Commissioning for Quality and Innovation (CQUIN)

Quarter 4 Report: January - March 2014

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

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14 April 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 agreed a further sixteen goals (goals five to twenty).

The North West Specialised Commissioning Group (SCG) 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 4 (January – March 2014).
## Performance Summary
### Quarter 4 (January – March 2014)

<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 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>NHS Safety Thermometer</td>
<td>To collect data in relation to pressure ulcers, falls, urinary tract infection and VTE</td>
<td>5.0%</td>
<td>186,274</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>Dementia</td>
<td>The proportion of patients aged 75 and over to whom the case finding question is applied following emergency admission; the proportion of those identified as potentially having dementia who are appropriately assessed and the number referred on to GP services.</td>
<td>3.0%</td>
<td>111,765</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 1: Assess and refer</td>
<td></td>
<td></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>
</tr>
<tr>
<td></td>
<td>Part 3: Supporting carers</td>
<td>Ensuring carers feel supported.</td>
<td>1.5%</td>
<td>55,882</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Venous Thromboembolism (VTE)</td>
<td>% of all adult inpatients who have had a VTE risk assessment on admission to hospital.</td>
<td>2.5%</td>
<td>93,137</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 1: Risk assessment</td>
<td></td>
<td></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>
</tr>
<tr>
<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>
</tr>
<tr>
<td></td>
<td>Part 1: Phased expansion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part 2: response rate and improvement</td>
<td></td>
<td>2.0%</td>
<td>74,510</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Part 3: improvement on staff survey results</td>
<td></td>
<td>1.5%</td>
<td>55,882</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>Advancing Quality (AQ): Acute Myocardial</td>
<td>Implement the AQ care pathway for Acute Myocardial Infarction</td>
<td>0.4%</td>
<td>14,902</td>
<td>✓</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Infarction</td>
<td></td>
<td></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>
</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>
</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>
</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>
</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>
</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>
</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>
</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>
</tr>
<tr>
<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 (84,670 each group)</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Staff Engagement Part 1: Care rounds</td>
<td>Implementation of care rounds.</td>
<td>10.6282%</td>
<td>395,950 (total) 131,984</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Staff Engagement 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>43,994 (each group)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Part 3: Shared decision making in outpatient services: (cardiac rehabilitation, women on high risk pathway, acne services)

Measure and evaluate shared decision making in outpatients using the following services: cardiac rehabilitation, women on the high risk antenatal pathway, patients with acne.

| 16 | Pressure ulcers:  
Part 1: Training | Increase the number of eligible clinical staff in post who have attended training for pressure ulcer prevention, assessment and management. | 6.8182% | 254,010 | ✓ |
| 17 | Prognostication and advance care planning | Identify and support patients in their last 12 months of life. | 6.8182% | 254,010 | ✓ |
| 18 | Medicines management | Reduce harm from omitted and delayed medicines in hospital. | 6.8182% | 254,010 | ✓ |
| 19 | Improving inhaler technique | Measure and improve inhaler technique for inpatients. | 6.8182% | 254,100 | ✓ |
| 20 | Advice line for GPs | Provide dedicated time where consultants are available on a regular basis to discuss patients’ management with GPs. | 6.8182% | 254,100 | ✓ |
| 21 | Retinopathy screening | Achieve 95% screening rate for retinopathy of prematurity (RoP) | 32,466 | ✓ |
| 22 | Total parenteral nutrition administration | Timely administration of total parenteral nutrition (TPN) for preterm infants | 32,466 | ✓ |

**RAG status:**

- **Achieved**
- **Off track but recoverable**  
  (applies only to Advancing Quality CQUIN where data is delayed by 4 months)
Not achieved
**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 January and March 2014, 100% of applicable patients were included in the NHS Safety Thermometer data collection process and this data was submitted to the NHS Information Centre.

The Trust has consistently achieved this level of performance throughout the year.

**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 for three consecutive months.

Progress Report
Since July 2013, when a dementia support assistant was appointed to support processes on the wards and data collection of the results, the Trust has consistently achieved 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>
<tr>
<td>January 2014</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>February 2014</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>March 2014</td>
<td>96%</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.

The awareness training 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.

On-going informal training and support is provided on a day to day basis by the dementia liaison nurse and the Dignity Matron. Plans are in place for further structured training provided by an Advanced Nurse Practitioner in dementia care from the local mental health Trust. This aims to address safe and sensitive ways to look after people with dementia within an acute setting.

Work has continued with Cheshire Hospices Education to provide support for staff caring for patients with dementia at end of life.

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 living with dementia. It has been a recurrent theme that responses to the audit have been low, despite all carers being given an information pack (containing the audit questionnaire).

Carers who do respond state that they felt supported by the hospital during their person’s stay. Carers report that, in most cases, they had been able to find someone to discuss any concerns regarding their person’s care. All clinical areas have an increasing awareness of the dementia nurse role and refer for clinical and carer support as needed.

The “Information about Me to Help You” document is supplied to carers of all people living with dementia, as near to admission as possible. All carers report receiving this and found it useful as a pen portrait of needs. Staff also find the booklet valuable in guiding sensitive and individualised care.

There has been variation throughout the quarter in carer feedback about how involved they felt during their person’s admission (54-100%). The dementia care bundle that is being developed will address this by enhancing partnership working with carers, involving them from the outset as experts in their person’s care. Audit figures show that all carers have been able to visit without restriction if required.

During this quarter, most of those surveyed felt they were updated about the medical treatment that their person was receiving. However, the majority of these felt that this only took place when they actively enquired. 57% of those surveyed in February reported being involved in discharge planning for their relative, whilst the remainder felt that discharge planning had not been relevant at the time of audit completion.

The dementia liaison nurse continues to work alongside ward staff and social care colleagues to improve carers’ experiences surrounding information provision and involvement in discharge planning.

The majority of carers audited throughout the quarter (86% in February and 81% in January) reported that they felt staff had a good understanding of dementia.
All carers who completed the audit reported that they had received written information about organisations representing people with dementia, alongside detailed literature from the Alzheimer's Society.

All carers are provided with information to sign post them to available resources, including how to access a carers' assessment. The Alzheimer's Society also has an information stand in the main out patients department where information can be accessed by all.
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% throughout 2013/14.

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 96%
January 2014 99.1%
February 2014 99.4%
March 2014 – Data not available at the time of the report.

Status

14
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 no confirmed hospital acquired VTEs in the final quarter of 2013/2014.

April 2013        No reported hospital associated thrombosis
May 2013          Two 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         Five 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      One hospital associated thrombosis were reported. Root cause analysis investigations have been undertaken
November 2013     One hospital associated thrombosis was reported. Root cause analysis investigation has been undertaken
December 2013     Two hospital associated thrombosis was reported. Root cause analysis investigation has been undertaken
January 2014      No reported hospital associated thrombosis confirmed to date
February 2014     No reported hospital associated thrombosis confirmed to date
March 2014        No reported hospital associated thrombosis confirmed to date

Status

✓
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 is using a texting service to ask the questions 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).

As shown in the graph below, the response rate has improved since the texting service began and the net promoter score is variable amongst the various touch points of care since this started to be collated in December 2013.

Status

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

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

Progress Report
The Trust has achieved above 15% during the first three quarters of the year and achieved more than 20% during quarter 4.

<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>20%</td>
</tr>
<tr>
<td>January 2014</td>
<td>26%</td>
</tr>
<tr>
<td>February 2014</td>
<td>26%</td>
</tr>
<tr>
<td>March 2014</td>
<td>25%</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
The Friends and Family Test questions from the annual staff survey are:

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

The 2013/14 staff survey results were published in February 2014 and showed that 66% of staff would recommend the Trust as a place to work. The average score for acute Trusts was 59%.

66% of staff would also recommend the Trust as a place to receive treatment. The average score for acute Trusts was 64%.

The results equate to a staff engagement score of 3.76 out of 5. This is an improvement on the Trust’s performance in the 2012/13 staff survey where the score was 3.70 out of 5. The average score for acute Trusts in 2031/14 was 3.74.

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 have to receive all the care elements. Current performance is summarised in the graph below. The slight dip in August’s performance has been investigated by the clinical team and the patients have received appropriate treatment. The database will be updated accordingly. The Trust remains a consistently high performer in this area and will meet the year-end 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 have to receive all the care elements.

The current performance is summarised in the graph below. The Trust has exceeded the target for most of this financial year. Occasionally, the heart failure team is not informed of a new diagnosis of heart failure which can lead to inconsistencies in practice. The heart failure team review the 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. Although off track at the start of the financial year, the Trust is likely to meet this target by year end.

![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 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 patients undergoing hip or knee replacement surgery. Changes to the criteria (reducing the time frame form 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 the 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 has shown some improvement in this measure. However, despite improvements, the Trust will not attain the target required for this financial year.
Hip and Knee Overview

- Appropriate Duration
- Prophylactic Antibiotics within one hour prior to surgery
- Appropriate Antibiotic regime
- Prophylactic Antibiotics discontinued within 24 hours
- VTE Prophylaxis ordered
- VTE Prophylaxis Timely
- Appropriate Care Score

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 have to receive all the care elements. A new pathway has been developed and 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 which began its pilot in November. It can be seen the ACS performance overall has improved over the year to date.

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**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.

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 remains under discussion with the commissioners.
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. The Trust is awaiting confirmation of CCG clinical leads for EPR and enhancing systems work streams.

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

Working with CCG representatives, work has progressed in deployment of E-mis web across the Trust

In addition, discussions are taking place regarding the use of the Medical Interoperability Gateway (MIG) as a means of sharing clinical information between the CCG and the Trust. The scheduled meeting January 2014 took place with agreements by all parties to explore the opportunity further.

Work has also taken place in relation to the Summary Care Records (SCR). Over the past months, there has been a concerted effort to upload patient information into the SCR. Working alongside the CCG, the Trust is reviewing how best this information can be used.

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 4 requires an audit of the number of AUDIT - C forms provided to primary care following assessment in the surgical and medical assessment areas (target = 50%)

Quarter 4 also requires the progression of plans to introduce the assessment process into the emergency department.

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

The alcohol assessment is undertaken with all emergency 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.

In Quarter 4, 81% of patients attending the surgical assessment areas have been assessed using the AUDIT - C form. All forms identified as positive, and with the patients consent, 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, 87% of patients have been assessed using the AUDIT - C form. This represents 2,049 patients. 162 patients were assessed as positive and 84 patients agreed to their forms being faxed to their GP and referral to HALS.

Discussions are underway with clinicians in the emergency department to progress the implementation of the assessment form into this area.

Status
✓
Goal 12: Readmissions

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

The intention was to work with the Commissioners to identify three clinical areas where readmissions are high and review the specific data for this activity. An action plan was then to be developed and implemented throughout quarters 3 and 4.

**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. Specific work has been undertaken to support elderly patients admitted from nursing homes, which has involved daily communication and joint planning for discharge with 27 nursing homes from local areas.

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.

The number of readmissions has fallen from 6.8% in April 2013 to 6.1% in February 2014 and, overall, the Trust’s performance continues to be better than peer when compared against other acute Trusts in the North of England.

**Status**
Goal 13: Reducing Cancellations

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

Progress Report
In January 2014, the Trust completed its planned roll out of a partial booking system for follow up patients. Although the full effect of this will not take place for a further 6-12 months, there has already been a 10% reduction in hospital initiated patient cancellations demonstrated up to February 2014. It is anticipated that this will continue over the months ahead and the impact will be a further significant reduction by March 2015.

The Trust has an established project group for reviewing outpatient services which has senior representation from all specialty areas across the Trust. This is one of the three key projects being progressed in the Trust and is a focus of high priority for the organisation. The work of the group is to improve the quality of outpatient services delivered for the Trust’s patients that includes the continual reduction of both hospital and patient initiated clinic cancellations as a key outcome. To support this improvement, there is focussed work in progress to review all specialty areas to ensure that patients are given adequate notice and choice of their appointment date.

A working group also 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 women & children’s 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 continuing 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.

The electronic Theatre Man system has over half the surgical specialities entered on it and this will be pivotal in helping to reduce elective cancellations through effective scheduling. The system also supports the management of patient flow during the course of theatre lists taking place which helps to make efficient use of the capacity. During the year, the Trust has seen a reduction of approximately 15% in cancelled operations.

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 new boards have been designed with clearer information on them. They are in the process of being made by an outside contractor and the staff expect them to be delivered within the next month.

- **Reduce waiting times for appointments:**
  The new Wednesday / Thursday clinic templates are now in operation and staff/patients have reported improved flow and less obvious delays.

- **Improve use of Pre-operative assessment (POAC):**
  Same day POAC is now assessed with individual patients and staff report this is more flexible approach

- **Reduce waiting times for investigations:**

- **There are discussions continuing to take place to try to improve availability/timeliness of MRI imaging**

- **Improve the environment in the waiting area:**
  A television has been purchased and has been installed in the clinic waiting area. Seating has also been changed in the clinic waiting area to facilitate better use of space. This also helps with hearing/sight impaired patients who are now facing the direction from which the staff call them through to clinic
**Glaucoma**

A review of feedback received from the focus groups held in September and October 2013 has taken place and two quality indicators were 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. The next support group meeting is scheduled to take place on 18 June in the Winnington Park Recreation Club Northwich 2-4.30pm. Guest speakers will included an ophthalmic consultant, nursing teams, social workers and the International Glaucoma Association. This will be advertised through the local media, flyers and through our clinics in the Eye Care Centre. It is hoped to build on the excellent attendance and feedback from the first support group.

2. **Two senior technicians to be available to undertake diagnostic tests at Glaucoma clinics**
   
It is nationally recognised that the demand in Ophthalmology has grown at a rapid pace. The development of technical diagnostic imaging for patients with ophthalmic conditions has also increased significantly in the last 2 years. The majority of patients now attending new or follow up appointments will require one or more of the following tests to diagnose / monitor disease progression:
   - Ocular Coherence Topography (OCT)
   - Glaucoma Diagnosis Scan (GDx)
   - Humphrey Visual Field analysis

Investment agreed within the approved business case has supported a number of changes to the nursing workforce within Ophthalmology, to deliver the current demand for ophthalmic imaging. A number of new roles were introduced in Jan 2014 including:
   - Band 5 Ophthalmic Photographer
   - Band 4 Ophthalmic Assistant Practitioner role
   - New Band 3 Ophthalmic Technician creating a total of 4.81 whole time equivalent staff

The new Band 3 Ophthalmic Technicians are being supported through a structured developmental programme to progress and achieve the skills and competencies required for this technical role. These new roles will support senior technicians being available to undertake diagnostic tests at Glaucoma clinics.

These changes will benefit both patients and carers by improving the quality of test undertaken and also improve patient flow through the clinic, reducing the appointment times.
**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 booklet ensuring all of the feedback received from the focus group was included.

Senior nursing staff from the stroke unit attended the Stroke Association user event in January 2014 where they discussed the results of patient questionnaires which led to the development of personal patient booklets.

The group were very impressed with the booklet and made some suggestions in relation to the content. Members felt that the booklet would have been beneficial to them during their stay on the ward, especially as they felt they did not retain some of the information given initially whilst in initial shock at their diagnosis.

Work is on-going in rewording some of the text as requested. The stroke Consultants have also read the booklet and contributed medical aspects in relation to stroke. Once completed, the booklet will then progress to being re-reviewed by the Stroke Association for feedback on the changes made prior to implementation.

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**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 4 requires the Commissioners to visit two ward areas from each clinical division to observe the adoption of care rounds in clinical practice and to discuss care rounds with patients and staff.

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, 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 the timings of the care rounds 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 five allocated times within a 24 hour period.

Dates are awaited from the Commissioners to observe the adoption of care rounds in practice. This will probably take place in May 2014.

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.

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:

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2. **Two senior technicians to be available to undertake diagnostic tests at Glaucoma clinics**
It is nationally recognised that the demand in Ophthalmology has grown at a rapid pace. The development of technical diagnostic imaging for patients with ophthalmic conditions has also increased significantly in the last 2 years. The majority of patients now attending new or follow up appointments will require one or more of the following tests to diagnose / monitor disease progression:
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These changes will benefit both patients and carers by improving the quality of test undertaken and also improve patient flow through the clinic, reducing the appointment times.
**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. The multi-disciplinary team are arranging to implement the stroke competency toolkit (SCoT) to help achieve this request. The toolkit is currently under review by the consultants, and staff are very keen to begin its completion.

The staff also felt they would like to participate in simple therapies/activities for suitable patients. In order to achieve this, they are currently looking at using the ImPRes booklet and there are 7 volunteers ready to assist with the implementation of this. The ImPRes booklet was discussed at the Stroke Association user event in January. The group felt it was very useful in understanding the difference between certain therapies and felt that it would enable them to receive ‘out of hours’ therapy to enhance their recovery. It is currently under review by the ward therapy team to decide how best to take this forward on an individual basis.
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 January and March 2014, 49 questionnaires were returned. Results demonstrated that patients continue to be happy with the service they receive and that they are involved in decision making in relation to their rehabilitation. They remain happy, not only with the venues available for CR, but also with having a choice of venue which makes their access easier. Written information was also appreciated and assisted their recovery. Where further support was required, this was delivered as part of individualised educational sessions and risk factor management.

Women on the high risk pathway
It was agreed to use knowledge gained from maternity participation in the Advancing Quality Alliance (AQUA) 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. Confirmation has been received from the National Options Grid Team that the Trust has permission to use their option grid when discussing with parents whether or not they wish to screen for Down’s syndrome. Modifications have been made and it requires final ratification.

2. Vaginal Birth after Caesarean Section (VBAC). Staff are continuing to use the existing checklist which is completed by medical staff when following the ‘previous Caesarean Section’ pathway. Two patient leaflets have been developed, ratified and professionally printed for use in the shared decision making consultations. One is for antenatal use and one for postnatal debriefing following a caesarean section.

3. Pre-Labour Rupture of Membranes.
An information leaflet incorporating an options grid has been developed and is issued in labour ward triage and the midwifery led unit. This is used in the triage for women with pre-labour rupture of membranes (PROM). Women with PROM have a discussion with the midwife regarding the options of induction of labour as opposed to watchful waiting for 24 hours. Data has not
yet been collated; however, anecdotally it appears that women prefer to wait 24 hours as opposed to having immediate induction.
Patients with acne
The survey undertaken in quarter three aimed to find out if patients felt they had been given enough information and enough time to make an informed decision about their choice of acne treatment. Thirty nine questionnaires were distributed and 36 responses were received back giving a response rate of 92%.

The findings suggest that the service is well received with patients feeling involved in the decisions about their treatment.

Positive feedback was given regarding the consultation with the Dermatology specialist nurse; 100% of patients agreeing that they had enough time to ask questions and that their questions were answered fully. Patients were questioned about the information received both verbally and written and all patients gave positive feedback. All patients felt they had been given enough time and enough information to make an informed decision about their acne treatment.

All patients with relatives living within the U.K would be likely or very likely to recommend Leighton Hospital to relatives and friends. All patients felt that they were treated with respect and dignity.

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.  

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 and in quarter 4, a further 207 staff were trained.  

This makes a total of 675 staff trained in pressure ulcer assessment, prevention and management. This equates to 82% of staff, as there are 817 staff working within the medical and surgical wards who are eligible to receive such training.
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% by the end of quarter 4.

Progress Report

Assessment and management
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 were discussed at the pressure ulcer operational group, which meets every month.

10% reduction in the incidence of hospital acquired pressure ulcers

In 2012/2013 – 290 hospital acquired pressure ulcers were reported
In 2013/2014 – 239 hospital acquired pressure ulcers have been reported
This equates to an 18% reduction in the number of hospital acquired pressure ulcers in 2013/2014 compared to the previous financial year.

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 available as a direct link from the Trust's intranet site. Drop in education sessions have been provided by the specialist palliative care team (SPCT) and the end of life facilitators for all clinical areas. Achieved.

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 been added to the current codes at the Trust. The SPCT is 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). Achieved.

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

The community 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 end of life care (EoLC) discussions/actions including GSF referral and ACP are recorded on a centrally held electronic template. The team feel well supported and will contact the SPCT if additional training is required. Achieved.

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. Achieved.

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 care issues. **Achieved.**

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).

Results of spot audit undertaken by SPCT showing the how many booklets were offered/ given out in January 2014

<table>
<thead>
<tr>
<th>Not Recorded</th>
<th>Given</th>
<th>Not Applicable</th>
<th>Refused</th>
<th>Previous ACP in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>16</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

This demonstrates that there were a high number of patients referred to the SPCT for whom the booklet was not appropriate at the time they were seen. This is because either the patient was drowsy / confused or was too unwell (i.e. in last few days of life).

In addition the Heart Failure Team have also given out 13 booklets during 2014.

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 appointed a Dementia Lead Nurse. This nurse is the point of contact for all patients and carers admitted to the hospital with a diagnosis of dementia and is pivotal in having end of life care planning discussions with appropriate patients. Following discussions with the end of life service model and the SPCT, the dementia nurse is aware of how to capture this information. She has access to, and uses, the discharge summary for end of life patients. An audit of 358 patient deaths across Central & Eastern Cheshire during 2013/14 showed that 78% of non-cancer patients with an established preferred place of death achieved their wish (this audit included people with dementia). **Achieved.**

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. The number of forms completed advising GPs to add a patient to the GSF was 93 in total and this included 15 non cancer patients. **Achieved.**

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.

Audits of omitted and delayed medicines have been undertaken to determine progress against the baseline audit which was 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 task...
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 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 was commenced in January 2014.

The audit results were collected on 1st April 2014.

Of the 30 patients audited and counselled, 3 patients were re-admitted with an exacerbation of COPD or asthma during the audit period (this represented an 11% readmission rate as 1 patient remained an inpatient and 1 patient died).

100% of patients who required a device change received a device change.

100% of patients were appropriately referred to the integrated respiratory team and

100% of patients had information about counselling documented on to their discharge letter.

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.

The Advice & Guidance Service commenced on the 2nd January 2014.

The paediatric mailbox is reviewed Monday – Friday by a Consultant Paediatrician.

Between January and March 2014:

- 45 referrals were received by the Paediatric Department
- 53% required advice only. 4% needed admission. The remainder received an out-patient appointment
- 88% received a response within 24 hours. The longest wait was 31 hours
- 15 GP Practices have used the service
- 63% of referrals have been received from Vale Royal GPs and 33% from South Cheshire GPs.

Feedback from GPs

- "Paediatric advice email service at MCHFT worked brilliantly for me (and patient) today"
- "Service seemed too good to be true"
- "This email service has been excellent (I have used it several times)".
The gynaecology mailbox is reviewed three times a week by the Consultant of the Week.

Between January and March 2014:

- 15 referrals were received to the gynaecology department
- 60% required advice only. 40% received an out-patient appointment
- 33% received a response within 48 hours
- 6 GP Practices have used the service
- 86% of referrals have been received from Vale Royal GPs and 7% from South Cheshire GPs.

The main issue for the GPs has been the inability to use the advice and guidance template (produced in Office 2010) which is incompatible with their current software. This is being addressed by the IT Support Team and a rolling programme to update the software has commenced.
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 31st March 2014

<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>
<tr>
<td>Jan – March 2014</td>
<td>10</td>
<td>9</td>
<td>90%</td>
</tr>
</tbody>
</table>
**Action plan:** The Badger.net reporting tool has been amended to reflect the criteria of *Retinopathy screen in window*. This is the number of babies discharged in the month who were eligible for screening in the unit, based on NNAP analysis criteria, who were discharged home before first screen and who were then screened as an outpatient within the extended screening window. These babies are screened on time but are classified in this way by NNAP.

For 2013/14, those babies meeting the criteria for inclusion for retinopathy screening: All (100%) who were still an inpatient at the time the first screen was due were screened on time and All (100%) who were discharged home before the first screen was due were screened on time.
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 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>
</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 1st October 2013 – 31st December 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>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

**Quarter 4 data 1st January 2014 – 31st March 2014**

<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>Jan 2014</td>
<td>0</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Feb 2014</td>
<td>0</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Mar 2014</td>
<td>0</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Action plan</td>
<td>Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>✔️</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commissioners to confirm revised wording for CQUIN.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>