Learning Lessons to Improve Care

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Executive Summary

Context

The purpose of this report is to provide an update to the Governing Bodies for all LLR NHS organisations on (1) the progress taken to address the findings and recommendations in the Learning Lessons to Improve Care report and (2) progress against an interim set of outcome indicators.

Questions

1. Is the Trust Board content with the progress made to date and the interface work of the LLIC Clinical Taskforce

Conclusion

LLIC Clinical Taskforce considers that progress has been made as detailed in section 17 of the attached report. It is recognised that there is still work to be done.

Input Sought

We ask the UHL Trust Board to note the progress of the Learning Lessons to Improve Clinical Care Taskforce.

For Reference

Edit as appropriate:

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

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

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

Organisational Risk Register	[Yes]
Board Assurance Framework	[Yes]

3. Related **Patient and Public Involvement** actions taken, or to be taken: [4 public engagement events held, and an LLIC website created within the BCT website]

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

5. Scheduled date for the **next paper** on this topic: (quarterly update]

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

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

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

Learning Lessons to Improve Care

REPORT OF LLR LEARNING LESSONS TO IMPROVE CARE CLINICAL TASKFORCE JUNE 2015

Purpose of report

1. The purpose of this report is to provide an update to the Governing Bodies for all LLR NHS organisations of
    - the progress taken to address the findings and recommendations in the Learning Lessons to Improve Care report and
    - to report progress against an interim set of outcome indicators.

Background

2. In the summer of 2014 the Leicester, Leicestershire and Rutland (LLR) provider organisations (University Hospitals of Leicester (UHL), and Leicestershire Partnership NHS Trust (LPT)) and 3 Clinical Commissioning Groups (CCGs) published the Learning Lessons to Improve Care report (LLtIC). The report detailed the findings of a clinical audit commissioned by health organisations in Leicester, Leicestershire and Rutland to examine the quality care of patients, and the action plan to address the areas of improvement identified. This is the second progress update since publication, outlining actions implemented to date, progress made and priority areas identified for the future.

Findings and recommendations

3. In response to the findings a clinical taskforce (CTF) was established which focusses on interface issues. Each NHS organisation has also its own quality and clinical governance plans, the required improvements are embedded in these plans. The task force crystallised a five Point Action Plan. The task force is part of the Clinical Leadership Group of Better Care Together (Appendix 1)

    - Clinical Leadership
    - Public and Patient Involvement
    - Integrated care pathways
    - Acute care pathway review and redesign
    - End of life care transformation

This paper provides an update against these action areas. At each meeting each institution makes a formal presentation of progress made. UHL, LPT and Primary medical care have demonstrated the actions they have undertaken and progress made.

Clinical Leadership

4. Clinical Leadership is an important aspect in delivering change across the system. We need to ensure that we have good clinical leaders who are empowered to effect change both in their organisations and across the patient pathway. The LLtIC Clinical Taskforce is fully integrated into the Better Care Together Programme (BCT), particularly the Clinical Leadership Group and is working to develop a clinical leadership programme to support clinical leaders. The current focus on this workstream is to develop a cadre of leaders trained in quality improvement and to drive forward change.

5. In order to focus changes in clinical practice in the right direction, further thematic analysis of the system themes has identified a number of recurrent themes which need addressing:

    - Medicines Management: right patient, right medication, right dose, right route, right time, right documents, right reason, right response!
    - Managing the Deteriorating Patient: recognition, action, escalation.
    - Discharge Process: planning, documentation, follow up.
    - End of Life Care: planning, palliation, progression, patient choice
    - Clinical Responsibility: decision making (juniors), management (seniors)

    UHL and LPT have developed and implemented their own actions to address the findings of the review. To ensure sustainability of those changes they have embedded the changes in their existing quality improvement mechanisms.

    UHL, LPT and the 3 CCGs have reported progress against their plans to the LLtIC Clinical Taskforce and have been able to demonstrate good progress in addressing the concerns identified in the review.

6. The LLtIC Clinical Taskforce has facilitated two clinical summits for clinicians from primary and secondary care to come together to share their experiences of delivering care in LLR and assist in the development of practical solutions; those solutions are either embedded in the BCT workstreams or the actions for the Clinical Taskforce. The second summit was attended by approximately 40 clinicians and, although the numbers are low, there was a feeling that care was improving across the system. We clearly need to build on this and test the views from a wider cohort of staff. Work is underway to build on the UHL Listening into Action work and the LPT Pulsecheck to develop a feedback mechanism from all clinicians across LLR.

7. In order to continually improve the care that we provide our patients we must ensure that we continually learn from the care we provide our patients, particularly when care goes wrong. The LLtIC Clinical Taskforce is working to further improve the reporting of incidents and serious incident and ensure that there is a mechanism for learning across the whole system rather than across individual organisations. The good incident reporting culture in UHL and LPT needs to be replicated across primary medical care, and CCGs. A task and finish group led by local primary and secondary care clinicians are progressing with this work.

8. UHL and LPT have reviewed their methods for undertaking morbidity and mortality reviews and are in the process of improving this across the two Trusts which will maximise the opportunities for learning across the whole healthcare system. From September 2015, all deaths in UHL will be routinely reviewed.

Patient and Public Involvement

9. Four patient and public engagement events have been held across LLR to gain a better understanding of what it feels like to receive care from our healthcare services. This information has been analysed by De Montfort University and has 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

   This information correlates with other patient feedback that individual organisations have received; a detailed summary is included as Appendix 2. The findings and the recommendations from the analysis are now embedded alongside the clinical actions required to make the changes needed.

   In addition each of the individual communications teams are working to ensure that our staff are fully aware of the findings from these engagement events so that they can understand the impact that their care has on the experience of patients using our services.

   In order to share progress with the wider public, a LLtIC website has been created within the BCT website.

Integrated care pathways

10. One of the key aims following the publication of the review was to ensure that any actions to improve the care for patients was embedded in the BCT programme. The CTF agreed that, in order to address the concerns identified in the review relating to fragmentation of care, the appropriate delivery mechanisms are the BCT workstreams. To this end each of the workstreams are aware of the findings of the review and the actions they need to implement through their pathway changes to improve services for patients. This is a key piece of work to address the findings in the report associated with the fragmentation of care.

11. The CTF are actively engaged in the BCT Delivery Board and associated workshops to ensure that the relevant actions are reflected in the BCT workstream plans.

12. A focus has been on improving communication between primary care and secondary care. For example, the ED has a live System one viewer to look at GP records. There has been a push to improve discharge letters. GPs have been supported by the use of electronic special patient notes which can be emailed to the out of hours service and available also to NHS111 service.

13. Following the first clinical summit, The Local Medical Committee (LMC) and UHL are developing an interface forum to enable primary and secondary care clinicians to come together to review patient pathways to ensure that the care was in line with best practice and current literature.

Acute care pathway review and redesign

14. The BCT Urgent Care workstream and Urgent Care Board action plan have incorporated the findings and recommendations form the LLtIC report. This work has also been shaped by the Ian Sturgess report, and work is already underway to improve the urgent care pathway. A recent review by Ian Sturgess has indicated that some improvements starting to be seen but we acknowledge that further work is required.

End of life Care

15. UHL, LPT and the three CCGs have come together to work to address the care pathway issues identified for patients at the end of their lives. The following progress has been made regarding end of life care (EoL):

- Standardised terminology across healthcare organisations
- Unified approach to 'Do Not Attempt to Resuscitate orders'.
- Unified advance care planning
    - Implementation of 'green bags' and 'message in a bottle' to ensure that medications and information is available to all healthcare practitioners
    - Personalised Care Plan: Deciding Right form has access to the Supportive and Palliative Care Indicators tool within it and is integrated into the EoL template across all 3 CCGs
    - Support in place for carers
- Unified approach to anticipatory care
    - Only anticipatory drugs to be included in the green bags – not all end of life medication
    - Out of hours access to anticipatory medications
- Access to equipment to aid care
    - Timely access to wheelchair provision for all EoL patients not just those in last days of life
- Methodology to support communication
    - All leaflets uniformed across LLR so the same source of information can be accessed to provide information to patients / carers and family

Further work is required on the end of life pathway and this is being addressed by the BCT end of life group.

Development of the outcomes framework

16. In order to monitor progress towards improvements in care across the system the LLtIC Clinical Taskforce are developing an outcomes framework. The following 5 indicators are currently being monitored as they are affected by whole system care:

- Standardised Hospital Mortality (SHMI)
- Deaths in the usual place of residence
- Avoidable admissions
- Admissions within 30 days of discharge
- Friends and Family test (Patient experience)

The data is included in Appendix 3, these charts demonstrate that more progress is required as the impact of local actions become embedded.

There is clear progress in reducing the UHL SHMI, with the current SHMI being at 103. In order to further reduce this, the CTF has reviewed the out of hospital SHMI, following this UHL are leading on a piece of work to review the deaths of patients who die within 30 days following discharge from hospital. This review is intended to inform the actions currently in place to test whether they are appropriate or whether further actions are required. The outcomes of the review will be reported in August 2015.

The CTF is working with a national lead for outcomes to develop a more sensitive set of indicators that will combine outcomes indicators, process indicators and balancing indicators to ensure that there are no unintended consequences from the changes being implemented.

17. **Conclusions**

The CTF acknowledge that, whilst there is still work to be done, the following progress has been made:

1) Leadership and commitment from senior leaders and institutions in the local NHS with a high level of engagement. BCT have committed resources to the work
2) Public and Patient involvement with analyses commissioned from De Montfort University and transparency with regular papers to public board meetings of the three CCGS, UHL and LPT.
3) Improvements demonstrated include a decreasing SHMI indicator, improving urgent care system (independent external report on urgent care which has been presented to the LCC), intensive efforts in end of life care focussing on patient held care plans and sharing of plans electronically to out of ours services, care planning for older people and collation of incident reporting in primary care.
4) Monitoring of data through an innovative outcomes framework which includes review of all deaths in UHL from September 2015.
5) The required changes are embedded within the BCT workstreams and there is a mechanism in place to test this.

18. **Recommendations**

The Governing Body Board is requested to note the progress of the Learning Lessons to Improve Care Clinical Taskforce.

Learning lessons to Improve Care
Key themes for thematic analysis – May 2015

Key themes emerging as a result of thematic analysis of Listening into Action events with health care professionals, patients and family carers.

- In July 2014 the three CCGs in Leicester, Leicestershire along with LPT and UHL published the findings of a quality review – learning lessons to improve care
- The review looked at patient case studies and their experience of NHS services to understand where lessons about care could be learned
- A series of listening events were held with patients, carers and staff in late 2014 to explore the perceptions of service users, their carer and professionals
- An analysis of the research was undertaken by SUCRAN Audits Research (Service User and Carers Research Audit Network)

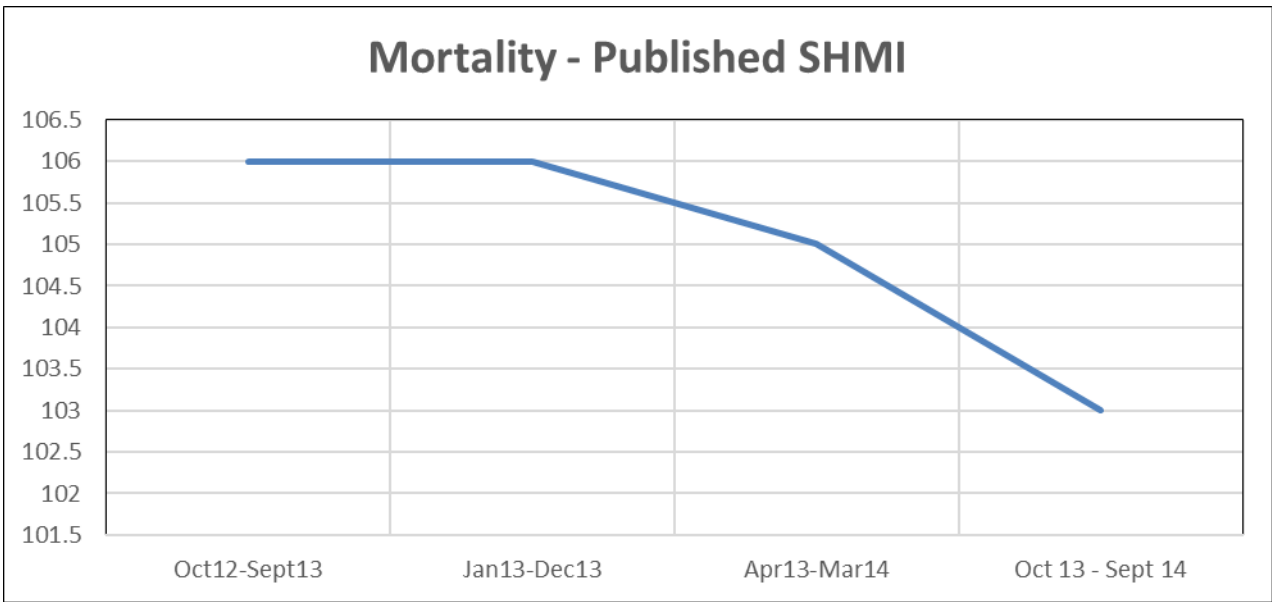
There are 4 key themes emerging from the research:

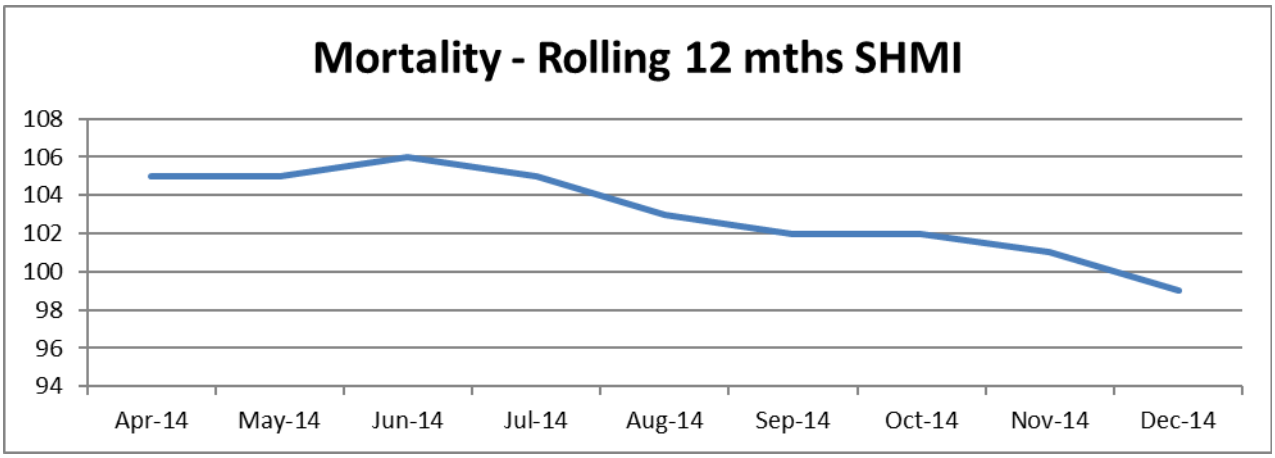
- Communication
    - Quality of healthcare is highly dependent on the quality of the interaction with healthcare professionals
    - Communication needs to work well on all levels
    - Patients suffer from 'Story telling fatigue'
    - Improvements needed in IT
    - Information needs to be appropriate, accurate, relevant and in an accessible format and consistent
    - People feel disempowered by the pressure of time constraints
    - Carers need to be an integral part of the communication about the person they care for
    - Need for Directory of Services for staff
    - Culturally appropriate communications
    - Interpreter services improvement
    - Promotion of self-care
- Dignity and respect
    - People want to be spoken to 'like a human'
    - Patients want to be treated with empathy, compassion, dignity and respect
    - Dignity is also affected by physical environment
    - Dignity makes people feel in control, valued, comfortable and able to make decisions
    - Staff need to feel valued and celebrate success
- Consistency and continuity
    - Closer integration within individual organisations and across organisations
    - Quality transfer experience
    - Consistent delivery of care
    - Inter-professional and inter-organisation training
    - Support to manage complex needs
    - Efficient and effective link between GP surgeries and hospitals
    - Holistic approach
- Speed and access

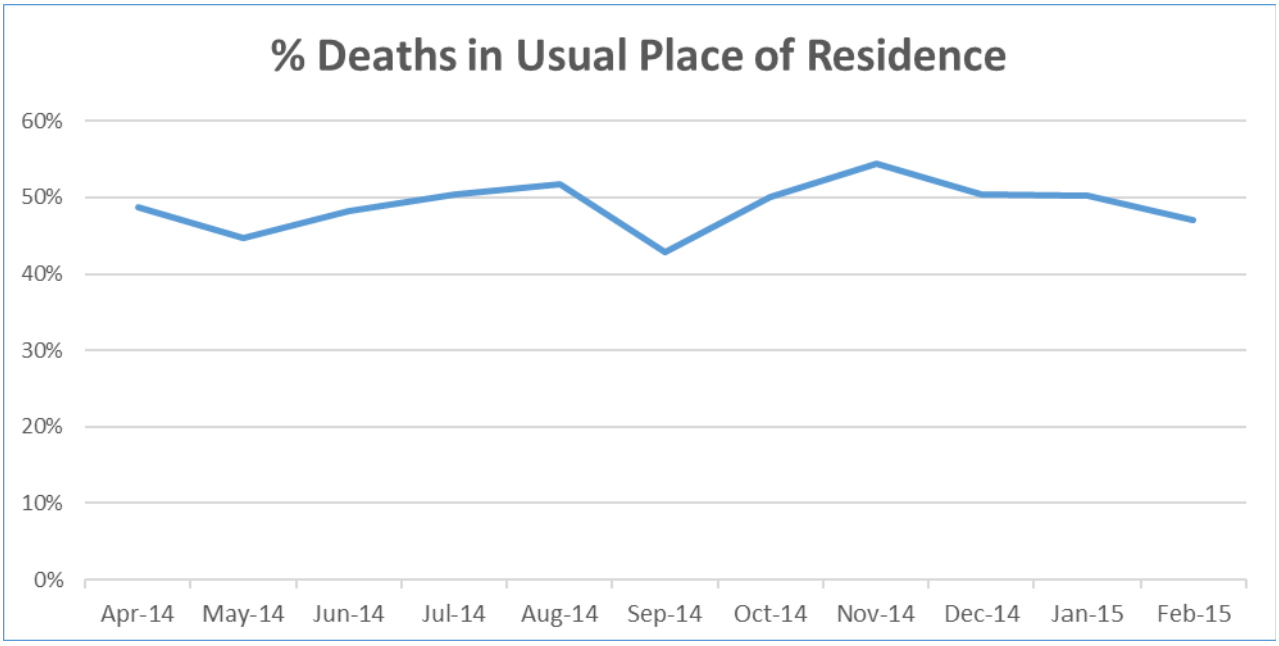
- Waiting times an area of concern
- Timely access
- Lack of out of hours or weekend access to GPs and absence of an effective alternative
- Length of time to make appointment

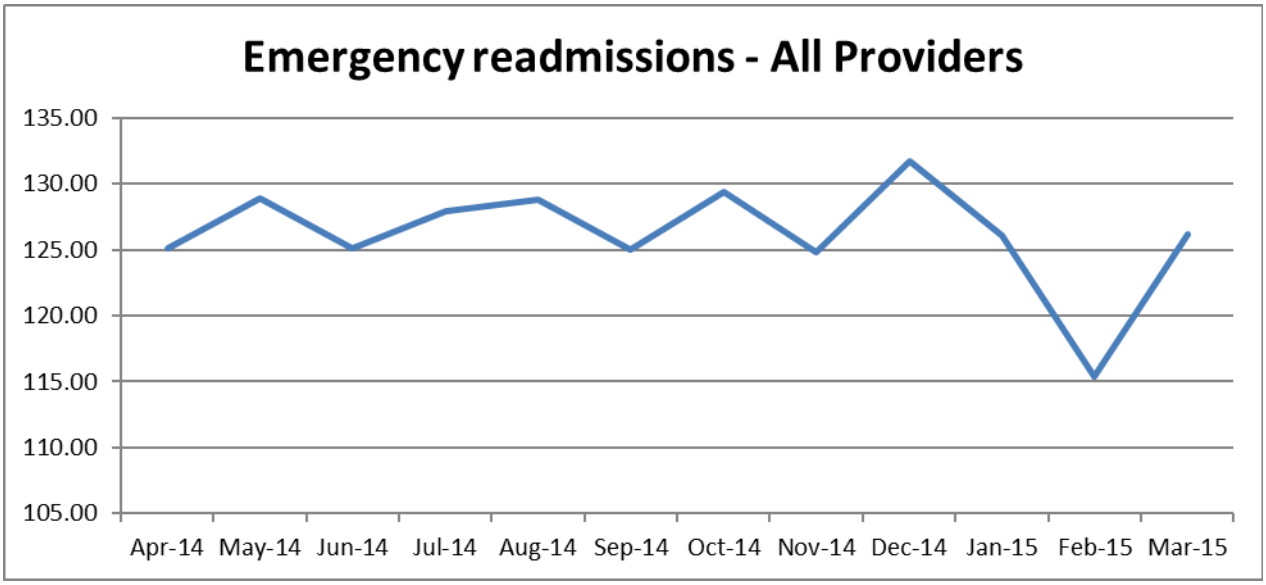
Action as a result of the findings of the research:

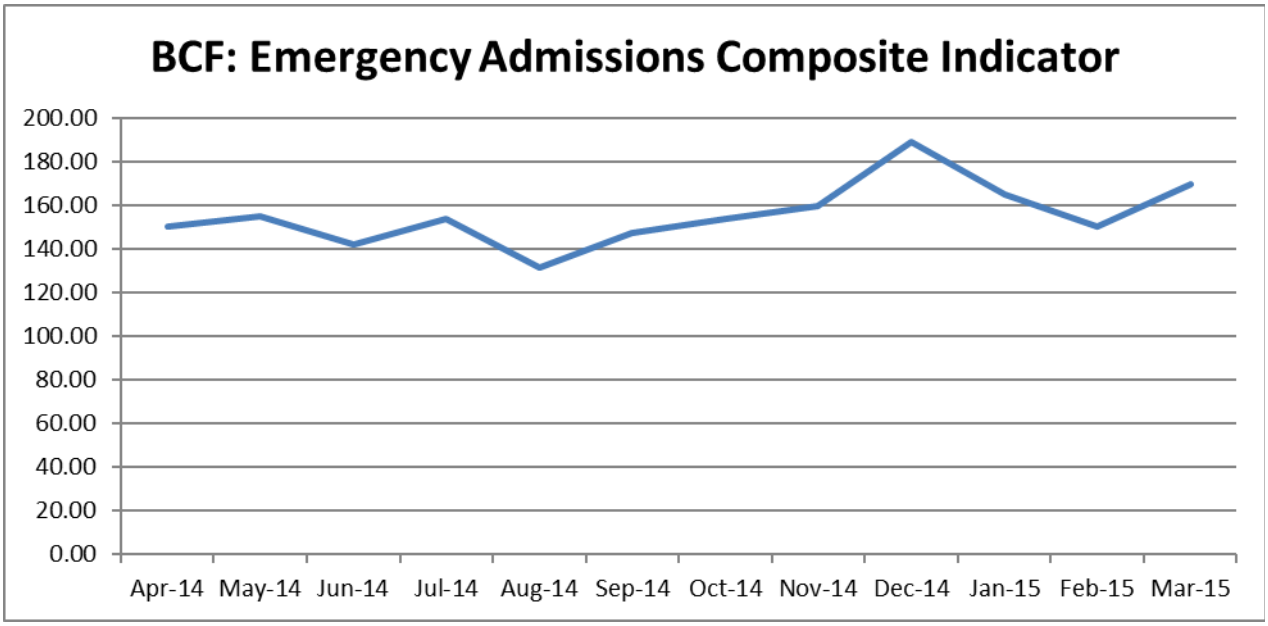
The Learning Lessons to Improve Care Clinical Taskforce will ensure that a gap analysis is undertaken to identify whether all work stream actions plans, already being implemented, meet the needs identified through the research. Where this is not evidence modification will be made to actions, influenced by the research findings.

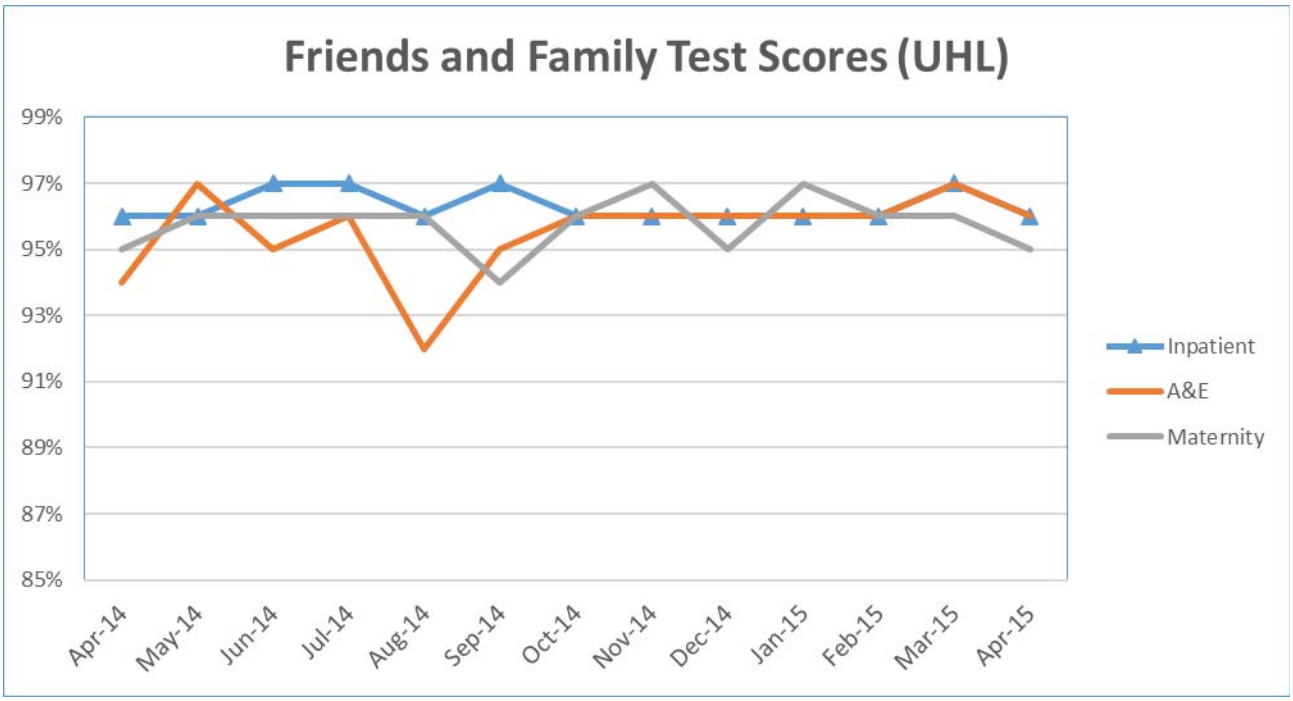

Mortality - Published SHMI
106.5
106
105.5
105
104.5
104
103.5
103
102.5
102
101.5
Oct12-Sept13
Jan13-Dec13
Apr13-Mar14
Oct 13 - Sept 14

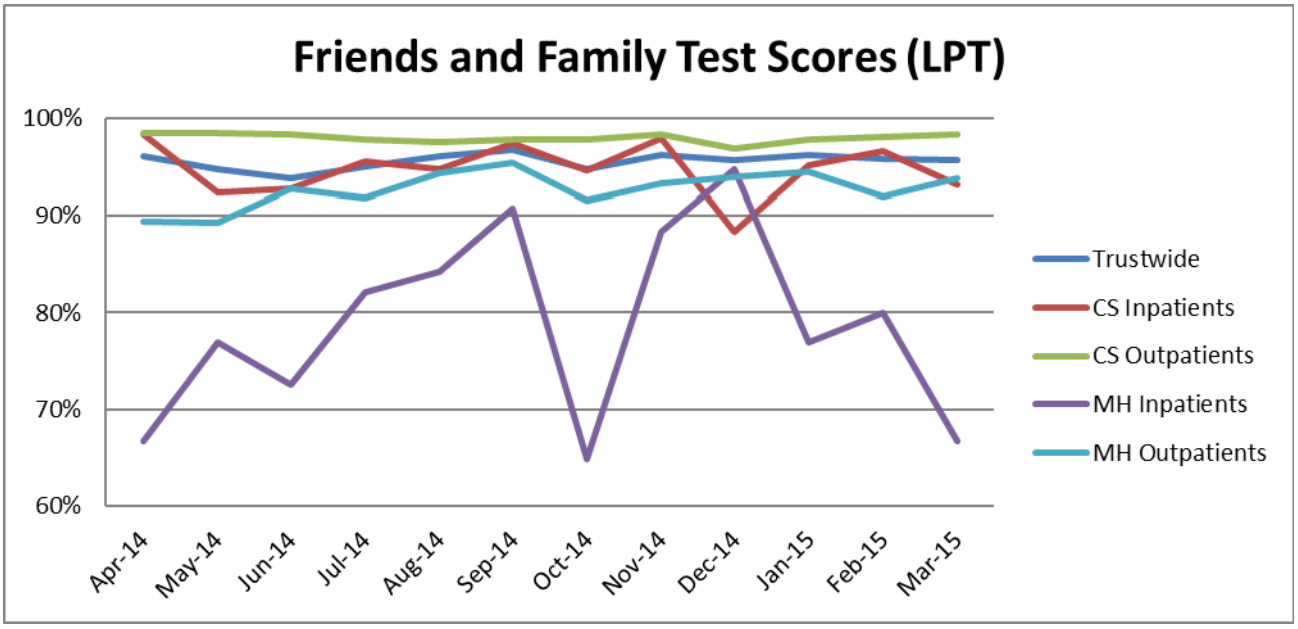

Mortality - Rolling 12 mths SHMI
108
106
104
102
100
98
96
94
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14


% Deaths in Usual Place of Residence
60%
50%
40%
30%
20%
10%
0%
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15


Emergency readmissions - All Providers
135.00
130.00
125.00
120.00
115.00
110.00
105.00
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15


BCF: Emergency Admissions Composite Indicator
200.00
180.00
160.00
140.00
120.00
100.00
80.00
60.00
40.00
20.00
0.00
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15


Friends and Family Test Scores (UHL)
99%
97%
95%
93%
91%
89%
87%
85%
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
Inpatient
A&E
Maternity


Friends and Family Test Scores (LPT)
100%
90%
80%
70%
60%
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Trustwide
CS Inpatients
CS Outpatients
MH Inpatients
MH Outpatients