia Guide” is provided to all people identified as caring for someone with dementia.

**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 eight 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  97.1%
October 2013  96.7%
November 2013  97.6%
December 2013  Data not available until the end of January 2014

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 third quarter of 2013/2014.

There are a further 3 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  Three hospital associated thrombosis were reported. Root cause analysis investigations have been undertaken
June 2013  Three hospital associated thrombosis were reported. Root cause analysis investigations have been undertaken
July 2013  Seven hospital associated thrombosis were reported. Root cause analysis investigations have been undertaken
August 2013  Two hospital associated thrombosis were reported. Root cause analysis investigations have been undertaken
September 2013  Four hospital associated thrombosis were reported. Root cause analysis investigations have been undertaken
October 2013  Three hospital associated thrombosis were reported. Root cause analysis investigations are being undertaken
November 2013  One hospital associated thrombosis was reported. Root cause analysis investigation is being undertaken
December 2013  One hospital associated thrombosis was reported. Root cause analysis investigation is being undertaken

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
The Friends & Family test was introduced into Maternity in October 2013 in line with national requirements.

The Trust has chosen to use a texting service to ask the questions. 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).

There have been introductory technical issues which are being worked through to ensure all women are offered the opportunity to respond. However, as shown in the graph below, the response rate has improved during the quarter as has the net promoter score.

<table>
<thead>
<tr>
<th></th>
<th>Oct-13</th>
<th>Nov-13</th>
<th>Dec-13</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>F&amp;FT Response Rate</td>
<td>5%</td>
<td>6%</td>
<td>15%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Promoter Score</td>
<td>64</td>
<td>56</td>
<td>65</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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>
<tr>
<td>October 2013</td>
<td>19%</td>
</tr>
<tr>
<td>November 2013</td>
<td>21%</td>
</tr>
<tr>
<td>December 2013</td>
<td>Data not available until the middle of January 2014</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 2013/14 staff survey was circulated to 850 staff in September 2013.

The 2013/14 staff survey results are due to be published in February 2014.

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 is summarised in the graph below. Despite the slight dip in August's performance, which is being investigated by the clinical team, previous results indicate 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 current performance is summarised in the graph below. The Trust has exceeded the target twice during this financial year. Occasionally, the heart failure team is not informed of a new diagnosis of heart failure. This can lead to inconsistencies in practice. The heart failure team review case notes of patients whose referral may have been delayed and are to pilot a new heart failure pathway which is designed to reduce this inconsistency.

![Heart Failure Graph]

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 (VTE) 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

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. The main area of inconsistency relates to VTE prophylaxis.

The guidelines for AQ VTE prophylaxis changed in April 2013. Until that point the Trust had always been a consistent performer in the care bundle delivered to the hip or knee replacement patient. Changes to the criteria (reducing the time frame from 24 to 12 hours and introducing a new drug option) have resulted in a variation in the performance against this measure.

VTE prophylaxis in the orthopaedic patient has been controversial nationally and the clinicians at this Trust have been careful to evaluate at all times if they are acting in the best interests of their patients. The initial response in April 2013 was to introduce a new drug, Apixiban, which was licensed for use 24 hours post-surgery. This was audited by the wards and clinicians and it was found that this resulted in an increase in “oozy wounds” and the Trust has reverted back to the use of Enoxaparin which has been introduced in the following way:

- The standard time for the first administration of the drug will be 10pm on day of surgery with subsequent doses at 6pm. This new time will make the administration within the 12 hour time frame as required by the AQ measure
- The surgeons are to record clearly on the integrated pathway if they have any reason that a particular patient should not receive the drug at this time, for example, excessive intraoperative bleeding.

The graph overleaf shows the Trust’s performance to date which demonstrates a steady overall improvement in this measure.
Status

😊
Goal 8: AQ: Pneumonia

Aim
To ensure patients 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
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. A new pathway has been developed and is being introduced by the advanced nurse practitioners and acute physicians in the medical assessment unit. It is anticipated that this will increase the consistency of treatment for patients against all AQ measures. In particular, the pathway will:

- Increase the capability for data capture
- Provide timely feedback to clinicians so that practice can be improved.
- Focus specifically on the recording of smoking cessation advice / counselling in the patient's notes

The graph below shows the performance against the measures to date, however this does not yet reflect the effect of the new pathway.

![Graph showing performance against measures]
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.

The stroke specialist nurse, discharge coordinator and ward coordinator meet daily to discuss capacity and demand and to identify patients suitable for rehabilitation/discharge. Bed managers provide support when assessing patients suitable to move from the stroke ward. When stroke patients are ready (usually after 72 hours), they are given priority for beds on the rehabilitation ward.

The provision of specialised step down beds for patients who have suffered a stroke continues to be a health economy wide challenge and is under discussion with the commissioners.

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.

Progress Report

The workstreams in relation to the Trust’s EPR strategy are now well established, and the service delivery manager for the Clinical Commissioning Groups (CCGs) has been appointed.

Work is progressing to define deliverable milestones for the sharing of secondary data with primary care.

The Trust is currently working with primary care to share information stored on its radiology information system (RIG).

In addition, discussions are taking place regarding the use of the medical interoperability gateway (MIG). The next meeting is scheduled for January 2014 and work has started on identifying ways to replace traditional faxing of information with an electronic equivalent.

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.

Quarter 3 requires an audit of the number of AUDIT - C forms provided to primary care following assessment in the surgical and medical assessment areas (target = 25%)

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

The alcohol assessment is undertaken with all patients as part of their assessment process. The pathway stipulates that positive forms must be faxed to the patient’s GP and be referred to the hospital alcohol liaison service (HALS).

Staff training has been led by the hospital alcohol liaison and cascade training has taken place with the staff working in the assessment areas.

To date, 46% of patients attending the surgical assessment areas have been assessed using the AUDIT - C form. All forms identified as positive have been faxed to the appropriate G.P. and the patient has been asked if they would like a referral to HALS.

Within the medical assessment areas, 62% of patients have been assessed using the AUDIT - C form. This represents 1,056 patients.

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 through quarter 3 onwards.

Progress Report
Patients readmitted within 7 days are monitored daily at a local level to review the reason for admission and put into place any actions required that could prevent a future readmission.

The nominated matron leads for surgery and emergency care are working with four clinical specialties: cardiology, respiratory, breast surgery and urology to focus on improving readmission rates in these areas. Detailed audits have been completed at a local level, the results of which have been shared with the clinical leads. Actions identified are being progressed locally at specialty level.

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 ensures that 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 are in place in all assessment areas to identify patients that are readmitted within 30 days. Patients are reviewed by the nurse co-ordinator to establish whether the readmission is for the same condition as their previous hospital stay. If this is the case, that patient is transferred to the appropriate ward under the lead clinician and records are updated to indicate that this has been completed.

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 processes in the pre operative assessment clinic (POAC) and report on the elective surgery pathway.

Progress Report
The Trust is on track with the implementation of 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. It is anticipated that it will be approximately 3 - 6 months post implementation before a significant reduction in actual numbers will be seen.

In November 2013, the Trust set up its outpatient rationalisation project board. This committee has senior representation from all specialty areas across the Trust and is focussing on the quality of outpatient services delivered. One of the project’s key deliverables will be to continue to reduce both hospital and patient initiated clinic cancellations. Further focussed work is to provide patients with adequate notice of their appointment and improved communication.

A detailed report for all specialties has now been produced to monitor the on-going position for clinic cancellations at specialty level.

A working group continues to meet 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 reinforcing that this is the primary aim of preoperative assessment.
Work is also underway to review and improve links between the anaesthetic department and the nurses undertaking preoperative assessments and improving the patient experience by reducing the number of required appointments and visits.

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.

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. The themes were similar for both patient and carer focus groups and have been progressed as follows:

- **Improved communication required in relation to delays/waiting times in the ear nose and throat (ENT) out patient department:**
  Patient information boards have been provided and the staff who are responsible for updating boards with waiting times/delays are now identified at the start of each clinic. In addition, the staff are also now making a verbal announcements of delays and reasons.
- **Clearer information on display boards was requested and to stop using abbreviations:**
  The staff are in the process of redesigning the lay out of the boards to make them easier to read.
- **Reduce waiting times for appointments:**
  Clinic templates for the Wednesday afternoon cancer fax clinic and the Thursday afternoon joint clinic have been redesigned to allow streamlining of appointment times to reduce unnecessary waiting for patients.
- **Improve use of Pre-operative assessment (POAC):**
  Same day POAC for some patients is not appropriate, especially if they have just been given bad news. Patients will now be assessed on an individual basis and POAC deferred if this is felt to be in the patient’s best interest. Staff will be supported to make this judgement
- **Reduce waiting times for investigations:**
- **There are discussions taking place to try to improve availability/timeliness of MRI imaging**
- **Improve the environment in the waiting area:**
  A television has been purchased and will soon be installed in the waiting area
**Glaucoma**

A review of feedback received from the focus groups held in September and October 2013 has taken place and two quality indicators have been progressed.

1. **A patient support group for patients, friends and family to be held every four months.**
   The first support group meeting took place in October which was held in Crewe. Guest speakers included an ophthalmic consultant, nursing teams, social workers and the International Glaucoma Association. Over 60 members of the public attended. Excellent feedback was received from patients, particularly in relation to the question and answer session with the ophthalmic consultant. Future meetings are planned at different locations to ensure members of the public have opportunity for equal access.

2. **Two senior technicians to be available to undertake diagnostic tests at Glaucoma clinics**
   Feedback from both patients and staff indicated that if senior technicians were available in Glaucoma clinics, it would enhance patient information and improve the waiting time in the department for diagnostic tests. This indicator is now being progressed and will be reviewed in quarter 4.

**Stroke**

Meetings took place in June and October 2013 to discuss the main themes for action which included patients identifying that they felt 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.

The patient focus group subsequently looked at patient booklets being used in other Trusts and have compiled a draft booklet ensuring all of the feedback received from the focus group has been included.

All members of the multi-disciplinary team have contributed to the development of the booklet which will be presented in January to the Stroke Association Service user event where staff will ask for comments/feedback prior to finalisation.

**Status**

Head and Neck: ✔️  Glaucoma: ✔️  Stroke: ✔️

33
Goal 15: Staff Engagement
Part 1: Care Rounds

Aim
To implement care rounds in all adult inpatient wards.

Quarter 3 requires an update in relation to implementation of the care rounds

Progress Report
Care rounds have been standardised and fully implemented across all inpatient areas in the emergency care and surgical divisions.

The Care rounds initiative has been embraced by the divisions as it gives them a way of ensuring patients are being seen and cared for and their needs met. Nurses need to be assured that the patient is as happy and as comfortable as possible, and importantly, both the patient and their relatives need to feel that the nurses looking after them are there to help.

In the surgical division, care rounds are either completed hourly or 2 hourly dependent on the condition of the patient and the safety huddle criteria. Patients requiring 1 hourly care rounds have this recorded on the nursing handover sheet. Any patients who are confused, hoisted, have reduced mobility, are unable to press the call bell or have had previous falls have their care rounds completed hourly for the whole 24 hour period. All remaining patients have care rounds completed 2 hourly between 14.00 hours and 06.00 hours. These patients have been assessed as being independent with their activities of daily living but can change if there are any conditional changes to the patient throughout the shift.

In the emergency care division, care rounds ensure that patients’ requirements for nutrition, continence, skin care, pain and risk of harm are assessed and met by any member of the multidisciplinary team on a 2 hourly basis. They also ensure the qualified nurse responsible for that patient completes the care round at 5 allocated times within a 24 hour period.

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 views sought from all staff. The themes discussed were similar for both patient and carer focus groups and have been progressed as follows:

- **Improved communication required in relation to delays/waiting times in the ear nose and throat (ENT) out patient department:**
  Patient information boards have been provided and the staff who are responsible for updating boards with waiting times/delays are now identified at the start of each clinic. In addition, the staff are also now making a verbal announcements of delays and reasons.

- **Clearer information on display boards was requested and to stop using abbreviations:**
  The staff are in the process of redesigning the lay out of the boards to make them easier to read.

- **Reduce waiting times for appointments:**
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- **Reduce waiting times for investigations:**
- There are discussions taking place to try to improve availability/timeliness of MRI imaging
Glaucoma

A review of feedback received from the focus groups held in September and October 2013 has taken place and two quality indicators have been progressed.

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   The first support group meeting took place in October which was held in Crewe. Guest speakers included an ophthalmic consultant, nursing teams, social workers and the International Glaucoma Association. Over 60 members of the public attended. Excellent feedback was received from patients, particularly in relation to the question and answer session with the ophthalmic consultant. Future meetings are planned at different locations to ensure members of the public have opportunity for equal access.

2. **Two senior technicians to be available to undertake diagnostic tests at Glaucoma clinics**

   Feedback from both patients and staff indicated that if senior technicians were available in Glaucoma clinics, it would enhance patient information and improve the waiting time in the department for diagnostic tests. This indicator is now being progressed and will be reviewed in quarter 4.

Stroke

An initial meeting in June 2013 took place between the stroke team and the Commissioners with regard to starting a staff focus group.

A staff questionnaire was distributed to the ward staff to determine if there are gaps in staff knowledge in relation to the delivery of holistic care to the stroke patient. Following review of the results, it has been identified that staff would like more knowledge and training in stroke care so the multi-disciplinary team are arranging to implement the stroke competency toolkit (SCoT) to help achieve this request. The staff also felt they would like to participate in simple therapies/activities for suitable patients. In order to achieve this, we are currently looking at using the ImPRes booklet and there are 7 volunteers ready to assist with the implementation of this. It is felt this will enhance patient recovery and help alleviate boredom and lift mood.

**Status:** Head and Neck: ✔️  Glaucoma: ✔️  Stroke: ✔️
Goal 15: Staff Engagement
Part 3: Shared decision making in outpatient services

Aim
The intention is to understand patients’ perceptions of their ability to share decision making whilst an outpatient for the following patient groups:
Cardiac rehabilitation
Women on the high risk pathway
Patients with acne

Progress Report

Cardiac rehabilitation (CR)
Patient questionnaires are distributed at the end of each patient’s phase 3 cycle of rehabilitation. Between September and November 2013, 54 questionnaires were sent out and 40 were returned, providing a high response rate of 74%. Results demonstrated that patients were happy, not only with the venues available for CR, but also with having a choice of venue which made access easier. Written information was also appreciated and assisted their recovery. Where further support was required, this was delivered as specific educational sessions and risk factor management.

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 Down’s Syndrome. The Trust is waiting for confirmation from the National Options Grid Team that we have permission to use their option grid when discussing with parents whether or not they wish to screen for Down’s Syndrome.

2. Vaginal Birth after Caesarean Section (VBAC). The staff are continuing to use the existing checklist which is completed by medical staff when following the ‘previous Caesarean Section’ pathway.

3. Pre-Labour Rupture of Membranes. Shared decision making for patients with pre-labour rupture of membranes at term commenced in the shared triage area in December 2013. The choices of care are discussed with the woman and partner with the aid of the decision making grid. A copy of this is given to the woman to take home and filed in her hand held notes. The woman is invited to complete feedback on the form in her own time and this is removed from the notes when she attends for delivery of her baby.
Patients with acne
In quarter three, a survey was undertaken during the month of November. 39 questionnaires were distributed and 36 responses received back giving a response rate of 92%. The results will now be analysed and any areas of concern formulated into an action plan. First impressions are that the service is very well received with patients feeling involved in the decisions about their treatments.

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

Progress Report

As shown in the graph below, there were 214 staff who received pressure ulcer training in quarter 1.

A further 103 staff received training in quarter 2.

During quarter 3, there were an additional 151 staff trained.

This makes a total of 468 staff trained in pressure ulcer assessment, prevention and management. This equates to 57% of staff, as there are 817 staff working within the medical and surgical wards who are eligible to receive such training.

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 3 requires an audit of patients to show the number who have undergone a pressure ulcer assessment on admission and are receiving appropriate care as evidenced through a care plan. Results to be shown as a percentage of patients admitted to hospital

Progress Report

379 inpatient records were audited in Quarter 3. The graph below illustrates the percentage compliance with the elements of care required for the effective management of pressure areas. These results will be discussed at the next pressure ulcer operational group which meets every month.

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 care.

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 provided by the specialist palliative care team (SPCT) and the end of life facilitators have now been completed for all clinical areas.

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 has taken place between the end of life service model, SPCT and the dementia nurse to discuss ways in which the dementia nurse can capture this information.

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.

A repeat audit was carried out in November 2013 which showed a further improvement of 0.1% in all medicines and a 0.2% improvement in critical medicines. The clinical divisions have been tasked with reducing the number of omitted doses and wards are completing monthly audits. The monthly audits are being managed through the monthly performance meetings. The Trust wide audit will continue to be carried out every 6 months.

During quarter 2, incident reporting of omitted doses improved by 18%. In the November audit, this number increased to 53%. All incidents related to omitted doses are discussed at the Trust’s Safe Medicines Practice Committee.

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.

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.

Progress Report

Training for staff in relation to correct inhaler technique and the use of inspiratory flow is in progress. Training has been provided to pharmacists, pharmacy technicians, nursing staff on the respiratory ward and respiratory physiotherapists. A training matrix has been produced to evidence this training.

Inhaler counselling for patients has commenced on the respiratory ward. This involves the assessment of a patient’s inhaler technique, patient counselling and ensuring patients have been prescribed the correct device. This information is then documented onto the patient’s electronic discharge prescription.

The agreed audit of 30 patients who have been admitted with an exacerbation of asthma or chronic pulmonary obstructive disease (COPD) commenced in December 2013.

The training of staff in the assessment areas will commence in January 2014.

The full detail of this CQUIN goal was agreed in December 2013.

Status

✔️
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
The advice and guidance template has been agreed by the Consultant Paediatricians, Obstetricians & Gynaecologists and GPs.

A press release has been prepared and circulated in the December edition of the GP link. All GPs have also received an individual email and each surgery a copy of the press release for cascading and sharing with colleagues.

All Consultant Paediatricians and their associated administrative teams have received training on accessing the shared NHS.net email account and are well prepared and ready to commence the service on 2 January 2014. A seven week rota has been produced and issued for the Consultant Paediatricians, and a robust training session has been completed by all the Consultants.

The Gynaecology email account will be checked three times a week by the Consultant on-call to ensure responses are made within 48 hours.

Quarter 4 will be used for on-going communication to report on the implementation and progress of the service. In addition, audit data will be available to evaluate the number of referrals received and which option has been recommended.

Status

✔️
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 1 April 2013 to 31 December 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>12</td>
<td>10</td>
<td>83.3%</td>
</tr>
<tr>
<td>Oct – Dec 2013</td>
<td>11</td>
<td>9</td>
<td>81.8%</td>
</tr>
</tbody>
</table>
The two patients in quarter 2 and quarter 3 which met the criteria for inclusion but were not screened prior to discharge were discharged home before the screening was required (between 28 – 35 days postnatal age). The patients subsequently returned and had screening within the screening window.

**Action plan:** Paediatric Governance Committee (Jan 2014) to discuss the arrangements for retinopathy screening for babies with a birth weight of < 1501g or a gestation of < 32+0 weeks who are discharged prior to the screening window.
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></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>
<tr>
<td></td>
<td>Babies eligible for TPN based on the CQUIN criteria: 22</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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>
</tbody>
</table>
Babies eligible for TPN based on the CQUIN criteria: 11

**Quarter 2 data 1\textsuperscript{st} July 2013 – 30\textsuperscript{th} September 2013**

<table>
<thead>
<tr>
<th></th>
<th>Number of babies</th>
<th>Number of babies</th>
<th>Percentage achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;29+0 weeks gestation and/or &lt;1000g born or transferred in on day 1 of life.</td>
<td>&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.</td>
<td></td>
</tr>
<tr>
<td>July 2013</td>
<td>0</td>
<td>0</td>
<td>100%</td>
</tr>
<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

**Quarter 3 data 1\textsuperscript{st} October 2013 – 31\textsuperscript{st} December 2013**

<table>
<thead>
<tr>
<th></th>
<th>Number of babies</th>
<th>Number of babies</th>
<th>Percentage achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;29+0 weeks gestation and/or &lt;1000g born or transferred in on day 1 of life.</td>
<td>&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.</td>
<td></td>
</tr>
<tr>
<td>Oct 2013</td>
<td>0</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Nov 2013</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Dec 2013</td>
<td>0</td>
<td>0</td>
<td>100%</td>
</tr>
</tbody>
</table>

Babies eligible for TPN based on the CQUIN criteria: 8

**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**

49