Learning Lessons To Improve Care Health Overview and Scrutiny Meeting

10th June 2015

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

- Introduction
- Progress and achievements to date
- Outcomes
- Next Steps

Rationale for Joint Quality Review

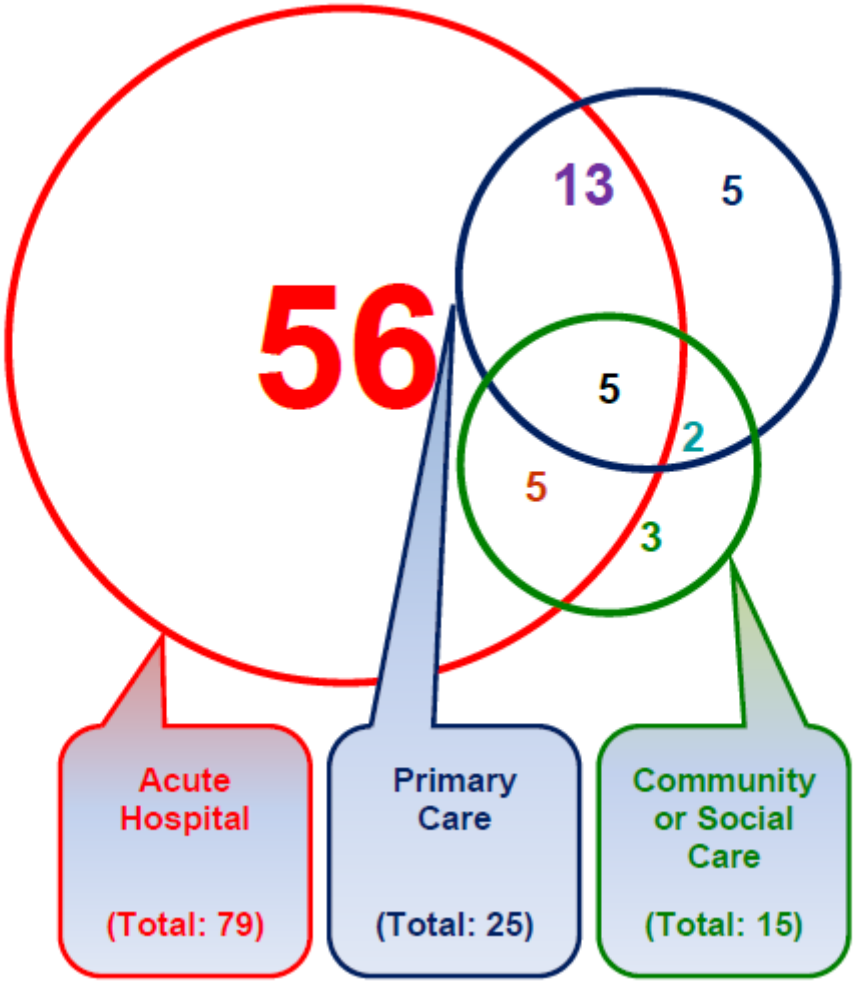
- This was a proactive review of the quality of patient care, a positive step taken by the CCGs, UHL and LPT. The aim was to:
  - Respond to UHL SHMI of 1.05 – but within expected limits, not a statistical outlier or in the national Keogh list
  - Address concerns of fragmentation of care in LLR raised via GP practices in reporting poor quality of care
  - Ensure ongoing improvements in the quality of care delivered to patients across LLR

Summary of Findings

- **Non random sample of 381 who had died**
- 89 cases (23%) - below an acceptable standard
- 292 cases (77%) - at least an acceptable standard
- Examples of good practice
- Significant variation in the quality of care - especially emergency care and end of life care
- Evidence of a lack of joined up care across LLR

Findings Across the Patient Pathway

Figure 4: Venn diagram showing healthcare setting for significant lessons to learn in the 89 cases with below acceptable standard of care



Examples of findings from the top 3 themes

- DNAR
  - *DNAR form should have been completed for this patient with metastases. Failure to inform the hospital of the existing community DNAR form in place*
- Clinical reasoning
  - *Failure to recognise that patient had significant bleed where initial assessment said that patient might have lost 300 ml of blood. Patient later on had cardiac arrest, subsequently discovered to be due to catastrophic GI bleed*
- Palliative Care
  - *Frail older patient admitted with general deterioration in community, community DNAR in place, secondary care unaware. Resuscitation was unsuccessfully initiated*

Principle

- Learning lessons is about embedding the learning in business as usual and is not about a stand alone project
- Therefore it must be in the fabric of the system transformation plan
- Should be seen alongside all the other initiative that are taking place including the Sturgess report into urgent care

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

QUALITY COMMITMENT

	Clinical Effectiveness Improve Outcomes	Patient Safety Reduce Harm	Patient Experience Care and Compassion
AIM	To reduce preventable mortality	To reduce the risk of error and adverse incidents	To improve patients' and their carers' experience of care
KPI	UHL's SHMI =/<100 by March 2016	Reduction in Harm Events by 5%	Trust level F&FT score to 97% by March 2016
2015 / 16 PRIORITIES	**Improve pathways of care:** • Review of all in-hospital deaths • Use of clinical benchmarking tools • Identify actions and work-streams where greatest potential for preventable mortality **Improve Consistency of 7 Day Services** • In line with Keogh 10 Clinical Standards	**Earlier Recognition and Rescue of the Deteriorating Patient** • Sepsis • Handover • EWS • Acting on results **Consistencies in Core Practices** • Medication Safety • Infection Prevention	**Further expand end of life care processes** • Early identification of patients requiring supportive and palliative care (SPICT) • Strengthen bereavement support **Improve the experience of care for older people across the trust** • 'Fixing the Basics' • Improve the Environment
	Learning and Development Implementation of Trust M&M Database for shared learning across all areas	**Learning and Development** Implementation of Safety Briefings in wards and departments	**Learning and Development** Triangulation and review of feedback from all sources and all key characteristic groups

UNDERPINNING WORK STREAMS

I.T. Enablers - Guidance and Monitoring Adequate Resources - Time in Job Plan and Admin Support

Trained and Motivated Workforce - "Team Around the Patient"

SUMMARY OF ACTIONS TAKEN DURING 2014/15

LLtIC Ref	Area for Improvement	Actions
3	Medicines Reconciliation	Pharmacists' Access to GP medication records via SystemOne in admission areas to confirm medicine history and allergy
		Revised policy on medicines reconciliation disseminated with supporting education
1a	Standardised Mortality Reviews to support on-going learning	UHL M&M Policy reviewed , revised and launched – includes revised M&M Review Templates and escalation process.
3b		Process for 'Screening of all in hospital deaths' developed and agreed and informatics and admin support identified.
2a	Standardised Clinical Handover	Nerve Centre Handover system implemented across all areas for nursing handover
1	Improve the experience of care for frail older people	Six wards successfully achieved the national Quality Mark for Elder Friendly Wards and improved care for older people Improvement ideas from Quality Mark wards developed into a ward pack to improve quality and patient experience for other areas
1a	Improve process for DNA CPR	Separate UHL DNA CPR policy developed and launched which incorporates guidance on completion of the East Midlands DNA CPR form and the 2014 'Cambridge ruling'
3a		E-leanring-package /video developed and launched to support medical staff with implementation of DNA CPR policy

SUMMARY OF ACTIONS TAKEN DURING 2014/15

LLtIC Ref	Area for Improvement	Actions
1b	Earlier recognition of severity of illness / Patients in correct care setting	Acuity recording tool implemented in all areas with twice daily review of patients acuity undertaken
3	Earlier recognition of Sepsis	Sepsis 6 Care Bundle implemented – 75% compliance by end of Q4.
1b	Discharge Communication	UHL Discharge Letter Standards reviewed and revised within the 'Letters Policy' to highlight importance of accurate recording of diagnosis, complications and any end of life care requirements
1a	Standardise End of Life Care Discharge documentation	UHL guidance and documentation relating to End of Life care reviewed and standardised to cross reference to documentation used in Primary Care and LPT
2b		Patients in last days or weeks of life discharged with anticipatory medication for the common symptoms at end of life and the standard LLR authorisation form for their administration completed
3	Implementation of AMBER for patients approaching end of life within the next year	Further embedding of AMBER care bundle on wards which commenced in 13/14 and implementation on additional 18 Wards in 14/15

Ongoing/New LLtIC Actions

LLR LLIC "Top 12 Theme"	UHL Action Plan Work-Stream	Monitoring Committee
Severity of Illness / Unexpected Deterioration and Responding to EWS	Embedding e-handover with medical staff*	'Deteriorating Patient' T&F Group - AC&ACB
	Compliance with Handover Policy*	
	EWS* implementation	
	Acuity monitoring and response	
	Ensure patients in correct care setting	
	Earlier recognition and management of Sepsis *	Sepsis T&F Group – AC&ACB
Clinical Reasoning / Clinical Management	Acting on Results* process	7 Day Services Board
	Ward Rounds Standards	
	Consultant Assessment of Emergency Admissions within 14 Hours*	
Supportive & Palliative Care (SPCA)	Improving transfer of care where death anticipated within a few days of discharge	End of Life and Palliative Care Board
	Patient Information about DNACPR and end of life care	
	Recognition of patients requiring SPCA*	
	AMBER Care Bundle implementation	

***Work-streams within the 15/16 Quality Commitment **Quality Schedule or CQUIN Scheme work streams**

Ongoing/New LLtIC Actions

LLR LLIC "Top 12 Theme"	UHL Action Plan Work-Stream	Monitoring Committee
Discharge Management / Discharge Communication	Monitoring quality of Discharge and Nursing Transfer Letters	'Discharge Communication T&F
	Supportive & Palliative Care Approach*	End of Life & Palliative Care Board
Medicines Management / Antibiotics	Medication Safety*	Medicines Optimisation Committee (MedOC)
Fluid Management	Implementing Fluid Management Policy and Guidelines	'Fluid Management T&F Group (reports to MedOC
	Improve Fluid balance monitoring	
Cross Cutting Themes		
Policies and Guidelines	Access to up-to-date guidelines	Policies & Guidelines Committee
Mortality & Morbidity Processes	Learning from M&M Reviews*	Mortality Review Committee
Older Frail Person Patient Experience	Improving the Environment*	Frail Older People's Committee

Organisation specific actions - LPT

- Quality Improvement Plan
  - overseen by Quality Improvement Program Board
- Clinical networks and forums across all 3 divisions
- Trust wide work stream on quality improvement
  - teams from each division participating on a PDSA cycles quality improvement focussed on patient safety- early stages
- Developed Co-ordinated Community Health Services to provide more locality based integrated teams
- Leadership Development Programmes
- Morbidly and mortality(M&M) review process for all deaths within in- patient areas

- Improved documentation and training – End of Life
- Integrated care with social care
- Morbidity & mortality review process implemented

Organisation specific actions – Primary Medical Care

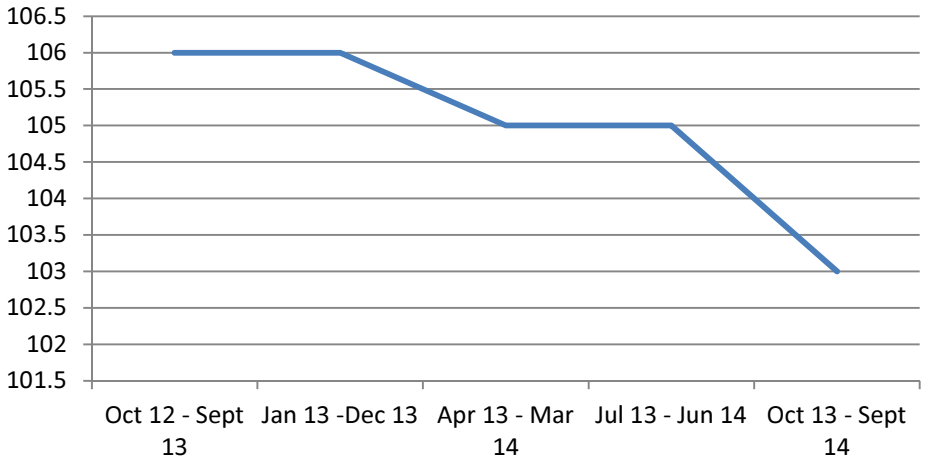
- Medicines Management
- Managing the Deteriorating Patient
- Discharge Process
- End of Life Care
- Clinical Responsibility:

The Joint Action Plan

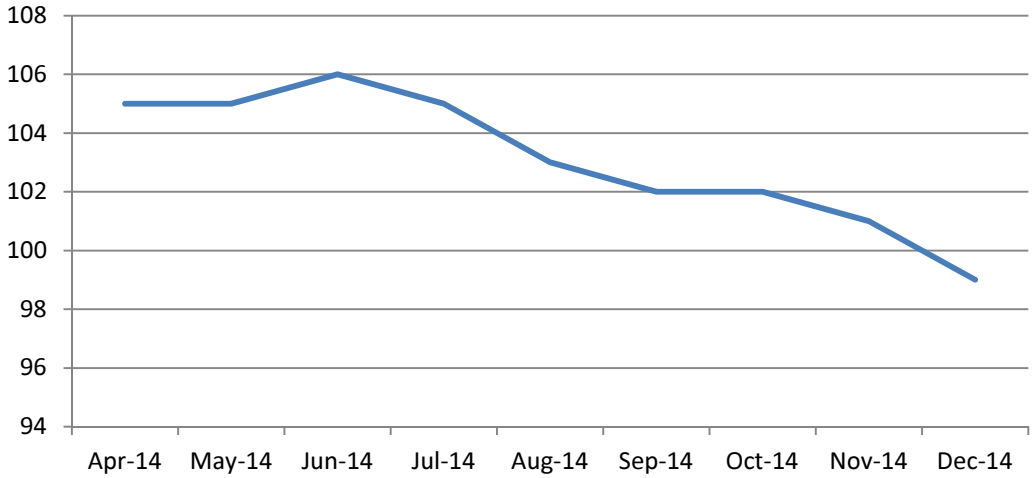
- System wide clinical leadership to ensure that patient care issues are addressed across the health community
- Patient and staff engagement, listening and action
- Effective care across interfaces between providers of health services
- Transforming emergency care in our wards, hospitals and communities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

Outcomes

Standardised Hospital Mortality Ratio

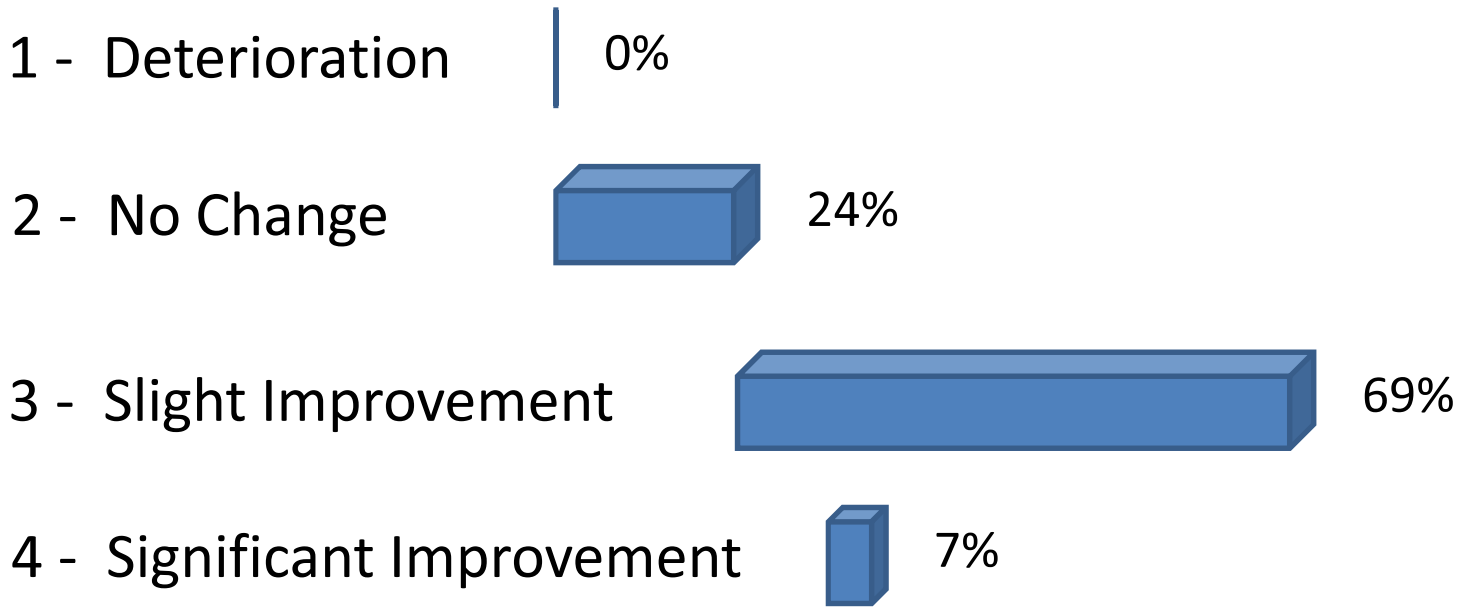


Mortality - Rolling 12 mths SHMI



Q1 – Quality of Care:

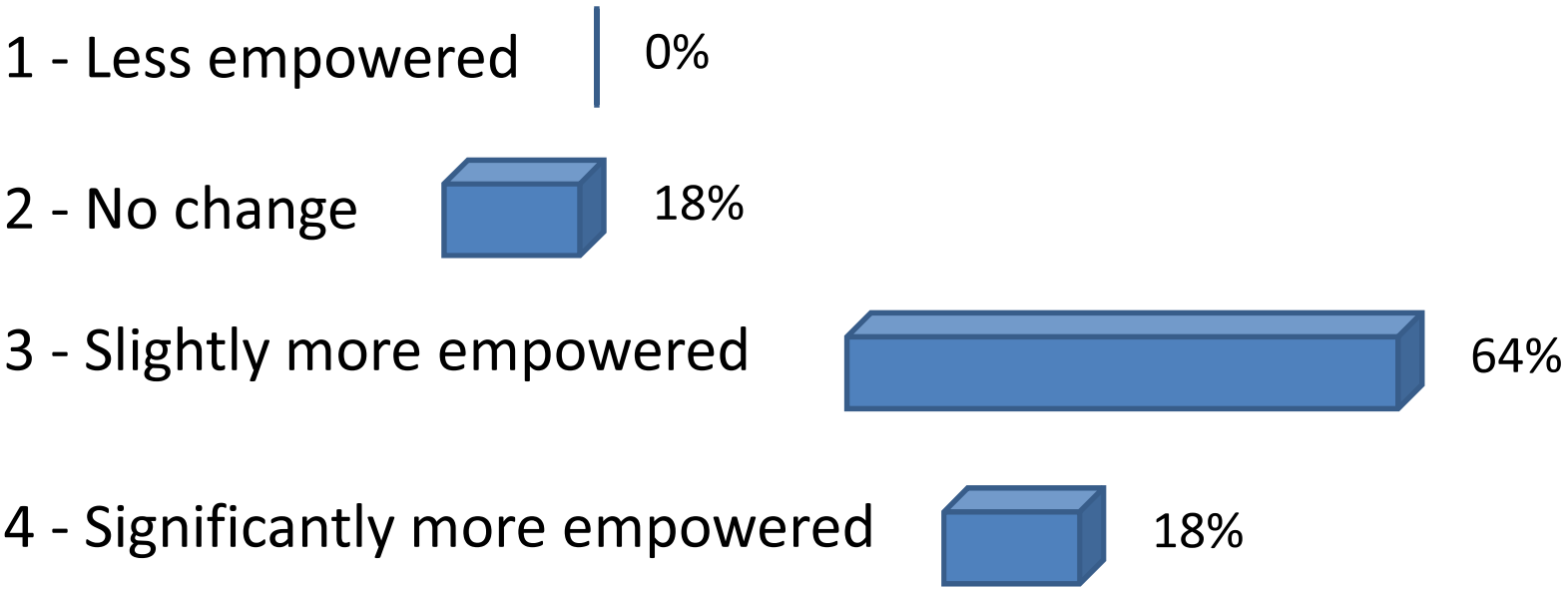
To what extent do you feel the quality of care delivered in LLR has changed since publication of the review in July?



Voting

Q3 – Empowerment:

To what extent do you feel empowered to influence the quality of care provided?



Outcomes Framework – Monitoring

- Interim metrics
  - Emergency readmissions within 30 days of discharge
  - Composite measure on avoidable emergency admissions
  - Death in usual place of residence
  - SHMI
  - Friends and Family Test
- Sensitive indicators to monitor progress across the system
  - Qualitative and quantitative
- Pulse check

Considerations regarding next review

- National advice regarding review
- Prof Nick Black key messages:
  - Right to look at deaths across health economy not by provider
  - Puts LLR well ahead of the curve,
  - Focus on qualitative learning not numbers

Summary

- **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**
- **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**
- **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.**
- **Monitoring of data through an innovative outcomes framework which includes review of all deaths in UHL from September 2015.**

Questions?