Learning Lessons to Improve Care

Author: Head of Outcomes & Effectiveness Sponsor: Medical Director Trust Board paper H

Executive Summary

Context

In 2014 the Learning Lessons to Improve Care (LLtIC) Review was published. The LLtIC Review looked at the quality care provided to patients who died either in UHL or within 30 days of discharge during the financial year 2012/13 and identified '12 key themes' where care could be improved.

UHL undertook a gap analysis against the 12 themes to see whether there were existing or planned initiatives, and where there was a need for new work streams. These were then incorporated into a UHL LLtIC Action Plan. 85 actions were in the original 14/15 LLtIC Action Plan and progress was monitored by relevant sub-committees of the Executive Quality Board (EQB) with quarterly reporting to EQB.

An LLR Joint Action Plan was also agreed and overseen by the LLtIC Clinical Taskforce (CTF), which was up after the review with the purpose of 'establishing system-wide clinical leadership across LLR health organisations and to ensure that patient issues identified from the review are addressed across the health economy.

Questions

1. What progress has been made with both the UHL and LLR action plans?
2. What are the next steps?

Conclusion

At the end of 14/15 Quarter 4, there were 24 actions that had not been completed and it was agreed that a separate LLtIC Action Plan should continue into 15/16 rather than incorporate uncompleted actions into relevant sub committees' work programmes.

At the end of 15/16 the EQB received an update on progress (Appendix 1) and were advised that all but two of the actions had now been completed. It was noted that for the two 'open actions' - 'acting on results' action is being monitored by the Adult Critical and Augmented Care Board (now the Deteriorating Adult Care Board) and the 'policies and guidelines' action is

being monitored by the Policies & Guidelines Committee both of which report to the EQB. In respect of all actions identified in response to the LLtIC themes, on-going improvements and monitoring has been incorporated into the relevant subcommittees' work programmes. It was therefore agreed to close down the UHL LLtIC action plan.

Progress with the LLR Joint Action Plan was reviewed at the August meeting of the LLtIC CTF (Appendix 2) where it was agreed to close down the LLR Joint Action plan and focus on 4 remaining challenges:

- Undertake a second review – future actions and timelines will be dependent upon the outcome of the review.
- Developing a continuous learning culture – actions are being developed following the Learning from Incidents report (Appendix 3)
- System wide clinical leadership – this is being taken forward by the Better Care Together (BCT) Clinical Leadership Group
- Primary/Secondary/Community Care Interface – work is underway to ensure safe transfer of care from secondary to primary care.

The second review will again look at the care of patients who died either whilst an in-patient in UHL or within 30 days of discharge but will this time include all patients over a one month period and also patients who died whilst in Community Hospitals.

Input Sought

The Board is requested to:

- Receive the update on the UHL LLtIC Action Plan and to note that ongoing actions are being monitored by the relevant committees.
- Receive the update on the LLR Joint Action Plan and Support the ongoing actions for the LLtIC CTF and
- Support the proposal for a second review

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes ~~/No /Not applicable~~]
Effective, integrated emergency care	[Yes /~~No /Not applicable~~]
Consistently meeting national access standards	[~~Yes /No~~ /Not applicable]
Integrated care in partnership with others	[Yes ~~/No /Not applicable~~]
Enhanced delivery in research, innovation & ed'	[Yes ~~/No /Not applicable~~]
A caring, professional, engaged workforce	[Yes ~~/No /Not applicable~~]
Clinically sustainable services with excellent facilities	[Yes /~~No /Not applicable~~]
Financially sustainable NHS organisation	[~~Yes /No /~~Not applicable]
Enabled by excellent IM&T	[~~Yes /No /~~Not applicable]

2. This matter relates to the following **governance** initiatives:

Organisational Risk Register	[Yes ~~/No /Not applicable~~]
Board Assurance Framework	[~~Yes /No /~~Not applicable]

3. Related **Patient and Public Involvement** actions taken: [Yes]

4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

5. Scheduled date for the **next paper** on this topic: [TBC]

6. Executive Summaries should not exceed **1 page**. [My paper does not comply]

7. Papers should not exceed **7 pages.** [My paper does comply]

APPENDIX 1

'LEARNING LESSONS TO IMPROVE CARE REVIEW' ACTION PLAN – 15/16 – JUNE 16 UPDATE

DATE COMMENCED:	DATE OF LAST REVIEW:	DATE OF NEXT REVIEW:	MONITORING COMMITTEE:	COMMITTEE CHAIR:
APRIL 14	JUN 16	AUG 16	EXECUTIVE QUALITY BOARD	CHIEF EXECUTIVE

EXECUTIVE LEAD:	OPERATIONAL LEAD:
MEDICAL DIRECTOR	HEAD OF OUTCOMES & EFFECTIVENESS

Ref	LLtIC "Theme"	Work-Stream	Monitoring Committee	Action	Lead	Due Date	RAG	Progress update – June 16
1.	**Severity of Illness / Unexpected Deterioration and Responding to EWS**	Embedding e-handover with medical staff	AC&ACB	Revised implementation plan and monitoring usage	Asst Chief Nurse (JB)	End Mar 16	5	<u>Sept Update</u> Devices provided for Ward Teams. Current focus is on embedding on medical wards following period of training. Increased support to be provided to wards with appointment of NHSLA project team. <u>Feb/Mar 16 update</u> Training of electronic handover for medical teams will be complete by end of March allowing this to support handover processes within each speciality. The template allows recording of those patients who require a consultant review within 24 hours. <u>Jun 16 update</u> Training for all medical teams completed end of March. All medical staff have access to electronic handover (Nerve Centre) Monitoring of usage on going .
2.		EWS	AC&ACB	Development, validation and implementation of Early Warning Score tool	Asst Chief Nurse (JB)	End Mar 16	5	UHL EWS tool drafted, incorporating parameters used by Salford and Nottingham. <u>Jul 15 update</u> EWS chart drafted and sent out for consultation. Meeting to review all comments on 14/07/15 <u>Sept Update</u> Further changes made to EWS chart following feedback. Validation process to commence during October

Status key:	5	Complete	4	On track	3	Some delay-expect to complete as planned or implemented but not consistently delivering	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

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								Feb/Mar 16 update The UHL revised EW chart commenced roll out week commencing 29th February and will be completed by end of March. The recommended trigger levels within this tool are more sensitive than the existing system and means that this will provide an enhanced level of surveillance and clinical review of patients with greater specificity in supporting consistent identification of those at risk of clinical deterioration. Fluid balance is now incorporated in the UHL Adult EWS. Jun 16 update Roll out completed end of march Revised tool configured for capture of observations electronically.
3.		Acuity	AC&ACB	Validation of Acuity data with monitoring of response and actions taken, as applicable	Asst Chief Nurse (JB)	End Mar 16	5	Sept 15 update Validation process in place. Improvement seen in accuracy of Acuity recording. Main issue had been continued recording of Level 2 Acuity due to this not being changed when patients transferred out of ITU Feb/Mar 16 update Continued improvement of accuracy and feedback being given as applicable. Further acuity reviews being undertaken on a 6 mthly basis. Patient Care at a Glance module being developed within NerveCentre which will enable realtime review of Acuity across the trust Jun 16 update Acuity continues to be reported and monitored .Patient Care at a Glance now available Work ongoing to roll thisout across the trust Aim to complete end of October 2016

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4.		Sepsis	Sepsis T&F Group – AC&ACB	Implementation of Sepsis Screening for all patients admitted with infection and improved adherence to the Sepsis6 Care Bundle	UHL Sepsis Lead (JP)	~~End Mar 16~~	~~2~~	66% of patients screened (as per CQUIN audit results for Q1). Education and awareness raising in ED and on assessment units. Q2 audit in progress. Compliance with Sepsis care bundle currently being audited. <u>Dec Update</u> Deteriroration in performance in Q3, particularly for patients presenting in ED. Screening tool revised and used across all areas of the trust. <u>Feb/Mar 16 update</u> Improved compliance with screening criteria but still variable performance in respect of antibiotics and other aspects of the care bundle Continued feedback given to relevant clinical teams where performance poor. Further revisions made to screening proforma following revised criteria for sepsis. Feedback results to team so as not to get complacent from good results of previous week. Issue of timely treatment still not resolved. Launch of new sepsis pathways and trust-wide educational initiative to be undertaken in April. Discussions underway with NerveCentre to develop Sepsis field within the Handover system. <u>Jun 16 update</u> New adult sepsis pathway launched April-May across all inpatient areas and ED, supported by extensive Comms and educational roll-out. Collaborative working with KGH. Education and training program on sepsis launched with agreement to incorporate into UHL resuscitation training from 01/09/16. 15-16 Q4 CQUIN data for screening and antibiotics 59% and 63% respectively (national goal 90%). 2015-16 quality commitment to improve sepsis 6 delivery in 1
						End Jun 16	5	

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								hour in ED partially met (amber). Review of sepsis 6 for patients admitted to LRI ICU, no significant fall from data collected in 2015 (14-15 local CQUIN). Nerve Centre sepsis clinical rules now in place and being trialled with roll-out across UHL over summer months. Sepsis team (six band 6 nurses) currently being recruited with start date on shop floor planned for 01/09/16. Ongoing monitoring of compliance process in place to ED, assessment units and inpatient areas.
5.	**Clinical Reasoning / Clinical Management**	Acting on Results	7 Day Services Board	Implementation of ICE Review and revision of Speciality Processes Review, revision and re-launch of Policy Monitoring of Incidents, audit of policy compliance and adherence with speciality processes	Associate Medical Director (AD)	~~End Mar 16~~	~~2~~	Feb/Mar update ICE upgrade implemented to include functionality for acknowledgement of results' and 'actions taken' . Policy to be reviewed and revised. Jun 16 update ICE has been configured to allow clinicians to acknowledge results however; the ability for doctors to track results is based on the consultant the patient is under rather than the doctor within the team looking after the patient. This upgrade will enable all grades of doctors to review and acknowledge results for subsets of consultant's patients thus filtering the patient lists for review across the team.
						End Sept 16	4	
6.		Ward Rounds Standards	7DSB	Revision of documentation, awareness raising and audit of compliance	Associate Medical Director (AD)	End Mar 16	5	All wards visited to confirm their ward round processes and observational audit undertaken, to be completed by end of November. Discussed at the Clinical Senate and agreed that more appropriate for Specialities to confirm their ward round standards rather than insist on using one set of standards across all areas.

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								Feb/Mar update Ward round standards have been produced and identify clear actions to take before ward round commences, before leaving a patient and actions after the ward round. Communication, confirming patients understanding of plans agreed, handover and need for escalation if required are all included. Each speciality can amend the lists where clinically appropriate. Multi-disciplinary ward rounds (Medical, Nursing and where possible pharmacist, and therapist) are evidenced as best practice. There are a number of initiatives within CMGs to improve multidisciplinary attendance
7.		Consultant Assessment of Emergency Admissions within 14 Hours	7DSB	Review and implementation of revised plans upon completion of audit.	Deputy Medical Director (JJ)	~~Mar 16~~ End Jun 16	~~2~~ 5	Reaudit in Q1 showed slight improvement overall. CMGs continue with their plans to increase consultant presence in assessment units. Feb/Mar update Reaudit being undertaken end March/April.. Jun 16 update Implementation plan has been reviewed. UHL is an Early Implementer for 7 DS and is working towards the deadline of March 2017 to implement the 4 priority standards in the 3 main specialities. In respect of standard 2 'assessment within 14 hours of admission ', there is considered to be sufficient consultant cover in General Surgery, Paediatrics, Gynaecology and Medicine. Respiratory and cardiology services remain a challenge and work is on going in these areas supported by NHSE.
8.	**Supportive & Palliative Care (SPCA)**	Death anticipated within a few days of discharge	EoL&PCB	Monitoring referral and communication process and anticipatory drugs provision, to include review of complaints	UHL End of Life Lead / Facilitator (LC/RP)	End Mar 16	5	Complaints relating to SPCA and end of life care are collated by Nicola Baker and discussed at the End of Life / Palliative Care Committee (EoLPCC). Work is currently being undertaken to review the Rapid Discharge Home to die process in conjunction with the

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								Discharge team, and this will include reviewing how we will identify difficulties and complaints arising relevant to discharge processes Feb/Mar update The majority of referrals to the specialist palliative care team are received electronically, with a minority being face to face or by telephone. 98% are seen within 24hrs. Team activity is discussed at the palliative care management committee and team meetings. Currently only 69% patients who are recognised as dying have medications prescribed on an 'as needed' basis and this is an area which needs to improve. The use of an end of life care plan improved rates of prescribing, as highlighted in the recent analysis of care of the "End of Life Care Audit: Dying in hospital", 2015 (a separate report has been submitted to the EQB). Jun 16 update **Referrals:** Received via ICE, telephone or face to face. **Anticipatory drugs audit (April 2016):** Prescribing for 12 patients identified as dying was reviewed – the auditors felt that 75% of these prescriptions could have benefitted from advice from the SPCT (dose, route, choice of drug). The EPMA 'preset' end of life drugs were widely used. **PPD (Jan/Feb 2016):** 83.3% patients who expressed a preferred place of death (PPD) were supported to die there. Reasons for not discussing PPD mostly related to patients being too unwell or confused at the time that the discussion was initiated. **Complaints:** Concerns highlighted to the BSS by bereaved relatives are discussed at the EOLPCC as well as formal complaints received via PALS.

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9.				Agree and implement 'out of hours' process for ensuring Authorisation Forms for anticipatory drugs available	UHL End of Life Lead / Facilitator (LC/RP)	End Mar 16	5	Feb/Mar Update LLR wide authorisation forms have been developed for anticipatory medication for common symptoms at end of life and subcutaneous infusion pumps (syringe driver). Final confirmation agreement for these forms to be made available in UHL is being sought prior to making these available via the palliative care page on INSITE Jun 16 update LLR wide authorisation forms have been developed for delivery of anticipatory medication for common symptoms at end of life and subcutaneous infusion pumps (syringe driver) in the community. Doctors completing discharge paperwork for patients having a rapid discharge home are asked to complete these by the discharge team.
10.		Recognition of patients requiring SPCA	EoL&PCB	Review of use of SPICT Tool in the Clerking Documentation and actions taken where patients identified as having S&PC needs	UHL End of Life Lead / Facilitator (LC/RP)	~~Mar 16~~	~~2~~	The SPICT tool is not being used in the Clerking Documentation at LRI despite the palliative and EOLC teams promoting its use during regular education and daily clinical sessions on MAU. Feedback from clinicians has been that they feel they already identify patients requiring palliative care input, and do not find SPICT helpful. Concerns have previously been raised by the EOLC team that its location within the proforma does not encourage its use, and discussion with medical and nursing staff reinforces has found they share this opinion. Development of eLearning around the 'Dying without Dignity' report (2015) and face to face 'Essential to role' training for CHUGS and MSK/SS staff is in the early stages of development. UHL is participating in the RCP Dying in Hospitals audit – data collection started in July 2015 and will be completed later this month. The documentation and strengths and weaknesses of our current approach will

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						End Jun 16	5	be reviewed in light of the audit findings, and a report fed back to EoLPCC and QAC Feb/Mar update Knowledge about the SPICT tool continues to be poor and may be contributing to it's under-utilisation. An education plan for SPICT has begun to improve engagement, and includes face to face teaching with junior doctors on MAU and promotion at education events for consultants which are currently on-going. There is significant concern that use of SPICT in its current form will not improve despite education and promotion. Increased recognition of patients being at end of life (within days) is one of the Quality Commitment workstreams for 16/17. The role of SPICT will be reviewed as part of this work. Jun 16 update Review of SPICT complete, and discussed at the EOLPCC in May 2016. It will continue to be promoted during education and training, and remains in the MAU admissions document, but the lack of medical engagement in its use has been highlighted as an on-going concern. The decision has been made to re-evaluate the role of SPICT in April 2017 and how the teams on MAU can be supported to use this.
11.		AMBER	EoL&PCB	Further implementation of AMBER approach to care and embedding in areas already introduced.	UHL End of Life Lead / Facilitator (LC/RP)	End Mar 16	5	The AMBER care bundle is in use on 43 wards across all 3 hospital sites. AMBER continues to be embedded throughout UHL and is currently in use in the following CMGs: RRC, MSK and Specialist Surgery, Emergency and Specialist Medicine, CHUGGS and Womens. All have been given a green RAG rating for Quarter 1. Within RRC and Emergency and Specialist Medicine, there are some concerns relating to the identification of patients at risk of dying, which may adversely affect their RAG rating if this does not improve.

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								Priorities for quarters 1-2 have been daily training sessions across all 3 sites and targeted training to wards with the greatest need. A more detailed report on the AMBER care bundle by CMGs has been submitted separately. Jun 16 update The AMBER care bundle is in use on 43 wards across all 3 hospital sites. AMBER continues to be embedded throughout UHL and is currently in use in the following CMGs: RRC, MSK and Specialist Surgery, Emergency and Specialist Medicine, CHUGGS and Womens. The focus for the End of Life facilitators for 2016/17 will be on recognising the dying person, and care in the last days of life, which is a shift away from the focus on AMBER. Wards will continue to be supported to use AMBER but there are no plans to implement it in new areas unless requested. An audit of AMBER (reported in Q4 2015/16) found that of patients having their care supported by AMBER - 80% had a clearly documented escalation plan - 90% patients had a documented resuscitation decision in their notes - 60% had evidence of advance care planning At the time of the audit, 1/3 patients had subsequently died. Of these, 80% had their care supported by an individualised end of life care plan – this is significantly higher than the 19% in the Care of the Dying Audit (RCP, 2016) We will continue to highlight the role of AMBER supporting end of life care in education and training

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12.	**Discharge Management / Discharge Communication**	Quality of Letters	'Discharge Communication T&F Group'	Audit of Discharge Letters to be under taken in 15/16	CMIO (SJ)	End Mar 16	5	Draft standards for Nursing discharge letters out for consultation prior to inclusion in the UHL Letters policy. Audit planned for Q4. Jun 16 update Discharge letters audited during 15/16 and ongoing cycle of audit being undertaken during 16/17. Immediate feedback being given to doctors where practice of a high quality or improvement needed.
13.		Supportive & Palliative Care Approach	EoL&PCB	Review and revision of SPCA / End of Life information included in discharge letter, as applicable	UHL End of Life Lead / Facilitator (LC/RP)	~~Mar 16~~	~~2~~	A review of all Emergency Healthcare Plans (EHCP) completed throughout 2014 is in progress. Preliminary results indicate that 71.6% patients who had EHCP completed have since died – from the data so far it is has not been identified how many of these died in their preferred place of death, or the readmission rate. Feb/Mar update Discussion has been had with Project Lead for the Nursing Letter standards, to include a palliative care section on the practice/district nurse discharge letter but at present this is not part of the ICE template for those letters. A MER will be required to add this. Jun 16 update Importance of including advanced care planning, end of life care, in discharge letter and other documentationhas been highlighted in discharge planning guidance, discharge letter policy, DNA CPR policy etc. Will continue to be monitored as part of the Discharge letter audit, Mortality reviews and the 'care of the dying audits'.
						End Jun 16	5	
14.		Patients' status at discharge	NET	Confirm timing of observations and patient review prior to discharge Agree actions as	Senior Site Manager/Asst Chief Nurse (JB)	~~Mar 16~~	~~2~~	Preliminary discussions held to scope appropriateness of routine observations prior to discharge. Out of Hospital SHMI review included this aspect of care but difficult to confirm timing of last observations due to lack

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				applicable		End Jun 16	5	of documentation around when patients left the ward. Feb/Mar update To be considered as part of discharge policy and guidelines review/updating and also as part of e-obs implementation plans Jun 16 update Discharge Policy standards updated to reflect this. Awareness raising part of the relaunch of the policy.
15.	**Fluid Management**	Fluid Management Guidance	'Fluid T&F Group' - MedOC	Complete and launch Policy and supporting Guidelines, to incorporate ePMA for IV fluids Develop education package Audit of compliance	AKI CQUIN Nurse (CB)	~~Mar 16~~ End Jun 16	~~2~~ 5	Delays in completing the Policy Critical Care CQUIN project lead providing support and has met with Nephrology Consultant re IV fluids aspect of the guideline. Feb/Mar update update Draft of policy completed and out for consultation. Due to be submitted to the April P&G for launch in May/early June. Jun 16 update Draft policy reviewed by Fluid & Nutrition T & F group and accepted. Identification of Fluid balance Champions on most wards and rolling out of education package.
16.		Fluid balance monitoring	'Fluid T&F Group' - MedOC	Review of effectiveness of monitoring fluid balance within the EWS tool	AKI CQUIN Nurse (CB)	End Mar 16	5	Proposed UHL modified EWS includes fluid output within the scoring and Fluid Balance chart with 'balance monitoring' included in the EWS document. Feb/Mar 16 update UHL EWS implemented on all 3 sites and includes fluid balance monitoring. Jun 16 update Ongoing monitoring part of the Nursing metrics. Fluid balance chart should be available on Eobs within the next 6 to 12months. Spot audit on Fluid balance charting to be undertaken in July August on identified wards by medical students.

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	Cross Cutting Themes							
17.	**Policies and Guidelines**	Access to up-to-date guidelines	P&G Ctte	Sharepoint development and review of processes Review and updating of Category C P&Gs Awareness raising of newly developed or approved P&Gs	Head of Outcomes & Effectiveness	~~Mar 16~~ Aug 16	2 4	New Policies and Guidelines Library launched. Still large number of clinical guidelines with 'review date passed'. Delays with recruiting P&G administrator as post required job evaluation. Mar 16 Sharepoint development completed and 'Policies and Guidelines Library' (PAGL) now up and running. P&G administrator in post. Plans in place to ensure all P&Gs that have passed their review date are updated within the next 5 months. Work underway to establish a process of raising awareness of newly developed P&Gs. Jun 16 update Policies and Guidelines Library launch and awareness raising undertaken. 200 P&Gs still passed their review date and where no agreed timescales for completion of review, being escalated to the Director of Corporate & Legal Affairs. P&G administrator in post tosupport the ongoing review process with monthly reporting to the P&G Committee

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Better care together
Leicester, Leicestershire & Rutland health and social care

LEARNING LESSONS TO IMPROVE CARE
UP-DATE TO BOARDS AND GOVERNING BODIES.

1. INTRODUCTION

The purpose of this report is to inform LLR NHS organisations of the work undertaken by the Learning Lessons to Improve Care (LLtIC) over the two quarters set against the Joint Action Plan five themes:

- System wide clinical leadership to ensure that patient care issues are addressed across the health community
- Patient and staff engagement, listening and action
- Effective care across interfaces between providers of health services
- Transforming emergency care in our wards, hospitals and communities
- Transforming End of Life Care (EoL)

In the summer of 2014, University Hospitals of Leicester, and Leicestershire Partnership Trust and West Leicestershire, East Leicestershire and Leicester City Clinical Commissioning Groups published the LLtIC report. The report detailed the findings of a clinical audit commissioned by health organisations in Leicester, Leicester and Rutland to examine the quality care provided to a particular group of patients that died, and the action plan to address the areas of improvement identified.

The LLtIC Clinical Taskforce (CTF) was established with the purpose of: ‘establishing system-wide clinical leadership across LLR health organisations to ensure that patient issues identified from the Learning Lessons to Improve Care audit are addressed across the whole implemented delivered by the system. It should be noted that the healthcare system has changed since the initial audit and there are many examples of where patient centred pathways have been developed to address many of the failing identified in the first report.

The LLtIC CTF continues to be responsible for this programme of work reporting providing assurance, implementation and facilitating solutions and actions. Following the establishment of the BCT Governance structure the LLtIC reports progress to the Better Care Together Clinical Leadership Group; this is a key reporting mechanism as many of the actions are delivered through the BCT Clinical workstreams. .

This report includes:

- An up-date against the LLtIC Joint Action Plan (Appendix A)
- A plan for the remaining actions for the LLtIC CTF

2. REMAINING ACTIONS FOR THE LLtIC CTF

2.1 The Next Stage Review

In preparing the next stage review the CTF reviewed the evidence base from other health economies including Torbay and Yorkshire and Humber. In addition advice was sought from Prof Nick Black, London School of Hygiene and Tropical Medicine. The changed landscape of the NHS was discussed, including local initiatives such as the improved Morbidity and Mortality Reviews in UHL and LPT and the UHL Medical Examiner model, as these have improved our collective ability to lean from reviews into the care of patients. The national agenda has also changed significantly since the decision to undertake a next stage review, particularly with the introduction of the National Avoidable Mortality Review.

The decision taken by the LLtIC CTF was to progress with the Next Stage Review as the changes listed above do not review care across the primary/secondary care interface, which is where many of the concerns were identified by the original review. In addition, the proposed methodology will allow us to test these new methods to ensure that they identify future learning opportunities.

Following discussions with UHL, LPT and CCG Boards the Next Stage Review scope has been agreed and is supported by all members of the Clinical Task Force.

Cohort of patients to be reviewed

- all deaths in defined month in UHL and those who have died in the 30 days after discharge from UHL (SHMI Cohort) including deaths in community hospitals and primary care.

A retrospective case note review will take place in (Quarter 4 date to be defined) 2016 to ensure that we include in the review those who died in hospital and 30 days after discharge. It is anticipated that the total number of case notes to be reviewed is approx 400, with 72% dying in hospital and 28% dying either in a community hospital or in the community.

- The retrospective case note review will include UHL, LPT and primary medical care records.
- Relatives of the cohort of patients will be made aware that the review is taking place and contacted to identify what their experience of care was. Further work is needed to confirm the mechanism for this. The findings from this will be fed into the final analysis of the report.
- In the event that any case notes reviewed identifies a serious incident, the case will be reported as a serious incident to the CCG team in order for a full investigation to be carried out. The case will be subject to a full root cause analysis and the relatives of the patient will be contacted in line with Duty of Candour.

- The external audit team will report the findings to the LLtIC CTF in the form of a report. This and all the data will be owned by the CTF and they will be responsible for reviewing the findings and up-dating the existing action plans as a result. The CTF will be responsible for publicising the findings to LLR healthcare organisation boards.

Next Steps
The CTF has agreed that the audit will be undertaken by an external team, commissioned by the 3 CCGs which all five NHS organisations in LLR have agreed to fund.

2.2 Developing a continuous learning culture

A multi-professional review of patient journeys across primary and secondary care highlighted aspects of poor quality care for some of our patients.
An Incident Reporting Task & Finish Group was formed in 2015 to develop a patient-centred, collaborative approach to learning from patient safety incidents in Leicester, Leicestershire and Rutland. The multi-disciplinary group of clinicians and patient safety leads from across local commissioning and provider organisations had a remit to explore barriers to and identifying opportunities for cultural change across organisations and identify ways to cement a positive, collaborative relationship across organisations.

Five main challenges were identified by the group:

- **Limited opportunities for shared learning across organisations:** instead, relationships of trust need to be developed across primary, secondary, community and social care, commissioners and providers.

- **Greater collaboration is needed across organisations in responding to incidents:** a shared vision is needed.

- **Inter-professional and inter-organisational engagement is needed to drive this agenda forward:** this requires the foundation and development of a multi-disciplinary community of practice.

- **The community needs to be up to date and equipped:** this includes being connected to the bigger ‘patient-safety picture’ and evidence-base, good-practice current and research.

- **Incidents are often investigated and actions taken at an organisational level:** a 'system-wide' understanding and perspective is needed so that the patient is the main focus.
-

One of the key outputs of this Task & Finish Group was to initiate a Learning LLtIC Incident Reporting Workshop on 23 May 2016 which looked to address the following:

- Identifying local strengths and areas of improvement
- Developing a shared vision for learning for incidents
- Engaging in inter-professional and inter-organisational learning on key issues – human factors and learning/feedback following patient safety incidents.
- Fostering the formation of a 'community of practice' across organisational boundaries.
- Share learning on new developments in patient safety: human factors and effective learning and feedback.
- Develop a shared vision for learning from patient safety incidents.
- Build inter-professional and cross–organisational relationships and foster a community of practice to drive this vision forward.

Reflections
78 delegates attended the event, with representation from all three local clinical commissioning groups; acute, community/mental health and ambulance trusts; GP practices; social services; public health and local care homes. The event successfully brought together a wide, multi-disciplinary group from across organisations. Through the day, a shared vision and understanding of some of the challenges to collaborative working was reached.

Key themes were

- Strong consensus from the focus groups over need for joint vision
- Clear appetite for collaborative work and building better relationships across providers related to learning from incidents
- A sense of urgency to improve how we do things and a willingness to innovate
- Widespread recognition of the problem that many patient safety incidents span organisations and/or generate learning points at 'cross organisational' level and recognition of the need to learn from these jointly.
- Frustration at current approaches to investigation – often slow and burdensome, removed from the front line, offer limited feedback and can be focused on blaming individuals at times.
- The Task & Finish Group felt that we were now best placed to develop these areas within the Better Care Together collaborative framework.
- A plan is now being developed to take these objectives forward.

Next steps to be defined and a plan moving forward were agreed by the CTF in August 2016. A copy of the full report is attached as appendix 1.

2.3 System wide clinical leadership

In Spring 2016 initial discussions were undertaken with regard to the possible establishment of a programme for developing system leaders and leadership and a paper was taken for discussion at the June Clinical Leadership Group which will underpin the cultural shifts required to deliver the changes within the Better Care Together programme and the STP and continue to drive forward the LLtIC agenda.

The purpose of the BCT system wide clinical leadership programme will be to:

- Enable further and faster integration of the LLR Health and Social Care economy through the development of a common language of change and transformation
- Create a 'social movement' of leaders, with the ability to influence across the system regardless of hierarchy or job role based on sound clinical or professional judgement and a passion to learn, innovate and share
- Equip a cadre of leaders with the skills and tools necessary to drive and deliver positive change in support of STP priorities and new models of care delivered through the Better Care Together transformation portfolio
- Apply the collective talent and perspectives of leaders from across the system in resolving the 'big ticket' challenges facing the system
- Identify, support and engage emerging and/or younger leaders so as to secure succession and continuity –this process is called talent development e.g. leaders within the first five years of qualification such as junior doctors or new GPs and nurses

An engagement event for primary/secondary and community care clinicians is being organised for the 22 September 2016 to show case the way forward for system leadership in light of all the leadership work being undertaken across the system. The details of this are being finalised through the BCT Clinical Leadership Group.

2.4 Primary Care/Secondary Care Interface

LLtIC identified gaps in joint working across primary and secondary care with a lack of consistent structured approaches to joint working. A proposal from UHL was reviewed by the Clinical Task Force in January which outlined a structured approach to:

- Building bridges/re-establishing closer relationships
- Learning lessons and sharing knowledge
- Building trust
- CPD

The proposal is that the model is piloted in each CCG area. A project plan needs to be defined and a lead organisation to take this forward identified.

The Transferring Care Safely Task and Finish Group has been working to ensure that as we move to more integrated working across the system that this is done in a safe way. The principles include:

- Effective transfer of care should enable workforce solutions.
  It should take account of the skills, capacity, and communication needed to deliver services safely.

- Cost effective transfer of care should lead to integrated team approaches, where the person best placed to deliver the care needed, is resourced to do so.
- Safe transfer of care should include systems that can continually learn, refine and improve the service.

3. SUMMARY

It should be noted that the CTF are not responsible for implementing all the actions included in the update included as Appendix A; but this paper reflects the changed clinical environment since LLtIC was published and some of the progress made by NHS organisations in improving the care for patient.

It has been 2 years since the publication of the LLtIC report and the CTF have taken stock of their ongoing actions. They have agreed to close down the Joint action Plan and focus on 4 remaining challenges:

- The Next Stage Review – future actions and timelines will be dependent upon the outcome of the review.
- Developing a continuous learning culture – actions are being developed following the Learning from Incidents report
- System wide clinical leadership – this is being taken forward by the BCT Clinical Leadership Group
- Primary/Secondary/Community Care Interface – work is underway to ensure safe transfer of care from secondary to primary care.

4. RECOMMENDATIONS

Boards and Governing Bodies are requested to:

- **RECEIVE** the update on the LLtIC Joint Action Plan
- **SUPPORT** the ongoing actions for the LLtIC CTF and
- **SUPPORT** the proposal for the Next Stage Review

Appendix 2a

Better care together
Leicester, Leicestershire & Rutland health and social care

Clinical Task Force Action Plan – update August 2016

Action Area	Actions required	Progress to date	Outcomes
1. System-wide clinical leadership to ensure that patient care issues are addressed across the whole health community	Define the actions required to ensure sustainable change relating to the findings of the audit;	3 events held to bring clinicians from primary to secondary care together, including combining with UHL Clinical Senate, to identify key areas to identify issues across the primary and secondary care interface. Key issues identified were communication and developing a learning culture A Grand Round process being implemented to support communication across primary and secondary care to: • Build bridges/re-establishing closer relationships • Learn lessons and share knowledge • Build trust • CPD The proposal is that the model is piloted in each CCG area. A project plan is being defined and a lead organisation to take this forward identified	There is improved communication between clinicians in different care settings. The BCT clinical workstreams are focussing on ensuring that their patient pathways address issues identified when crossing the primary/secondary care interface. Plans are in place to further develop integrated teams across health and social care through the BCT/STP work. The Transfer of Care Safely Task and Finish Group are working to implement measures to ensure safe integrated working.
	Develop mechanism to receive assurance from the action groups (as defined in the governance structure and action plan) that change is underway and within defined timescales;	Task and finish groups established to focus on: • Learning from serious incidents • Next stage review • Addressing the culture challenge Regular reporting process established for UHL, LPT and CCGs to share progress against the	SI task and finish group have identified recommendations to improve the learning culture associated with incident reporting.

Action Area	Actions required	Progress to date	Outcomes
		12 clinical themes identified in the audit: • DNAR orders • Clinical reasoning • Palliative care • Clinical management • Discharge summary • Fluid management • Unexpected deterioration • Discharge • Severity of illness • Early Warning Score • Antibiotics • Medication	UHL/LPT and the 3 LLR CCGs bespoke action in place to address these areas, resulting in organisational focus on the key issues. Process changes have been implemented aimed at improving the actions of clinicians in these areas. It is acknowledged that these areas are the same wicked issues that other organisations are tackling. Monitoring serious incidents and subsequent actions ensures ongoing monitoring of these issues.
	Develop a cultural change strategy to enable ongoing learning o Respond to the steps to overcome change o Where necessary identify and address organisation barriers to change to support the actions undertaken by the action groups;	Progressing Clinical Leadership Academy through BCT Clinical Leadership Group to focus on Systems Leadership BCT Workstreams led by clinicians across primary and secondary care interface demonstrating leadership to ensure patient pathways are patient focused.	The framework has been established to develop an LLR wide approach to system leadership and supporting our clinicians in understanding their part in systems leadership.
	Have oversight of the LLR-wide Sign up to Safety commitments;	Incorporated into organisation's Quality Framework/Quality strategies	This ensured a whole health economy focus on the individual change requirements for Learning Lessons as well as the cross organisational requirements.

Action Area	Actions required	Progress to date	Outcomes
			We have continued to have senior clinical leadership for the LLtIC work to drive forward the changes required.
	Be a central point for sharing learning from ongoing audits/reviews (morbidity and mortality/after death reviews) o Establish an ongoing mechanism for sharing best practice across clinical disciplines through an LLR-wide clinical forum o Identify learning opportunities to be taken forward through clinical training programmes o Identify areas for shared clinical audit o Agree the mechanisms for sharing learning across the LLR health community	Findings from LLtIC audit shared across BCT Clinical Workstreams Shared across primary and secondary care clinicians in joint meetings Learning from Lessons Incident Reporting group established reporting to CTF to review mechanism for learning lessons in a non-blame culture. Learning Lessons from Incident Reporting event May 2016 – looked at development of the themes – further actions to be agreed by CTF in August 2016	Learning from incidents is complex and the challenges faced by LLR are mirrored nationally. LLR is distinguished by the significant steps that have already been taken to work together across organisations and build academic links. There is significant grass roots enthusiasm to improve, collaborate and innovate, and a sense of urgency to do so. Through collaboration, we have the opportunity to develop approaches which are not only more effective (resulting in better quality investigations, action plans, learning and feedback), but also more efficient (creating much needed 'headspace' within organisations and patient safety teams). From this position, and with a shared commitment, we have the opportunity to both improve locally and shape the national policy agenda.

Action Area	Actions required	Progress to date	Outcomes
	Commission a further audit of care to ascertain progress	Next Stage Review for 2016/17 in development. Review to focus on improvement rather than assurance Detailed proposal in main body of the paper.	This will allow the health economy to identify whether the improvement areas that the WHE are working on are still the key issues and test whether new mechanisms for morbidity and mortality reviews are suitable to ensure continuous learning across the system.
	Develop mechanism to receive quarterly assurance from individual organisation's boards regarding o Implementation of organisational actions o Progress relating to culture change	Regular reporting process established for UHL, LPT and CCGs to share progress against the 12 clinical themes identified in the audit: • DNAR orders • Clinical reasoning • Palliative care • Clinical management • Discharge summary • Fluid management • Unexpected deterioration • Discharge • Severity of illness • Early Warning Score • Antibiotics • Medication	UHL/LPT and the 3 LLR CCGs bespoke action in place to address these areas, resulting in organisational focus on the key issues. Process changes have been implemented aimed at improving the actions of clinicians in these areas. It is acknowledged that these areas are the same wicked issues that other organisations are tackling. Monitoring serious incidents and subsequent actions ensures ongoing monitoring of these issues.
	Provide quarterly assurance to individual organisation's boards of the progress of the LLR-wide actions	Regular Board reporting to boards and Governing Bodies established Regular reporting into BCT Clinical Leadership Group.	This has ensured that the learning from the initial review continues to influence system leaders and developments to improve patient care.

Action Area	Actions required	Progress to date	Outcomes
2. Patient and Staff engagement, listening and action	Staff listening event • Listening into action • Feedback from staff • Actions identified to feed into existing workstreams	3 events held to bring clinicians from primary to secondary care together, including combining with UHL Clinical Senate, to identify key areas to identify issues across the primary and secondary care interface. Key issues identified were communication and developing a learning culture • Grand Round process being implemented to support communication across primary and secondary care Improvements to discharge letters progressed through UHL & LPT contractual mechanisms	Actions fed into BCT Workstreams 4 patient and public engagement events held across LLR to gain a better understanding of what it feels like to receive care from our healthcare services. The information was analysed by De Montfort University and identified the following themes: • Improved communication • Requirement to be treated with dignity and respect • Increased consistency and continuity of care • Speed and access for care Findings were incorporated into BCT PPG activities
	Patient/relative carer event • Commission external organisation (August 2014) • Planning (August 2014) • Feedback (Jan 2015) • Actions (Jan 2015)	Postcards for Deciding Right and speaking up were distributed across CCGs	
	Identify mechanisms to bring patient/carer feedback into 5 year planning	BCT PPG Group and patient/carer input into individual workstreams	
3. Effective Care across interfaces between providers of	Electronic transfer of information	BCT IM&T Group developing electronic process for ensuring care plans available across a range of providers to ensure continuity of care – summary care record Version 2.1 as initial solution	Progress is being made to ensure that health care professionals across LLR have consistent access to patient information to ensure

Action Area	Actions required	Progress to date	Outcomes
health services		Incorporated into Digital Roadmap CCG support for GPs to ensure appropriate use of advanced care plans Audit of care plans undertaken across CCGs	that care plans can be implemented across the 24/7 period. The work ensures that patients have advanced care plans in place has meant that their care needs are understood by a wider clinical group.
	Review of the quality of discharge and referral information	Improvements to discharge letters progressed through UHL & LPT contractual mechanisms Feedback from primary to secondary care when problems occur through GP concerns UHL & LPT contract teams reviewing the NHSE publication 'Improving discharge from secondary to primary and social care' to ensure that tests and investigations are followed up after discharge.	Joint work between primary and secondary care clinicians to improve the quality and timeliness of care plans has improved communication following discharge from hospital
	Improved data sharing across organisations: • Progress LLR-wide data sharing policy	Commitment from Caldicott Guardians across Health & Social Care to support Caldicott 2 principals to ensure that information is shared appropriately to support the care needs of the individual.	Information Governance teams are becoming involved at earlier stages of developments to ensure that we can supporting the transfer of information to aid in the care of patients
	Development and implementation of ambulatory care pathways	Taken forward through the Planned Care BCT Workstream	Improvements have been seen in access to diagnostics for primary care. This work continues to progress.
	Individual Care plans and MDT care planning	CCGs promoting Advanced Care Plans in primary care	Progress is being made to ensure that health care

Action Area	Actions required	Progress to date	Outcomes
		Audit of care plans undertaken across CCGs Electronic mechanism being developed	professionals across LLR have consistent access to patient information to ensure that care plans can be implemented across the 24/7 period. The work ensures that patients have advanced care plans in place has meant that their care needs are understood by a wider clinical group.
4. Transforming emergency care in our wards, hospitals and communities	Emergency Care Pathway Review, including recommendations from Ian Sturgess Report.	Taken forward through the Urgent Care BCT Workstream and Vanguard Urgent Care Programme Board with all key partners established. Operational Resilience group with all key partners occurs fortnightly	The urgent Care Vanguard work is developing new and improved integrated patient pathways across LLR to improve outcomes for patients.
	Community-based older People's assessment and support service	Loughborough Older Persons Unit established Included in the Frail Older People's BCT Workstream	Improvements have been seen in access to diagnostics for primary care. This work continues to progress.
	LLR-review of support for older people to enable them to stay in their usual place of residence	Taken forward through the Frail Older People's BCT Workstream FOP Programme Board with all key partners established.	The FOP workstream is progressing with their aims to improve care for these patients supported in their homes by Integrated Teams.
5. Transforming	Establish LLR EoL Care working group to develop unified approach to EoL care across	Taken forward through the End of Life BCT Workstream	The EoL workstream was established as a separate

Action Area	Actions required	Progress to date	Outcomes
end of life care (EoL)	all LLR healthcare organisations and agree mechanism for taking forward longer-term pieces of work	EoL Programme Board with all key partners established. EoL Operational group with all key partners occurs bi-monthly.	programme of work to ensure focus on EoL.
	Standardisation of EoL care plans & process for sharing key information across organisations	Personalised Care Plan: Deciding Right form has access to the Supportive and Palliative Care Indicator tool within it and is integrated into the EoL template across all 3 CCG's. Implementation of "green bags" and "message in a bottle" EPaCCs – BCT IM&T group and EoL Programme Board have agreed on SCR V2.1 as an EPaCCs solution to address the issues around sharing information across organisations.	This work has improved the discussions between patients and clinicians regarding plans for EoL. Ensuring that medications and information is available to all healthcare practitioners when patients require them The work ensures that patients have advanced care plans in place has meant that their care needs are understood by a wider clinical group
	Implementation of a joint EoL care pathway across LLR	A Health Needs Assessment was completed in July 2016. This work provided a systematic review of existing provision of services for EoL/Palliative patients across LLR and the predicted demand on the system. The EoL programme has just entered the Strategy development phase and the Operational group will be co-developing this as a shared vision for patients across LLR. This	A Health needs analysis has been undertaken that identifies where there are gaps in EoL care for patients across LLR. The EoL Strategy will ensure that there is an improved service for EoL patients supported in their homes by Integrated Teams.

Action Area	Actions required	Progress to date	Outcomes
		will be a move from 5 Strategies across LLR to 1.	
	Design and implement training and development for GPs/nurses/care homes on EoL care planning & DNAR orders	Every year in each CCG there has been training sessions provided to GP's through protected learning time. LOROs have a rolling training programme that is provided across provider organisations. In 16/17 LLR were successful in securing HEEM funds to continue to provide training to GPs/nurses/care homes on EoL care planning & DNAR. A training needs analysis was completed in June and co-ordinated at a regional level by the Strategic Clinical Network. Results due in the next few weeks.	The training has improved the knowledge of clinicians for care at EoL.
	Revision of guidelines & teaching of best practice for DNAR orders	There is now a unified approach to DNACPR orders. More work need to be done in this area specifically around access to this information in and out of hours in all care settings and to improve the overall quality of care planning which includes DNACPR status.	Consistency across organisations for DNACPR enables better communication of the patient's wishes.
	Rapid Discharge for EoL patients to named GP. Where DNAR orders in place flagged prominently on discharge summaries	Fast Track CHC is in place to facilitate rapid discharge when required. Community services "Hospice at Home" set up to respond within 2 hours. Overnight offer is provided by Marie Cure and	These processes ensure that patients are bale to be discharged from hospital to die at home without incurring delays.

Action Area	Actions required	Progress to date	Outcomes
		ICRS or District Nursing Service.	
	'Electronic patient record' in fast track development to share EoL / discharge and patient management plans seamlessly across all organisations	See above regarding EPaCCs developments	The work ensures that patients have advanced care plans in place has meant that their care needs are understood by a wider clinical group.

Better care together
Leicester, Leicestershire & Rutland health and social care

Learning Lessons to Improve Care

APPENDIX 3
VERSION 1.0
JULY 2016

LEARNING FROM INCIDENTS TASK AND FINISH GROUP: FINAL REPORT AND RECOMMENDATIONS

PRESENTED BY:

DR CHRIS WILLIAMS (GP CLINICAL LEAD)

MRS TRACY WARD (HEAD OF PATIENT SAFETY, LLR CCGS)

LEARNING FROM INCIDENTS TASK AND FINISH GROUP: FINAL REPORT

CONTENTS

ACKNOWLEDGEMENTS

We would like to thank Rebecca Perry, Arlene Neville, Reeja Sarai and Rachel Parker who have organized and supported our task and finish group. We acknowledge the time, commitment and vision of members of the group, drawn from patient safety and clinical teams across LLR, and other colleagues who provided advice and soundings; the support of Leicestershire Improvement, Innovation and Patient Safety Unity (LIIPS) and the East Midlands Patient Safety Collaborative; the contribution of academic and public health colleagues who facilitated small group sessions and focus groups, and colleagues from across the local health community who joined us at the Learning from Incidents Event.

EXECUTIVE SUMMARY

This report summarises the work of the Better Care Together/Learning Lessons to Improve Care Learning from Incidents Task and Finish Group between October 2015 and May 2016.

Purpose: To *'assess the policies and procedures for incident reporting across LLR and to identify mechanisms for sharing information and learning from incidents across LLR. The key emphasis for this group is sharing the learning across LLR organisations'.* Within this remit, the group recognised that investigations do not always successfully identify underlying safety issues, that learning and feedback are challenging and do not routinely happen across organisations. The group's activity therefore focused on these areas.

Composition: Membership was open to members of patient-safety teams and clinical staff from local commissioning and provider bodies; and brought together patient safety and clinical personnel.

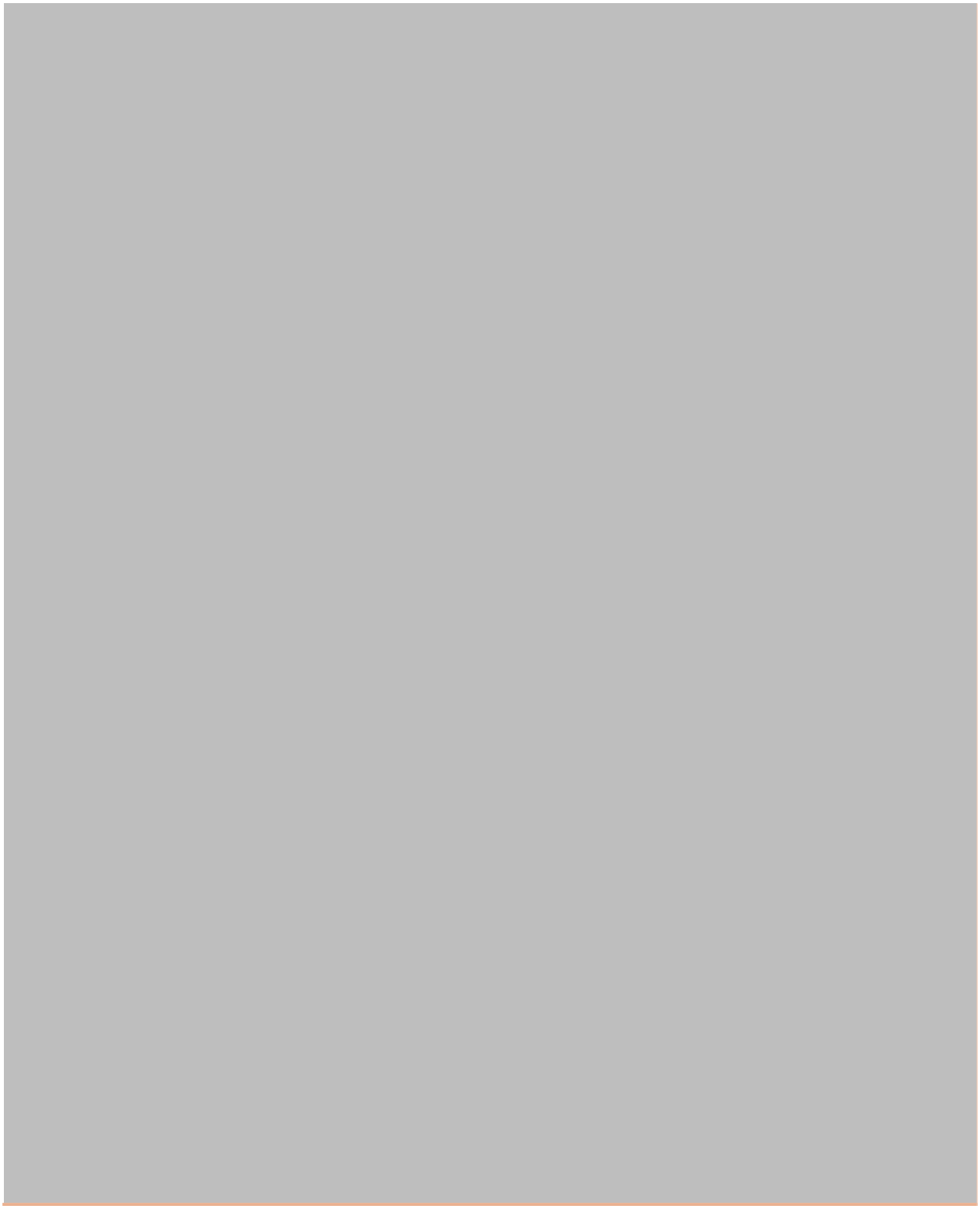
Summary of activities: The group met on four occasions between November and March 2016, with further exploratory meetings with other stakeholders and extensive e-mail discussion. Our early work focused on generating and refining ideas about improving learning from incidents; and this led to the organisation of a one day workshop jointly with LIIPS (Leicestershire Improvement, Innovation and Patient Safety Unit) on 26 May 2016, which attracted 85 delegates from across local commissioning and provider organisations. The event provided an opportunity to *(i)* learn from experts on patient safety challenges, human factors, feedback and learning from incidents; *(ii)* embed this learning through case discussion in inter-disciplinary, cross-organisational groups; and *(iii)* develop a vision for learning for incidents across LLR through a consensus building process. The event highlighted a clear appetite from delegates to undertake further collaborative work.

Analysis: The consensus building process addressed four questions: 'What does excellent look like?', 'What do we already do well?', 'What are the obstacles?' and 'How do we get to excellent?' Thematic analysis of delegates' responses was undertaken to develop a list of challenges and opportunities for Better Care Together.

Recommendations: Based on this work, we make a series of recommendations for next steps (listed overleaf) on *(i)* shared commitment and leadership, *(ii)* supportive dialogue and collaboration between providers and commissioners, *(iii)* development of a community of practice, *(iv)* supporting investigations across organisational boundaries, *(v)* strengthening feedback and learning, and *(vi)* triangulating incidents and other sources of patient safety data.

Conclusions: Learning from incidents is complex and the challenges faced by LLR are mirrored nationally. LLR is distinguished by the significant steps that have already been taken to work together across organisations and build academic links. There is significant grass roots enthusiasm to improve, collaborate and innovate, and a sense of urgency to do so. Through collaboration, we have the opportunity to develop approaches which are not only more effective (resulting in better quality investigations, action plans, learning and feedback), but also more efficient (creating much needed 'headspace' within organisations and patient safety teams). From this position, and with a shared commitment, we have the opportunity to both improve locally and shape the national policy agenda.

SUMMARY OF RECOMMENDATIONS



INTRODUCTION

In 2013-14, the NHS in Leicester, Leicestershire and Rutland (LLR) undertook the **Learning Lessons to Improve Care Review.**[1] This used the innovative approach of bringing together clinical reviewers (medical and nursing) from primary and secondary care to review jointly the care of patients who had died in hospital or within 30 days of discharge. Whilst the lessons from these cases were difficult, it should be emphasised that this review was innovative and brave: bringing together professionals from different organisations in a single process, looking at patients' journeys across transitions with full access to records and focusing on a group of patients most likely (by virtue of their complexity) to experience problems in their care.

Better Care Together (BCT) is the local NHS integrated five year plan,[2] and encompasses the strategic response to the Learning Lessons Review, the NHS Five Year Forward View[3] and other local and national policy developments. BCT is intended to allow health and social care organisations to build relationships of trust and joined-up systems and processes of care. An early BCT priority, under the direction of the Learning Lessons to Improve Care Clinical Task Force, was to strengthen collaboration in learning from patient safety incidents.

Learning from patient safety incidents remains a major concern, at national level, as evidenced by recent plans for the **Healthcare Safety Investigation Branch (HSIB)**[4] to investigate the most serious incidents; and by recent **parliamentary**[5], **governmental**[6], **health ombudsman**[7] and **Care Quality Commission (CQC)**[8] reports. Some key points emerge from these documents as 'non-negotiables':-

- **Providers** have responsibility for identifying and investigating patient safety incidents.
- **Commissioners** are required to ensure that investigation and action plans are appropriate.
- **Transparency and engagement with patients and families** is expected throughout the process.

These documents provide insights into the national policy environment and set some external limits on how we might choose to collaborate locally. Local organisations also have their own policies and procedures which are time-consuming and resource intensive to re-write.

Learning from incidents is an area where there is also much innovation, nationally and locally: examples include work within UHL on safety huddles, the safety portal and investing to recruit 'in-house' human factors expertise; and within LPT on Human Factors Analysis and Classification System (HFACS), zero tolerance to suicide and 'round table' approaches to investigation. It should be noted that the NHS in LLR is well linked with academic expertise in this area through LIIPS (Leicestershire Improvement, Innovation and Patient Safety unit) and the East Midlands Patient Safety Collaborative.

This report summarises the work of the BCT/Learning Lessons to Improve Care Learning from Incidents Task and Finish Group between October 2015 and May 2016. It describes the main activities of the group, outputs and recommendations for future work.

PURPOSE

The purpose of the group was:-

'to assess the policies and procedures for incident reporting across LLR and to identify mechanisms for sharing information and learning from incidents across LLR. The key emphasis for this group is sharing the learning across LLR organisations'.

A key priority was to understand what 'Better Care Together' means in the context of learning from incidents, and to develop solutions. The group recognised that investigations do not always identify underlying safety issues; that feedback and learning are challenging, and do not routinely happen across organisations. The group's activity therefore focused on these issues.

COMPOSITION

Membership of the group was open to local commissioning and provider bodies, across primary, secondary and community care; and the group attracted a multi-disciplinary group of interested clinicians and patient safety professionals (with representation from LPT, UHL, CCGs and primary care).

SUMMARY OF ACTIVITY

The group met formally on four occasions between November 2015 and March 2016, with further informal meetings with other stakeholders and e-mail discussions. The work was divided into two stages:-

Generation and refinement of ideas

The multi-disciplinary nature of the group made it a useful forum for triangulating different perspectives on learning from incidents. Early meetings discussed a wide range of issues related to:-

- current approaches to incident investigation and feedback.
- opportunities and barriers for closer collaboration between providers.

These discussions highlighted that the initial barriers to closer working across organisations were primarily cultural: a shared vision was needed across organisations, underpinned by relationships of trust.

The group identified the need for broader engagement across organisations to shape our approach to learning from incidents, and therefore proposed a **one-day workshop** as a first step towards building relationships across the health community and changing culture.

Development of a Learning from Incidents workshop

The workshop was open to clinicians and patient safety professionals from health and social care commissioner/provider bodies across LLR; and was designed to foster a patient-centred, collaborative approach to learning from patient safety incidents across the health community.

The event had the following objectives:-

- Identify local strengths and areas of improvement.

- Engage in shared learning on key 'hot topics' in patient safety: human factors and effective learning and feedback.

- Develop a shared vision for learning for incidents

- Build inter-professional and cross–organisational relationships to drive this vision forward.

The event was organised jointly with LIIPS (Leicestershire Improvement, Innovation and Patient Safety Unit), with further support from the East Midlands Patient Safety Collaborative. Invitations were sent to clinicians and patient safety teams from all organisations which deliver health and social care services in LLR (as commissioners or providers).

85 delegates attended, with representation from major local health providers, including UHL, LPT, EMAS and primary care; commissioning bodies; social care and nursing/residential homes.

<u>Structure of the event</u>

The event was developed from the priorities identified through earlier consultative work with the task and finish group. This included:-

- **Large-group sessions** on patient safety challenges (Professor Mary Dixon-Woods, University of Leicester), human factors underlying patient safety incidents' (Professor Sue Hignett, University of Loughborough) and feedback and learning from patient safety incidents (Dr Jonathan Benn, Imperial College London).

- **Small-group sessions** to embed this learning through a 'fictional' case study drawing on the themes in the Learning Lessons Review.

- **Focus group discussions** (with inter-disciplinary and inter-organisational groups) to build a consensus vision for collaboration in learning from safety incidents.

To allow networking and raise awareness of local initiatives, the day also included 'rapid fire' presentations from local organisations and opportunities for informal discussion during tea/coffee and lunch breaks.

Shaping future vision

To develop a vision for collaboration in learning from patient safety incidents, a four stage process was embedded within the event:-

1. Pre-event questionnaires – focusing on four questions:-
    a. 'What does excellent look like?'
    b. 'What do we already do well?'
    c. 'What are the obstacles?'
    d. 'How can we get to excellent?'
2. Individual responses were synthesised before the event and presented verbally to delegates as a prompt to further discussion.
3. Focus group discussions during the event were used to develop and refine this vision, identify areas of consensus and disagreement.
4. The outputs of this (recorded on flip charts and through feedback from facilitators) were synthesised and triangulated with the pre-event questionnaire.

Data is presented as grouped themes for each question (see section 3 of this report) and then incorporated into a list of **challenges and opportunities** for Better Care Together and **recommendations** for next steps.

ANALYSIS

The themes which emerged from the questionnaire and focus group discussions are presented below.

a) 'What does excellent look like?'

Culture	**Patient centred, transparent** and **seamless** **Comfortable to admit** and **willing to learn** from mistakes, a **non-judgemental** approach Staff feel **valued**, **safe to speak out, challenge colleagues** and **ask questions** Staff are **supported** (emotionally and psychologically) through investigations (decisions about suspension are handled sensitively) Focus on **learning not blaming** (individuals and organisations). Develop '**organisational memory**' **Commitment to change** (organisations and individuals) **Collaboration and trust** between organisations and individuals (respect, avoid them/us)

Reporting process	**Make reporting system clearer** • Clarity over **which route** to report through • Training in how to use incident reporting systems
Investigation process	**High quality investigations** • carried out by those with appropriate **skills/experience** • develop **'independent' investigators** • information provided **promptly** by all involved • access to information **from other organisations** • develop a shared set of expectations so investigations are signed-off first time by commissioners **Move investigations closer to the front line** (although also important to ensure that those involved in the incident are not on the investigation team) **Reflective discussion** (to understand and identify actions) • **Include all** individuals with a perspective (including the person who has made the mistake) in the investigation and action plan • Avoid investigation as a '**distant' activity** Ensure **transparency** –patients/families and public Focus on system **underlying causes** • Avoid **blaming the individual** • **Systems**, **processes**, **human**, **relational** and **cultural** factors • Recognise **organisational failures** around the person • Avoid recommending actions because they are 'measureable' or can be easily **'achieved'** or **'ticked off'** **Prioritise** actions that will make the biggest difference Learn from **near-misses** and **staff concerns** (not just incidents where harm resulted) Undertake **joint investigations**, **reports** and **action plans** (especially where incident spans teams and organisations) Ensure that the **approach to investigation is proportionate** to the incident
Learning and feedback	Share **good practice** as well as mistakes Use **effective educational approaches** (e.g. reflective practice, action learning sets) Patient safety discussions in **all team meetings** All **staff are connected** to the bigger 'safety' picture and patient perspective Information is **shared in a timely way** Ensure learning messages are **re-infored** – "repetition re-inforces retention" Use **stories** to help staff remember **Joint forums** for sharing learning **across professional groups** and **organisations** Share lessons with the **right people**: • Avoid 'information overload' • Some learning is best **targeted** locally to specific individuals, teams or services • Other learning needs to be shared widely • When necessary, **action needs to be taken beyond the organisation** in which it was investigated – e.g. by commissioners, other organisations or central NHS bodies
Monitoring	**Systems to ensure lessons and actions are put in place** **Regular, systematic monitoring** to confirm actions are completed **Publicise improvements** – to encourage reporting and lead to culture change **Collate recurring themes** and **recurring actions** to identify • underlying issues • priorities • areas where further work on learning is needed
Collaboration	A **supportive role** for commissioners towards providers **Aim for better integration –** with standardised approaches across health and social care

b) 'What do we already do well?'

Delegates had different perspectives, with some finding it difficult to recognise the strengths that others had observed elsewhere in the system. This perhaps reflects that organisations have developed their approach to learning from incidents relatively independently, and that in large and complex organisations, there will be differences in adoption.

Strengths	**Passion** to improve Collaborations between clinicians and academics Beginnings of **cross-system working** **Ongoing training** **Encouraging reporting** of incidents **Knowledgeable staff** who have expertise to share, and are willing to support investigations Moving towards **open culture** - although people still feel vulnerable to blame **Involving patients and carers**; duty of candour **Willingness (in some parts of organisations) to try new approaches** to learning from incidents Working to improve safety within systems that are **'overwhelmed'** and **lack resources** **Governance team** checking that action plans have worked
Innovations	**Local reflective discussions** and meetings following patient safety incidents **Learning from experience group** on SUI report writing Logging and investigating **professional concerns** and **'things which could be done better'** but do not reach the threshold of a significant event

Some 'strengths' were balanced with a corresponding 'weakness' suggesting the need for a balanced view of these themes.

Investigation process	Clear **processes** and **deadlines** which are **complied** with	Lack of flexibility means that emphasis is on 'process', 'deadlines' and compliance with policy rather than learning
Role of CCG sign-off group	Robust **scrutiny/challenge** from CCGs	Feeling that this can be rigid and too focused on 'assurance' rather than learning and improvement
Clinical governance, morbidity and mortality meetings and patient safety bulletins	Strengths that these exist across the health and social care system	Concern that these can sometimes be blameful or poorly targeted

Delegates also mentioned strengths in other safety-critical industries: an independent expert investigation team with skills to analyse and make recommendations; and the practice of reviewing and learning from recurring themes in incidents (including near-miss analysis).

c) 'What are the obstacles?'

Structural	**Time**, **financial** and **human** resources **Ageing** population **High-demand** and **expectations** **Workforce challenges** **Complexity of system** – large number of commissioners, multiple providers, contracts Reliance upon **good-will** Priorities are not aligned at operational level
Cultural	Willingness to make **radical changes** – tendency to rely on **'tweaks'** of existing systems Sense of **partnership** across organisations, reluctance to allow other organisations into SI discussions **Defensiveness**, **fear of blame**, feeling of **vulnerability** and **wariness to talk openly** Lack of willingness to learn from **other industries** **Engagement** from some staff groups Resilience to **negative media** and **political exposure** **Legal fear** (coroner and clinical negligence) **Regulatory** pressures
Processes	Not enough safety scientists and other experts to provide expert input Lack mechanisms for **joint investigations**, **action planning** and **learning** **Incident reporting systems** (ICT) are laborious **Data sharing** across institutions **Flexibility in policies** –individually agreed targets for investigations **Long delay** between incident occurring/being reported and lessons circulated Lack of communication back to shop floor Difficult to know how to go get organisational approval to do new things to improve learning from incidents Different terminology in different organisations
Educational	Lack of understanding of **what should be reported and how** **Lack of feedback** of how reporting improves things Difficulties getting information effectively **to shop floor** Reliance on (possibly) **'ineffective' methods of sharing learning** (e.g. 'sending an e-mail')

d) 'How can we get to excellent?'

Patient centredness	Adopt a **patient centred approach** **Engage** with patients/service users
Cultural change	Change **culture**, **hearts and minds** Make a genuine commitment to **'just culture'** Recognise safety as **top priority** Commit to **continuous improvement** Ensure engagement from across the organisation/health community
Leadership	Ensure **strong leadership** across the health system in patient safety
Empowerment	Encourage staff to focus on what is within their control Recognise that everyone will spot something important Ensure that information is 'well-received' when staff speak up Ensure staff are supported, not blamed, during investigations

Work across organisations	Build **relationships of trust** across organisations Develop terms of reference for **joint investigations** Build **community** of like-minded people to come together to work in this area in LLR Build collaborations between academics and clinicians related to patient safety
Use of ICT	Make **appropriate use of ICT** and other channels to disseminate learning
Strengthen investigations	Learn from **other safety-critical industries** and get support and advice from safety experts Be **willing to try and share new approaches** Aim for 'independent' investigations Develop staff with the right skills Develop better ways of working with clinical staff to develop and implement action plan Develop **cross-mapping/theming** of incidents; include other sources of safety data such as professional concerns
Provide better opportunities for learning and feedback	Make **time and opportunities** for front line staff to learn and share good practice Get people round the table to discuss the incident, bringing together investigation and learning Provide meaningful and timely feedback to those involved in the incident Be willing to simplify systems to improve patient safety (e.g. contracts, providers, single points of access)
Allow time for change	Allow time for new systems to bed in and become effective – knowing when 'not' to change things

CHALLENGES AND OPPORTUNITIES FOR BETTER CARE TOGETHER

The work undertaken by the task and finish group has identified nine challenges and corresponding opportunities. These form the basis of our subsequent recommendations.

Culture

a) **Staff remain to be convinced about 'just culture':** whilst many recognise that we are moving towards this, there are still anxieties.
The incident reporting day has brought together local professionals with an interest in patient safety who can, if harnessed effectively, act as 'bottom-up' agents of change within their teams and organisations. Better Care Together provides a corresponding opportunity for a shared 'top-down' commitment. (See recommendations 1a, 3a)

Patient centredness and transparency

b) **We need to work to 'involve' as well as 'inform' patients/families.**
If we engage sensitively and positively, they can act as 'witnesses' to events and provide an important perspective on actions/solutions. (See recommendation 1a)

Strengthening investigations

c) **There are multiple inefficiencies in the investigation process.** *Tackling these would generate 'headspace' for hard-pushed organisations. (See recommendations 1b, 2a, 2b, 2c)*

(i) **Many common incidents have recognised root-causes** (e.g. falls, pressure ulcers) which are the subject of ongoing quality improvement work. CQC recognises that lengthy investigation of such incidents is unlikely to add to learning. *There is scope to agree a robust but more efficient approach to analysing these incidents whilst still satisfying duty of candour. (See recommendations 2b and 6a)*

(ii) **Investigations are often heavily reliant on senior figures within organisations.** Whilst this reflects a commitment to taking incidents seriously, it may also stifle discussion amongst more junior staff about the wider failures which led to the incident.
W*e should explore models which allow some investigations to be facilitated by more junior staff, under supervision, with appropriate training. (See recommendations 2a, 2b, 2c, 3a, 5a)*

(iii) **Reports often contain lengthy narrative descriptions which contribute little to learning.** This problem is the subject of recent CQC recommendations.
There is scope to produce shorter reports which still satisfy the requirement of a robust, transparent investigation. (See recommendations 2a, 2b, 2c and 6a)

(iv) **A significant number of reports have to be revised or amended before CCG sign-off.** *Through collaboration, it should be possible to strengthen reports, analysis and action plans so that a greater proportion of reports are signed-off 'first time'. (See recommendations 2a, 2b, 2c)*

d) **Investigations are often 'invisible' to the front line clinicians:** front line staff are well-placed to understand the underlying problems and identify solutions but lack of timely feedback generates anxiety or ambivalence.
Several models (such as REFLECT, which was presented at the workshop and has been successfully used locally) involve facilitated 'round table' discussion' to identify root causes and actions. For some incidents, this model could be more effective and efficient than standard root-cause analysis and such approaches should be explored. (See recommendations 2a and 2c)

e) Upskilling and support for investigating and generating action plans: the need for investigators to identify underlying themes using 'systems thinking' and 'human factors' techniques has training implications.
There is scope to develop this collaboratively and build on expertise within local providers and academic units. (See recommendations 1b, 3a, 5a, 6a)

Working across organisations

f) **We struggle to deal with incidents which span organisational boundaries:** many 'error trajectories' span providers and there is a need for better co-ordination of data gathering and action planning across organisations.
Better Care Together provides a mechanism for exploring how to approach these investigations. (See recommendations 1b, 2a, 4a, 6a)

g) **'Silo-working' presents a challenge to effective learning from incidents:** better connections are needed within organisations (for example, between patient-safety and 'shop-floor' clinical teams) and between organisations.
Learning from incidents is a 'thread' which should run through the health community and the incident reporting day laid the foundations of a potential 'community of practice' which spans organisational boundaries to share ideas and expertise. (See recommendations 1b, 2a, 3a, 5a)

Feedback

h) **A systemic approach to feedback is needed:** to ensure learning reaches the appropriate people in a timely way. This includes ensuring:-

(i) timely feedback to those involved in the incident.
One solution identified through this work is greater involvement in the investigation. (See recommendations 2b, 5a)

(ii) targeted feedback to others who will benefit from knowing.
Possible methods include 'champions' within clinical teams, targeted publicity, direct feedback from supervisors, training and simulation. (See recommendations 2c, 5a)

(iii) mechanisms to allow incidents to inform decision-making at different levels within the system (within teams, directorates, providers, commissioning groups, regional and national bodies).
Models of effective feedback and learning mechanisms have been published and could be developed locally. (See recommendations 5a, 6a)

Triangulation

i) Incident data needs to be triangulated within and across organisations. The advantages of this are:-

(i) identify priorities for quality improvement activity.
(ii) provide a more complete picture of underlying causes to shape action planning.
(iii) highlight risks/weaknesses which persist despite quality improvement activity.

Effective triangulation also may also identify recurring scenarios, potentially reducing the need for highly detailed narrative descriptions of events in these cases. (See recommendation 2b, 5a, 6a)

RECOMMENDATIONS

The following recommendations are based on the thematic analysis of delegates' views, discussion within the task and finish group and the national policy framework.

1. Shared commitment and leadership

a) The health community in LLR should enact a 'just culture' and make a joint commitment to learn from patient safety incidents. This should include statements, expressed clearly and in layman's terms, on patient-centredness, transparency, supporting staff and working across organisational boundaries.

Rationale: Improving culture is recognised locally and nationally as a key challenge. A joint commitment will underpin effective collaboration and make it easier to align policy and practice across organisations. It is important that this is both a 'top-down' and a 'bottom-up' commitment; and this work provides an indication of the commitment that local clinicians and patient safety teams want to make. Our policies and procedures must then align with this shared commitment.

b) The health community in LLR should ensure that there is clear leadership to drive learning from incidents within and across organisations.

Rationale: Strengthening learning from incidents is a long term challenge for the health community. This requires leadership within and across organisations.

2. Supportive dialogue and collaboration between providers and commissioners

a) Providers and commissioners should foster a collaborative and mutually supportive relationship, mindful of each other's roles in clinical governance as defined by national policy.

Rationale: Our work highlights some (perhaps inevitable) tensions between commissioners and providers but it is clear that collaboration is key to developing effective, efficient processes and working across organisations. Better Care Together provides a framework for mutually supportive relationships.

b) Providers and commissioners should jointly explore how serious incident reporting can be simplified for common, recurring scenarios.

Rationale: Certain scenarios (e.g. pressure sores, falls) are regrettably common. Treating these as 'isolated events' with a detailed narrative report and full root-cause analysis for each episode is likely to be less valuable (and less efficient) than triangulating with existing knowledge. CQC has already suggested, at a national level, that such incidents can instead be investigated together.

c) Providers and commissioners should work together to develop and pilot new approaches to investigation based on collaborative round table discussion, and agree when they would be a suitable alternative to traditional root-cause analysis.

Rationale: Root-cause analysis remains an accepted standard for serious incident investigation. However, it is recognised (including by CQC) that other approaches to investigation will be more appropriate in some situations. Round table discussion strengthens the link to the 'front line', integrates 'investigation' and 'learning', allows staff to generate ideas through discussion about underlying causes and possible solutions. Such models have already been trialled successfully in LLR and elsewhere, and resulted in a suitably robust investigation report which was signed-off by the CCG. 'Round table' approaches might be particularly appropriate in primary care, which has notably low levels of incident reporting.

3. Development of a community of practice

a) The health community in LLR should establish and foster an inter-organisational, inter-disciplinary 'community of practice' for learning from incidents (involving local clinicians, patient-safety professionals and academics) to share ideas, identify training/development opportunities (and explore funding to support this), transfer knowledge and champion culture change.

Rationale: There is enthusiasm, passion and sense of urgency to improve learning from incidents and collaborate across organisations. This momentum can provide the beginnings of a community of practice for learning from incidents. It is envisioned that such a community would help address challenges including culture change, dissemination of learning, training and inter-organisational working.

4. Supporting investigations across organisational boundaries

a) Organisations across LLR should ensure mechanisms exist to support collaboration in investigating and sharing learning from incidents which span organisational boundaries: including an agreed protocol for information sharing and exploring the feasibility of 'joint investigations' for particularly complex incidents.

Rationale: Whilst national policy stipulates that providers retain responsibility for investigating patient safety incidents, organisations must collaborate in investigating and learning: information from other providers is often needed for investigations and it is important that this is provided promptly; and for particularly complex incidents, it may be difficult for a single provider to investigate fully and better learning might follow a 'joint investigation' involving multiple providers. Collaborations increase the scope of investigations to identify sources of error and actions across the system.

5. Strengthening feedback and learning

a) Organisations should work together to strengthen feedback and learning across the health system, adopting evidence-based approaches and good practice in feedback and learning, human factors and systems thinking. Mechanisms are needed to ensure that incident reports are a catalyst to better systems and processes at team, divisional, organisational, commissioning and strategic levels.

Rationale: Feedback and learning are recognised, nationally, to be the neglected aspects of serious incident processes. Local data suggest a tendency to rely on 'easy' but less effective methods of feedback; and recommend actions which can be 'signed off' rather than those which will address underlying causes.

6. Triangulating incidents and other sources of patient safety data

a) Organisations should strengthen existing mechanisms to systematically identify and share recurring themes in incident reports, and triangulate this with other sources of patient safety data (such as professional concerns, patient feedback, complaints, morbidity and mortality data).

Rationale: Recognising common scenarios and recurring themes allows a more comprehensive understanding of safety threats, provides a focus for quality improvement work and helps to prioritise these efforts. Where there is ongoing quality improvement work, it may be appropriate for organisations to investigate new incidents within a thematic group, rather than as 'isolated incidents'.

CONCLUSIONS

Improving our approach to learning from incidents is complex problem and it should be recognised that similar issues to those found in LLR are identified across the UK in national reports. LLR is, however, distinguished the significant, proactive steps which have already been taken to collaborate across the entire health system, bringing together providers and commissioners and developing strong links with relevant academic groups. (Examples include the Learning Lessons Review, Better Care Together and, on a smaller scale, the work of this Task and Finish Group). This collaborative approach resonates with emerging national recommendations and LLR therefore has the potential to become recognised as a leader in this area. If we can make a shared commitment, we have the opportunity to both improve care locally and shape the national policy agenda.

At grass-roots level, there is a strong consensus vision for learning from incidents; and a recognition that many patient-safety incidents span organisations and generate learning points at 'cross-organisational' level. Despite some tensions, there is a clear appetite for collaborative work, willingness to improve, innovate and build better relationships across provider and commissioner bodies. There is also a noticeable sense of urgency.

The work of Learning from Incidents Task and Finish Group is a starting point for what needs to be a long term focus on learning from incidents across the health community. The recommendations in this report are intended to provide a focus for the next stage of development but these must be considered as part of a long-term commitment. In a system under pressure, our work also highlights that there are opportunities to improve both the effectiveness and efficiency of learning from incidents through closer collaboration across local NHS organisations.

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