Quality Improvement Plan: 2012-2015
Supporting the delivery of High Quality Care

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1. What are we trying to accomplish?

The Trust corporate quality strategy sets out a vision for the organisation and identifies key strategic aims. As part of that strategy and in addition to the activity described (Appendix 1), we have also set out specific quality improvement projects. Continuous improvement, focused on the quality of services and the care we provide to our patients’ is essential for the achievement of these aims and to reflect ‘safe, caring, reliable’ care. The improvement plan describes how we are going to meet those improvement aims.

KEY AIMS:

SAFE: Provide safe care by reducing the risk of harm
- Reduce mortality: achieve a position in 10% of organisations with lowest risk adjusted mortality
- Reduce Harm: 95% of patients are harm-free

CARING: Own and enhance the patient experience, end to end
- Improve the patient/staff experience: achieve top 20% for patient and staff experience surveys

RELIABLE: Deliver effective care systematically and consistently
- Provide reliable care: Achieve 95% reliability across LTC pathways and all NICE Standards

2. Delivering the Quality Improvement Plan: A programme of projects

The overarching vision and activities to support that vision, highlighted in our quality strategy to provide ‘safe, caring and reliable’ care will be achieved in the first year by a series of further supporting improvement projects as part of our Quality Account requirements.

The strategic priority improvement areas have been developed by integrating and analysing programmes of work, reviewing quality information and alignment to our CQUINs and Quality Account agendas.

Commissioning for Quality and Innovation Network (CQUIN)

We have been in consultation with commissioners and patient stakeholders and the targets for next year are currently being agreed. The targets reflect our integrated approach as an acute and community provider and our progress against last year’s CQUIN targets and related improvement programmes, they include:
- National Targets: VTE and prophylaxis (continued), patient experience feedback (continued) and a new target relating to patients suffering the symptoms of Dementia
- Local targets include:
- Safety: clinical communication continued and enhanced further via handover programme, NHS Safety Thermometer that includes, falls, VTE, Pressure Ulcers and UTIs and Safeguarding
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- Experience: Further development of end of life care, improving patient experience in A&E
- Reliability/Effectiveness: Development of non-elective and planned care pathways

The improvement programmes below align to our strategic objectives, CQUINs and our Quality Account requirements.

SAFE: Reducing mortality and harm

- Extend the Never Events focus to ensure that newly identified patient safety leads within operational teams monitor and further develop ways to reduce the risk of these events occurring
- NHS Safety Thermometer programmes to reduce Falls, VTE, Pressure Ulcers and UTIs will be led by CNO and supported by medical, nursing and AHP teams to ensure that we show an increase in patients who are ‘harm-free’ within the organisation
- To ensure that all Trust medicine management systems and processes adhere to The Royal Pharmaceutical Society Safe and Secure Storage and Handling of Medicines guidance (2005).
- Handover, communication are key contributory factors for all safety incidents/complaints and improving our communication across the care pathway will be a key programme of work in the next year and linked to the preparation towards the introduction of 24/7 working.

CARING: Patient focused

- Deliver the locally agreed improvement targets for early identification of patients with dementia – Find, Assess and Refer (FAR) - in relation to all admitted patients aged 75 years and older by April 2013 and ensure that all CQUIN targets are met and compliance with NICE Quality Standards for Dementia.
- Increase compliance to 95% of 5 key measures on the Liverpool Care of the Dying Pathway (LCP) by April 2013
- Continue and expand the collation of information from our patients across the community via the Patient Experience tracker and show annual improvements in positive responses.

RELIABLE: Effective

- Meeting our QuIPP and CQUIN targets in our continued work on designing integrated pathways for five long term conditions, emergency admissions/re-admissions.
- Increasing the number of health assessments carried out for looked after children form April 2012 baseline.

Learning from Technology Development

High Impact Innovations (DH 2012) requires NHS Trust to prove to commissioners that they are implanting technological and innovative solutions to improve quality. As a Trust we are already exploring the use of technology to reduce face to face contacts i.e. electronic consultations using telemedicine, email/text reminders, Strata-pathways, we need to continue to do more to drive down inappropriate and unnecessary contacts. Opportunities to explore the use of technology further should be sought for example:
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- We will look for new technologies and work with procurement to ensure we have a continued ethos of procuring for safety i.e Oesophageal Doppler Monitoring (ODM) to assist anaesthetists in safe administration of fluid and drugs
- Consider implementing the 3 million Lives –Whole Systems Demonstrator programme
- Launch local drive to fully implement fluid monitoring technology into practice, ensuring its compatibility with EPR
- Review Decision making tools and incorporate these into EPR/SystmOne

Appendix 2, outlines in more detail our quality projects for this year, as reflected in our Annual Quality Account and sets out our 3 year objectives (including CQUIN targets).

Additional activity will be outlined in the relevant supporting strategies identified within the quality strategy. All Quality Indicators are included in and monitored via our Quality Account report.

3. Improvement approaches

We intend to implement the proposed projects using appropriate quality improvement methods on a project by project basis. The delivery of the strategy will therefore be through a programme management approach to a series of projects, linked to our corporate objectives. Some projects will already have a proven change package and are intended to address system wide issues involving many stakeholders and several microsystems (specialities) we will use the IHI Breakthrough Series collaborative model, as we did with the falls collaborative

Lean

Lean methodology is being used in taking forward our QIPP programmes, supported by the Service Improvement directorate. Lean methodology aims to map out and eliminate waste and improve quality and efficiency whilst reducing costs.

Clinical Microsystems: For smaller project it may be appropriate to take a more localised view, in this case Clinical Microsystems Approach (CMA). The CMA approach involves supporting teams to lead and manage their improvement work by focusing on the needs of the patient. Teams are supported in identifying and addressing areas for improvement through a framework of data collection and tools and techniques, PDSA, case review for example. The focus of clinical microsystem approaches is to ensure the smallest replicable unit (for example ward, department, service), within the organisation is performing optimally. We will therefore require different teams to take the programmes forward depending on whether or not the change relates to specific services or is a trust or system wide programme.

Organisational Culture

Organisational culture is very difficult to define but is vital to address if the ambition to be the ‘best in class’ is to be achieved. Organisational culture can be defined as the assumed understandings between the staff of an organisation. It means that they share views on the way staff should work
together and treat each other and their patients. We have an ambition to be an organisation that has a safety culture with the main elements of:

- Open and frequent communication
- High functioning multi-disciplinary teams
- ‘Just’ culture: understanding of systems vs individual errors
- Robust error reporting systems that ‘close the loop’
- HR practices that support a culture of safety
- Strong clinical Leadership at all levels
- Willingness to address bad behaviours
- Accountability for improvement and safety at all levels
- Measurement and information that is of high quality, available real time and supports assurance, governance and performance monitoring systems and processes and that is used effectively by all staff.

**Workforce Development**

Over the next 3 years we will embark on a series of projects aimed at fostering an enhanced culture of quality and safety. These initiatives include training and coaching in teamwork and communication. Human Factors application in system development and integration of quality and improvement programmes into every day working at every level. The strategy identifies some of these programmes in addition to the work currently undertaken by the service Improvement directorate in relation to promoting our core values.

In order to sustain change we need to engage staff fully in the improvement agenda. We will do this by allowing ownership of the agenda to staff, ensuring strong clinical leadership and accountability at all levels, building the capacity and capability of our staff, both clinical and managerial across the organisation. The list of capabilities needed to drive system wide improvement includes:

- An understanding of Human Factors, systems thinking, and patient safety
- Concept of safety systems, reliability assessments
- Customer Care
- Improvement methodologies, including scale up and spread
- Change management principles
- Measurement skills and knowledge
- Flow and service redesign management

We will engage the support of the corporate teams, along with relevant HR executive directors and teams to further develop our capacity and capability programmes, ensuring that all staff also meet all MAST requirements. Quality advisors will act as clinical micro system coaches to ensure that all areas improve their own settings in a systematic way. We further develop feedback systems and processes so that we are constantly assessing the ‘temperature gauge’ of staff in relation to their feelings, morale, level of engagement and to identify the support they need.
4 QUEST membership

The Trust became a member of NHS Quest and this network will enable us to accelerate the work outlined in the strategy. NHS Quest is a new model of working that is breaking down traditional boundaries and is focusing on networking among like-minded organisation across England with a shared ambition of improving safety and quality.

Founding members of QUEST have already demonstrated a pedigree of excellence through routinely reported metrics. Priorities have been set around reducing mortality, NHS Safety Thermometer and hospital re-admissions. These are all in line with our strategic plans for improvement, being an active member will help us to achieve these aims. A review of our membership will be taken in 2013/14 when it is due for renewal.

5 Project approach

The timescales for each of these projects will vary, depending on the availability and complexity of underlying re-design, resources and complexity of the change, data requirements and service integration. All programmes will require a project initiation document and plan.

All programmes will be included in an overarching database to ensure we have oversight and knowledge of progress against all programmes. It is envisaged that each operational area will have their own quality programme board that will maintain and update progress against their own projects.

6 Risks and mitigation –Trust wide standardised approach

All programmes will utilise the trust wide risk management strategy approach, completing risk registers using the Datix system and managed as set out in the risk management strategy. The identified risk against not delivering CIP objectives and our improvement programmes and the potential impact to the organisation will be shared across and within the organisation via Datix web.

One of the most important risks to control is the size and number of the programmes going through the system. We need to take a planned, prioritised approach to ensure that we do not have a situation whereby the vision and focus is lost and staff suffer from ‘change fatigue’ or have to crisis manage change. It will also be important to monitor risks more closely during periods of large organisational change, i.e. EPR, 24/7 models, managing transition.

7. Conclusions

The improvement programmes need to be flexible and responsive to change with the changing needs of the organisation and external demands whilst re-structuring of the NHS continues. At the core of this plan is improving patient care and bringing about a step change in ‘how we improve and manage the quality agenda’. The aim is to make quality everyone’s business to increase the profile of the work staff currently do in relation to this agenda, bring about a system of total quality management that creates a culture of team working, efficient working practices, based on the newest technology, systems based thinking, best evidence and a culture of continuous improvement.
## Appendix 1: Our organisational development targets for 2012-15

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<thead>
<tr>
<th>Topic</th>
<th>2012-13</th>
<th>2014-15</th>
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<tbody>
<tr>
<td><strong>Strategies</strong></td>
<td>All supporting strategies agreed and implementation started</td>
<td>On-going implementation and review</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td>Executive leadership accountability agreed</td>
<td>Ongoing implementation and review</td>
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<td></td>
<td>Non-executive and governor involvement agreed</td>
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<td></td>
<td>Re-structuring of medical and nursing roles, responsibilities and accountabilities</td>
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<tr>
<td><strong>Structures and processes</strong></td>
<td>Review of performance management structures</td>
<td>On-going implementation and review</td>
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<td></td>
<td>Review of committee structures</td>
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<td></td>
<td>Strengthening of governance systems and processes, Investigation and Learning Unit</td>
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<tr>
<td><strong>Engaging staff, developing culture</strong></td>
<td>Workforce development programmes agreed</td>
<td>On-going implementation and review</td>
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<td></td>
<td>Clinical Director training programmes agreed</td>
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<td></td>
<td>Feedback and surveys developed</td>
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<tr>
<td><strong>Engaging patients</strong></td>
<td>Develop single point of access</td>
<td>On-going implementation and review</td>
</tr>
<tr>
<td></td>
<td>Review and develop communication and feedback systems</td>
<td></td>
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<tr>
<td></td>
<td>Engage patients in improvement programmes</td>
<td></td>
</tr>
<tr>
<td><strong>Information development</strong></td>
<td>Development of Business Intelligence Unit and team</td>
<td>On-going implementation and review</td>
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<td>Further development of other data sources and rationalisation of indicators</td>
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<td></td>
<td>Dashboard development at all levels</td>
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<tr>
<td><strong>Technology development</strong></td>
<td>Phase 1 and further implementation of EPR</td>
<td>On-going implementation and review</td>
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<td>Further development of SystmOne</td>
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<td>Decision tools review</td>
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<td>Fluid Balance monitoring tools</td>
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## Appendix 2: Detailed Improvement programme YEAR 1 (2012/13)

### Quality Account: 2012/13 (and on-going 2011/12) Improvement Programmes

<table>
<thead>
<tr>
<th>Topic</th>
<th>New or On-going</th>
<th>Objectives : 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAFE</strong></td>
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<tr>
<td>Never Events</td>
<td>On-going</td>
<td><strong>Zero Never Events</strong></td>
</tr>
<tr>
<td>Medicines Management</td>
<td>On-going, expanded</td>
<td><strong>Increase in compliance with safe and secure medicines management from April 2012 baseline.</strong></td>
</tr>
<tr>
<td>NHS Safety Thermometer</td>
<td>New</td>
<td><strong>Introduce and improve data collection in relation to falls, pressure ulcers, UTIs and VTE assessments in acute and community setting from April 2012 baseline.</strong></td>
</tr>
<tr>
<td>Communication</td>
<td>On-going</td>
<td><strong>Improve quality and timeliness of referral and discharge letters from April 2012 baseline.</strong></td>
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<tr>
<td><strong>CARING</strong></td>
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| End of Life care Governor Indicator | On-going Expanded | **Increasing compliance by 95% of 5 key measures on the Liverpool Care of the Dying Pathway (LCP) by April 2013**  
**Reducing the number of inappropriate Fast Track discharges to Community Health Care** |
| Patient Responsiveness       | On-going        | **Increasing our responsiveness to our patients needs using a composite indicator of care from April 2012 baseline,** |
| Dementia                     | New             | **“To deliver the locally agreed improvement targets for early identification of patients with dementia – Find, Assess and Refer (FAR) - in relation to all admitted patients aged 75 years and older by April 2013”** |
| **RELIABLE**                 |                 |                                                                                     |
| NICE Quality Standards       |                 |                                                                                     |
| Dementia                     |                 | **Meeting NICE quality standards for Dementia (as part of programme above)**          |
| Health Assessments for Looked after Children | New | **Increase the number of health assessments carried out for looked after children and young people from the April 2012 baseline.** |
| CQUIN                        | 2012/13 programmes | **As described**                                                                    |

Each of the new quality improvement initiatives and how we will achieve them is set out in the following pages.
Quality Improvement Plan 2012 - 2015

Our detailed NEW quality improvement projects for 2012/13

Priority 1a: Patient Safety Programmes (on-going and expanded)
To ensure that all Trust medicine management systems and processes adhere to The Royal Pharmaceutical Society Safe and Secure Storage and Handling of Medicines guidance (2005).

How and who collects the data
The Medicines Management Safety Group with the support of the clinical effectiveness and estates department will ensure that all quarterly audits are carried out to completion, that action plans and programmes of work are implemented robustly across the organisation, escalating any concerns to CSEC and the Board.

Why we were interested in this indicator
Annual audits carried out as part of 2011/12 programme in relation to our medicines code policy showed a level of compliance that required improvement. An action plan was developed and is currently being implemented and outcomes reported to CSEC.

What we are going to do
Over the course of 2012/13 the Trust will introduce further measures to improve practice and they will include:

- We will set up a Medicines Management Steering Group that includes Board Executive level leadership, relevant implementation leads and a project management approach to all actions identified in the annual audit of current practice in this area.
- The pharmacy and nursing teams and estates department will lead on implementing the improvement programme.
- Measures will be identified via the re-developed audit tools to assess the success of the programme with support from the Clinical Effectiveness Department.

How the data will be reported
The incidents and audits will be provided on a monthly basis to the Steering Group and on a monthly basis through the Medicines Safety Group and CSEC. The reports will be shared with all clinical staff and senior management, including the Board on a quarterly basis via the Quality Account report. On-going performance will be discussed, alongside all other indicators, at the regular meetings with the clinical service units.

Board Sponsor: Chief of Hospital
Executive Implementation Leads: Chief Pharmacist and Chief Nurse
Programme management: Relevant members of estates, pharmacy, clinical effectiveness teams.
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Priority 1b: (NEW): Introduce data collection for NHS Safety Thermometer

“Introduce and improve data collection in relation to falls, pressure ulcers, UTIs and VTE assessments in acute and community setting from April 2012 baseline.

How and who collects the data
Self-assessment forms will be developed for both acute and community setting to record data. On the second Tuesday of every month, every patient on every ward and every patient seen by community teams, will have an assessment made of their status in relation to falls, VTE, UTI and pressure ulcers. The data will then be scanned into our SNAP database, linked to a SQL programme that produces ‘real-time’ data and allows staff to access the information at all times via web portal to compare their progress and that of others.

Why we were interested in this indicator
When a patient suffers one harm (for example a fall) then they are at higher risk of subsequent harm. Ensuring that patients come to ‘no harm’ whilst in our care means they will have a better experience of care and also their length of stay will be reduced. The NHS Safety Thermometer was introduced as a pilot programme via our NHS Quest membership and given National CQUIN status this year.

How these will be reported
All information is reported on monthly basis to Patient Safety committee and upwards to CSEC in our quarterly reports. Progress will be included in the quarterly quality account report to CSEC and the Board.

Board Sponsor: Chief Nurse
Implementation Leads : Director of Quality and Standards
Programme managers: Group Nurses, System Developer, Patient Safety Team

Priority 2a Patient Experience (NEW)
“To deliver the locally agreed improvement targets for early identification of patients with dementia – Find, Assess and Refer (FAR) - in relation to all admitted patients aged 75 years and older by April 2013”

How and who collects the data
Data will be collected in line with national requirements and guidance – still to be provided.

Why we were interested in this indicator
Dementia is a significant challenge for the NHS with circa 25% beds occupied with people with dementia. Such patients tend to have extended lengths of stay, and the hospital ward environment is often recognised to be the wrong place for their long term well-being. In addition the percentage of the population with known dementia is set to increase quite significantly over forthcoming years and clinical evidence identifies that early diagnosis and commencement of appropriate interventions and drug therapies may have a significant impact on the individual and their family.

What we are going to do
Over the course of 2012/13 the Trust will introduce the as yet to be determined ‘FAR’ measures to include:

- Identify (Find) people with dementia - clarify on admission patients aged 75 years plus who have had significant problems with their memory over the past 12 months
- Assess people with identified memory deterioration with the – to be agreed – dementia risk assessment tool.
- Refer on for advice – once dementia risk assessment has been completed appropriate referral on to Liaison Team, a Memory Clinic or the GP.
Quality Improvement Plan 2012 - 2015

• Continue to ensure that all NICE Quality Standards for Dementia are met

How the data will be reported
Upon receipt of the (as yet unpublished) national guidance performance information will be provided to a number of Trust committees – including the Dementia Strategy Committee, Patient Experience Committee and on a quarterly basis through CSEC via the Quality Account report. The reports will be shared with all clinical staff and senior management, including the Board on a monthly basis. On-going performance will be discussed, alongside all other indicators, at the regular meetings with the clinical service units and via the Dementia Steering Group and the Healthcare of Tomorrow Programme Board (CQUINs module) and reported quarterly via the Quality Account Report to the Board.

Board Sponsor: Chief of Hospital, Executive Implementation Lead: Chief Nurse
Programme support: Dementia Clinical Lead, Deputy Chief Nurse, Relevant members of clinical effectiveness/information teams

Priority 3a: Clinical Effectiveness Programmes (NEW)
Increase the number of health assessments carried out for looked after children and young people from the April 2012 baseline.

How and who collects the Data?
This indicator will measure the effectiveness of the service in meeting statutory guidance on provision of health assessments for looked after children, with the goal of promoting their health and well being. Data for health assessments is currently obtained both from SystmOne and from data collection recorded manually from ‘entry to care’ medicals. Work is being taken forward to enable this information to be collected entirely from SystmOne.

Why is it important to us?
Evidence shows that looked after children, when entering care, often have additional health needs, due in part to the impact of poverty, abuse and neglect. It is important that these children receive their health assessment to identify individual needs and provide the correct level of care.

All children and young people should have an entry to care medical within 20 working days of entry to care, Children under the age of 5 years require a health assessment every 6 months, children and young people age 5-16 years require an annual health assessment. This can extend to age 18 if the young person has significant additional needs. In 2011/2012 data collection highlighted that statutory time frames were not being met, therefore work has been undertaken to review processes and build capacity. We need to consolidate this and ensure that standards are maintained.

What are we going to do?

• Work will continue to closely monitor capacity and demand for entry to care medicals, this will include reviews and follow up when a child has not attended scheduled appointments.

• Deliver staff training to ensure high quality health reviews by Universal Children’s Health Services

• Work with commissioners and Strategic Health Authority to enable reciprocal arrangements for children who are placed out of area.

How and where will the progress be reported?

• Via the Looked after Children’s Quality and Performance Group which reports to the Children and Young People Health Service performance and governance group.

• Via annual report and quarterly Quality Account report

Board Sponsor: Chief of Community Services
Implementation Leads: Quality Governance Lead, Head of Service
Programme managers: Health visitors
<table>
<thead>
<tr>
<th>Topic</th>
<th>2013/14</th>
<th>2014/15</th>
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<tbody>
<tr>
<td><strong>SAFE</strong></td>
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<tr>
<td>Reducing mortality</td>
<td>Plan for 24/7 working</td>
<td>Implement 24/7 working</td>
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<tr>
<td></td>
<td>&lt;75 SHMI trust wide and specialty specific</td>
<td>&lt;70 SHMI trust wide and specialty specific</td>
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<tr>
<td></td>
<td>Top 15% lowest</td>
<td>Top 10% lowest</td>
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<tr>
<td>Never Events</td>
<td>On-going</td>
<td>Ongoing</td>
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<tr>
<td>Medicines Management</td>
<td>Full compliance Medicine Code</td>
<td>Year on year reduction in medication errors</td>
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<td></td>
<td>Reduction in medication errors</td>
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<tr>
<td>NHS Safety Thermometer</td>
<td>85% harm free patients</td>
<td>95% harm free patients</td>
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<td></td>
<td>Patient Safety Strategy implemented</td>
<td>Lowest 10% nationally falls, VTE, UTIs,</td>
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<td>Pressure Ulcers</td>
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<td>Communication</td>
<td>Roll out pilot electronic handover</td>
<td>Implement EPR handover assessments</td>
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<td>Technology programmes planned</td>
<td>Innovative Technology solutions</td>
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<td><strong>CARING</strong></td>
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<tr>
<td>End of Life care Governor Indicator</td>
<td>On-going</td>
<td>All patients on EOL provided high level of cared in appropriate setting</td>
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<td>100% compliance CQUINs</td>
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<tr>
<td>Patient Responsiveness</td>
<td>Full implementation of Patient Experience</td>
<td>Top 10% questions patient survey</td>
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<td>Strategy</td>
<td>E4E targets met</td>
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<td>Energising for Excellence (E4E)</td>
<td>Equality and Diversity System actions</td>
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<td>complete</td>
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<td>Dementia</td>
<td>Implementation of strategy</td>
<td>All patients with Dementia referred and</td>
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<td>cared for appropriately</td>
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<tr>
<td><strong>RELIABLE</strong></td>
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<tr>
<td>NICE Standards</td>
<td>Quality</td>
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<td>100% compliance NICE Standards</td>
<td>100% compliance NICE Standards</td>
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<td>Implementation of CE strategy</td>
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<td>5 LTC Pathways</td>
<td>85% reliability</td>
<td>95% reliability</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Targets met</td>
<td>Targets met</td>
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