University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper F

TRUST BOARD – 30th OCTOBER 2014

LEARNING LESSONS TO IMPROVE CARE

DIRECTOR:	Medical Director ~ Dr Kevin Harris
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DATE:	30th October 2014
PURPOSE:	To provide update to the Board on the progress made to implement the recommendations arising out of the learning lessons to improve care review
PREVIOUSLY CONSIDERED BY:	QAC
Objective(s) to which issue relates *	[Y] 1. Safe, high quality, patient-centred healthcare [Y] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [Y] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [Y] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [Y] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	All next of kin of patients in the review have been contacted. Meetings with next of kin have been offered and when taken up undertaken to explain the outcome of the review. There is "Healthwatch" representation on implementation Task Force overseeing the required actions. Public engagement events to explore themes from the review are planned for later in the year.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	-
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [x] **Board Assurance Framework** [ ] **Not Featured**

ACTION REQUIRED *

For decision [ ] For assurance [x] For information [x]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group
Leicestershire Partnership NHS Trust
University Hospitals of Leicester NHS Trust
West Leicestershire Clinical Commissioning Group

Learning Lessons to Improve Care

Quarterly update to boards

1. INTRODUCTION

The following paper reports the actions taken following publication of the Learning Lessons to Improve Care review in July 2014.

The review was commissioned by health organisations in Leicester, Leicestershire and Rutland and examined the quality care patients received. It identified that of the 381 case notes audited, 208 (55%) were identified as having significant lessons to learn. Of these 89 (23%) were found to be below an acceptable standard. Thematic analysis of the findings identified 47 themes, the 'Top 12' being:

- DNAR orders
- Clinical reasoning
- Palliative care
- Clinical management
- Discharge summary
- Fluid management
- Unexpected deterioration
- Discharge
- Severity of illness
- Early Warning Score
- Antibiotics
- Medication

Many of the issues described by the review were already recognised locally and nationally as key areas for improvement and as such in many instances action is already being taken. Nonetheless the review has shown where, as a whole local health system, effort should be focused.

The local health organisations involved in the review have expressed regret over the findings and made a shared and public commitment to address the issues raised by the review and to do all in our power together and individually, to improve the quality and experience of care in Leicester, Leicestershire and Rutland.

2. PROGRESS TO DATE

2.1 Development of the Clinical Task Force

In order to address the themes that were either cross-organisational or common across

NHS organisations, a Clinical Task Force was established. The task force includes senior clinical representatives from University Hospitals of Leicester NHS Trust (UHL), Leicestershire Partnership NHS Trust (LPT), and the three local Clinical Commissioning Groups. All members have the authority of their governing bodies/board to take forward the work to make the necessary improvements in patient care. In addition Public Health England, Healthwatch and the Local Medical Committee are also represented on the task force.

The aims of the task force are to develop a granular plan that has the specific detail of what needs to be done by who (based on the LLR Learning Lessons to Improve Care Five point plan) and has clear timelines and outcomes. The task force are also responsible for facilitating the delivery of the plan and for evaluating the impact of the plan.

The plan is focused in five work streams – public involvement, clinical leadership, end of life care, urgent care and integration of quality and safety.

In order to ensure that the learning from the review results in sustainable change it is necessary to direct resources into the plan. It is suggested that the implementation of the plan will be a three-year project and therefore will need resourcing accordingly. A business case has been developed and shared with constituent organisations to ensure that the appropriate level of resource is identified to enable to actions to be implemented fully. All organisations have been requested to support the recommendations in the Business Case.

2.2 Workstream – Public Involvement

Contact with families
Prior to publication of the review, the local NHS made contact with the 381 families of the patients whose case notes had been reviewed in the audit. Letters were sent to each of the families explaining the review and its findings and indicating whether the reviewers had identified acceptable or unacceptable care in the case of their loved one. Relatives were offered the opportunity to call a dedicated phone number to find out more and to access support. The phone lines were staffed by senior nursing staff and patient experience leads from across Leicester, Leicestershire and Rutland.

76 families called the call centre and meetings were offered to discuss the care their relatives had received. 33 relatives took the opportunity to meet with clinical teams, from UHL, primary care or NHS England.

The full analysis of the call logs and the outcomes from the meetings is currently underway. Early indications indicate that most families welcomed the opportunity to discuss the care that their relatives had received. It is interesting to note that anecdotal evidence from these calls suggests that often families whose loved one had received ‘unacceptable care’ had a different view. This means there could be a disconnect between relatives’ understanding of acceptable care and that of clinicians. Once the information has been fully analysed the findings and recommendations will be incorporated into the action plan.

Public listening events
All local health organisations are committed to listening to, and acting on the views of patients and their relatives and significant work already takes place to enable this. Following the contact with the relatives of the patients involved in the audit, it has become

clear that there is more we can do collectively to understand about how our patients, relatives and carers experience care in LLR and to take shared action to address this.

To start this process, three public events are being held in venues across LLR in October and November so that we can better understand this aspect of care quality.

In line with the clinical events we will be undertaking a full thematic analysis of the findings to further shape the actions required.

A full communications and engagement plan is also being developed to support further work with the public.

2.3 Workstream – Clinical Leadership

Clinical leadership plays a very important part of the work to act on the findings of the audit and make improvements for patients. The task force has facilitated the first of a number of events where clinical staff from all disciplines and from all organisations across LLR can come together to co-produce the solutions to the problems.

The first of these events was held on 9th October using Listening into Action methodology. A total of 67 clinicians attended the event from UHL, LPT and the three CCGs.

Early feedback from the event is included as Appendix 1. The task force is working in partnership with De Montfort University to analyse the output from the event and identify themes and actions.

2.4 Workstream – End of Life Care

In recognition of issues relating to end of life care, a group was established to take forward the actions necessary to improve end of life care. Whilst there are still some ongoing actions for the end of life group the following achievements have been realised:

- Unified approach to Do Not Attempt Cardio Pulmonary Rehabilitation (DNR CPR)
- A singe DNACPR form in use across Leicester, Leicestershire and Rutland and available electronically for GPs and EMAS
- Unified Advance Care planning
- Green bags and wallets in place to ensure all staff are aware of care plans
- Anticipatory drugs
- Location agreed to ensure all staff are aware of preferred location
- Community access identified
- Timely access to wheelchair provision for end of life patients
- Standardising leaflets and terminology

2.5 Workstream – Urgent Care

The task force is planning to review the full report from Ian Sturgess on the Urgent Care pathway and review the findings and recommendations in conjunction with the learning from the clinical and patient listening events. The aim is to take these to a joint primary/secondary care clinical event in December.

2.6 Workstream – integration of quality and safety

The task force has been working to ensure appropriate governance arrangements are in place. It has been deemed essential that the learning from the audit be incorporated into the workstreams for Better Care Together (BCT). To this end the task force will be working closely with the BCT Clinical Reference Group to ensure that the objectives for the two groups are closely aligned in the aim to better develop clinical leadership. In addition the actions identified from the report have been shared with the BCT Clinical Leads to ensure that they are included in the planning for the individual workstreams.

3. FUTURE PLANNING

The clinical task force is determined to see tangible outcomes from their work every month and have developed a planning grid to identify actions. The planning grid is included as appendix 2, but it should be noted that this is an iterative document that will change over time.

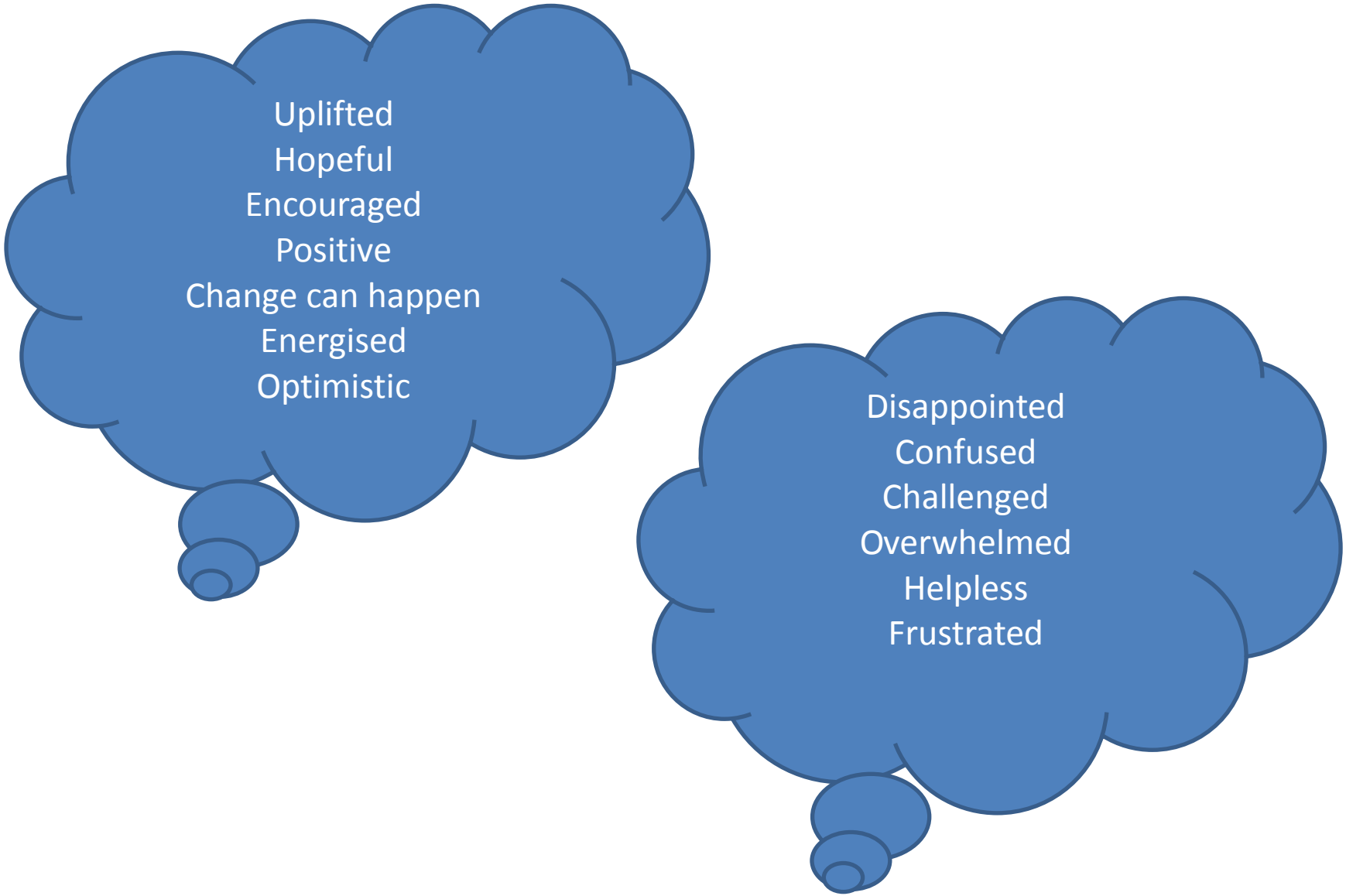
Key outcomes for the next quarter are as follows:

- Fast response to implement actions from the Listening events
- Repeat clinical event to ensure implementation of the actions and continues clinical engagement
- System clinical leadership development
- Identification of outcome indicators to ensure we can demonstrate progress
- Development of quality champions
- Agreement on the methodology to repeat the Learning Lessons study to allow us to benchmark ourselves.

4. RECOMMENDATIONS

Boards are requested to note the progress of the Learning Lessons to Improve Care Clinical Task Force.

Appendix 2 – evaluation from Listening into action event



Learning Lessons to Improve Care

NHS

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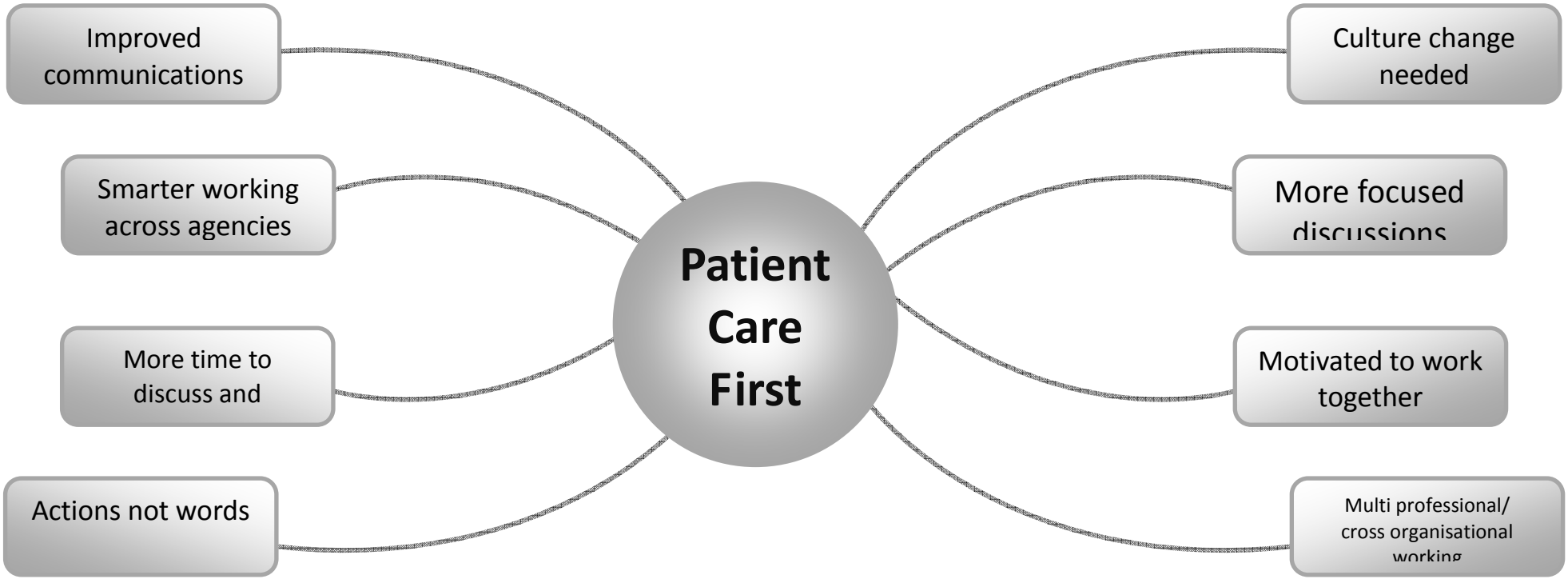

Appendix 2 - PLANNING GRID

MONTH	ACTION	LEAD	RESULTS/OUTCOME	COMMENT	ON-GOING
	Product, initiative event				Specific response to thematic analysis via clinical & operational huddles.
October	Clinical Summit - LIA, Public event	CTrev/RM	Clinical leadership & specific themes & actions. Patient &carer engagement,		
November	Postcards – shared decision making. Public events Impact report of bereaved relative stories. Communication highlight progress with individual institutional action plans Patient safety report.	RM/SV CTrev/RM CTrev RM Susan	Patient culture change & empowering patients, external facing LLR wide. Patient & carer engagement. Further development of the action plan. Duty of candour.		

	Serious incidents. Paper to all public Boards. Quick wins from LIA event. Commission learning lesson website & feedback mechanism (positive & negative) Receive IS report & agree appropriate actions for the task force. Journal article outlining work of CCGs in managing system quality.	Clennet. CTrev CTrev RM ML/KH ML	To monitor progress.		
December	Is quality and safety improving in LLR? Need performance dashboard commissioned by PwC. Way forward on repeat review by external organisation. Task force/LMC summit	ML CTF ML& KH	Metrics about joined up care in the whole health economy. Committed to a further study, awarding of the contract.		

	Launch hello my name is – across LLR.	Carole Ribbins.	Clinical leadership & engagement & top tips for GPs.		
January	Best example of integrated care & exceptional leadership Quality & care champions. Institutions to share their leadership strategy with the workforce. Event to encourage system leadership masterclass. PwC or Aiden Halligan	Carole Ribbins & Jude Smith DL, CTrev & CoB. CTF ML/KH	Measurement of clinical engagement, scale, plus xxx number of champions/leaders. System wide response. Culture development.		
February	Recognise the dying patient & talking to relatives about ACP upskilling. Shared record viewing EPR for EOL care.	RP/LF TB RP	Upskilled health economy in EOL care. UHL/practice interaction.		

	Enhanced SPN capability.				
March	Completion of review.				
April					
May					
June					
July					
August					
September	Conference to review progress & celebrate.				