Quality review action plans

Learning from the Leicester, Leicestershire and Rutland (LLR) quality review has identified a number of areas that require improvements.

Page 1 provides numerous examples of actions we had already started to implement and some new actions we have taken as a result of this review.

Should you wish to read the full version of any of the healthcare organisations action plans these are available on request

In addition, we are also working together across the health community on 5 key areas of action (see pages 2 & 3)

University Hospitals of Leicester NHS Trust Action Plan

We have invested to recruit an additional 200 ward based nurses since 2013/14 which will improve quality outcomes at ward level. The Trust has also committed to implementing 'Supervisory Status' of the Ward Sisters for 2 days a week on all wards to ensure quality standards are delivered.
We have standardised the approach to care for patients facing an uncertain recovery and who are at risk of dying in the next one to two months and invested in staff training to deliver this.
We have implemented an electronic system to improve safety of prescribing, supply and administration of medicines for inpatients and patients discharged from the medical wards at the LRI.
We have strengthened our ward communication and staff handover systems to ensure all patients have care and discharge plans in place, which are regularly reviewed with greater patient involvement.
To ensure patients at nights, weekends and bank holidays receive continuity of care we have put in place a multi-disciplinary team to oversee out of hours care.
We have redesigned our cardiac and respiratory care pathways to ensure appropriate patients are directly admitted to the Cardiac and Respiratory Units at the Glenfield Hospital.
We have established an Older Persons Board which is executively led to ensure the needs of frail and older patients are consistently met through various work streams and have already achieved the Quality Mark for 'Elder-Friendly Wards' for 7 of our wards.
Our 14/15 Quality Commitment work-streams and quality improvement schemes, agreed with our commissioners, include earlier recognition and response to the deteriorating patient, better care for patients with diabetes and reducing medication errors

East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group
Leicestershire Partnership NHS Trust
NHS England (Leicestershire & Lincolnshire Area)
University Hospitals of Leicester NHS Trust
West Leicestershire Clinical Commissioning Group

Contact details

- **East Leicestershire and Rutland CCG**
  www.eastleicestershireandrutlandccg.nhs.uk
- **Leicester City CCG**
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- **Leicestershire Partnership NHS Trust**
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- **University Hospitals of Leicester NHS Trust**
  www.leicestershospitals.nhs.uk
- **West Leicestershire CCG**
  www.westleicestershireccg.nhs.uk
- **NHS England**
  www.england.nhs.uk/mids-east

Leicestershire Partnership NHS Trust Action Plan

We have developed advanced nurse practitioners (nurses who have undergone further training and expanded their expertise) to lead care management in community hospitals with support from University Hospitals of Leicester (UHL)
We have trained advance nurse practitioners to complete Do Not Attempt Resuscitation (DNAR) forms for use across the LLR healthcare system.
We have developed a competency framework for nurses signing Do Not Attempt Cardiopulmonary Resuscitation (DNA-CPR), which will be implemented by the end of 2014.
We have created a 7 day face to face service between the hours of 9 to 5 supported by a 24 hour telephone advice service to support patients and family at the end of life *(Action for LOROS & LPT).*
We have committed to "Care in the last days of life" and training of 1000 staff by September 2014.
We have a co-ordinated community health service redesign work programme, which is ongoing and in collaboration with social care and GP practises.
We have a 'single point of access' for scheduled (planned) and unscheduled (unplanned) care.

LLR
Joint Action Plan
(See page 2)

Clinical Commissioning Groups Action Plan

We have provided training in 'Gold Standards Framework' in end of life (EoL) care for GPs/nurses/care homes.
All CCGs have end of life care schemes with national standards.
Computer templates for advance care planning in place.
All GPs have dementia screening in place through NHS Health Checks system.
We have implemented Advanced Care planning/Emergency Response Service to enable people to remain at home if appropriate to avoid hospital admission.
We continue to deliver high quality, well-attended 'Safeguarding' training and evaluation at appraisal.
All CCGs have been working alongside NHS England to identify practitioners in need of development or where concerns relating to practice exist.
We have developed and implemented a GP feedback and reporting concerns process across LLR to identify and take action on issues related to quality & safety.
We undertake regular unannounced visits to assess the quality of commissioned services- such as hospitals, care homes and health units.
We have GPs and nurse specialist measures in place to support EoL care across all three CCGs areas.

LLR Quality Review Joint Action Plan

Theme	Actions	Lead officer	Time frame	Examples/Benefits for Patients
1. System wide <u>clinical leadership</u> to ensure that patient care issues addressed across the health community	LLR clinical leaders commit to establish a system wide clinical leader task force: This will: - Monitor progress against the key themes identified within the quality review - Ensure there is collaborative system wide action taken to improve quality and safety - Commission a further independent review / evaluation - Oversee and receive ongoing patient feedback on LLR services We have a strategic plan to deliver optimum care across the health community – *Better Care Together*	Professor Mayur Lakhani	**In place** **Medium term (M/T)** **Long term (L/T)**	Working in the best interests of patients to address the key themes and lessons from the quality review has required organisations to work together. A number of examples of the benefit of this work are highlighted below to collectively improve and transform end of life care. We have worked together to develop a 5 year strategy for our health services across LLR which aims to deliver best practice care pathways to people within LLR
2. Patient and staff <u>engagement, listening and action</u>	- GP feedback systems on any quality care issues related in place across LLR - Listening events across LLR for patients, the public and staff - Patient safety campaign postcard: ask MAGIC questions to promote shared decision making (‘what is your diagnosis? can I plan for the future?’) - Hellomyname is a campaign to promote better doctor/ nurse/patient interactions and we will look to adopt and promote this across LLR	Chief Nurses (providers and commissioners)	**In place** **ongoing** **M/T** **M/T**	Feedback from GPs in the last 6 months have led to action being taken to make improvements as a result
3. Effective care across <u>interfaces</u> between providers of health services	- Electronic transfer of information e.g. patient discharge summaries from secondary care to primary care i.e. from hospitals to GPs - Review quality of patient discharge and referral documentation - Increased data sharing & monitoring across organisations to address current or potential gaps - Development and implementation of ambulatory care pathways (ambulatory care is where conditions can often be treated without the need for an overnight hospital stay). - Introduction of individual care plans following identification of risk stratification (risk stratification is a clinical evaluation used to determine a person's risks when suffering a particular condition) and Multi-Disciplinary Team planning for older people shared with health & social care providers	John Adler and Toby Sanders	**In place** **M/T** **M/T** **M/T** **In Place**	Patient’s care plans are followed both in hospital and community settings, with no break in care provided and care needs fully communicated across organisational boundaries Patient discharge documentation has been amended to put the key information for GPs to note at the top of the discharge letter. All clinicians can see all laboratory results on line

4. Transforming <u>Emergency care</u> in our wards, hospitals and communities	- Emergency care pathway review (LLR) - LLR wide sign up and commitment to National 'sign up to patient safety campaign' - Development of a community based comprehensive older peoples assessment service and support - LLR-wide review of support which would allow older people to remain in their usual place of residence, including a falls support service - Well-developed joint referral guidelines e.g. 2 week wait, Stoke/TIA, Urology with haematuria, acute retention of urine (all in place now).	Kevin Harris / Dave Briggs	**underway** **M/T** **M/T** **M/T** **M/T**	All patients aged 75+ have a named GP The most 'at risk' 2% of patients on GP lists will have individualised care plans, to intervene before a 'crisis' point is reached, to prevent admission to hospital 17 Senior doctors for older people now working across community and hospitals to support doctors making the best clinical decisions for frail older patients Consultant advice line for GPs considering admitting patients to hospital Clearer care plans for hospital patients with quicker decision making and action LPT have established an older peoples clinical working group to promote effective joint working between community and secondary care
5. Transforming <u>end of life care</u> (EoL)	LLR EoL Care working group is established to develop unified approach to EoL care across all LLR healthcare organisations and includes: - Standardisation of EoL care plans & process for sharing key information across organisations - Implementation of a joint EoL care pathway across LRR - Design and implement training and development for GPs/nurses/care homes on EoL care planning & DNAR orders - Revision of guidelines & teaching of best practice for DNAR orders - Rapid Discharge for EoL patients to named GP. Where DNAR orders in place flagged prominently on discharge summaries - 'Electronic patient record' in fast track development to share EoL / discharge and patient management plans seamlessly across all organisations	Dr Avi Prassad	**In place** **M/T** **M/T** **M/T** **M/T** **M/T**	EoL care plans now travel with the patient in a distinctive 'green bag', ensuring that wherever they are their status and wishes are accessible and known to clinicians 1,000 patients in the City in the last year have benefitted from EoL care plans and 85% died in their place of choice (national average 45%) Many clinicians have been trained in broaching EoL discussions with families and patients (primary and secondary care settings) We have introduced key nursing staff 'job swaps' with LOROS to gain experience of EoL and palliative care GP mentors & specialities nurse mentors in place across CCGs to support primary care clinicians 13 palliative (care for people with serious illnesses) specialists working in (hospital / community settings) providing quality EoL care and sharing their expertise with other nurses A new 'fastest' track discharge process for those inpatients who want to die at home and in the last hours of life… 6 hour maximum turnaround for support

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