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

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'Learning Lessons to Improve Care' – Publication of a Quality Review in Leicester, Leicestershire and Rutland

Local Clinical Commissioning Groups (CCGs), the Leicestershire Partnership NHS Trust (LPT) and University Hospitals of Leicester NHS Trust (UHL) have today published a 'quality review' conducted into previous patient cases in order to understand where lessons about care could be learned.

The quality review was commissioned as the Summary Hospital Level Mortality Indicator (SHMI) – one way in which mortality is measured – of UHL had been slightly above the average for the rest of the country since 2010/11. Although it was still within expected limits, the local health community decided to follow the advice of Professor Sir Bruce Keogh and to investigate to understand more about what the very best care should look like, whether there were any local factors affecting current services and what improvements could be made. The review was jointly commissioned by the CCGs, LPT and UHL.

The quality review focused on the healthcare that patients received between March 2012 and June 2013and looked at the care the patients had received before admission to hospital, during their stay in hospital and after being discharged, including care from local GP and social care services. The review was designed to shine a light on the quality and appropriateness of care rather than clinical outcomes. This is an important distinction, the reviewers were not looking at whether there was 'harm' or 'avoidable deaths' but whether the quality of care was as good as it could be in the notes they studied.

The review employed a unique and innovative methodology, never before used in this country, which deliberately selected a group of patient records where, because of the complexity of the cases, it was most likely that quality issues would be found. The review specifically set out to look for problems and set the bar high in terms of the definitions of care which was characterised as having 'lessons to learn' or deemed 'unacceptable'.

381 case records were reviewed by the team of local doctors and nurses from primary care, community health services and hospitals. Of the patient records considered, 64 per cent of the patients died in hospital and 36 per cent died in the community, which reflects the fact that SHMI looks at mortality in hospital and 30 days after discharge from hospital.

The reviewers found 'significant lessons to learn' for all healthcare partners in just over half of the cases they examined. Examples included:

- confusion about Do Not Attempt Resuscitation (DNAR) orders
- delay in giving antibiotics
- communication problems between hospitals and GPs
- cases where a patient's management plan was not clear.

89 cases (23.4 per cent) of the patient records examined were deemed by the reviewers to show care that was unacceptable in one or more aspects. 30 of these patients were admitted to hospital when the reviewers thought that they should have received other types of care such as end of life, palliative or continuing care rather than being admitted. Of the total sample of 381 case notes reviewed 79 (21 per cent) were deemed to have had 'unacceptable' care in hospital and from at least one other healthcare provider.

Most of the issues related to patients who were on the Leicester, Leicestershire and Rutland emergency care pathway. For example the reviewers found that communication between different parts of the local health system and within hospital was poor which sometimes meant that diagnosis was delayed or test results were not acted upon in a timely manner. As a result of this the local NHS has asked Dr Ian Sturgess, a renowned expert in emergency care, to work with both GPs and hospital doctors on 'root and branch' change to emergency care pathways. This work started 2 months ago and changes are already being made to practices and established procedures.

The reviewers also found that patients did not always receive the most appropriate type of end of life care, including palliative care and the use of 'Do Not Attempt Resuscitation Orders' (DNAR orders), due to issues in the way the local health system is organised. In most cases, this meant that patients who were at the end of their life and may have expressed a preference to die outside of hospital were still brought into hospital, while some patients in hospital were not recognised as being at the end of life. As a result patients were resuscitated or had other forms of medical intervention when it would have been in their best interests to have had end of life care and comfort.

In order to improve end of life care for the future, the local NHS community will be holding a series of listening events across Leicester and the surrounding counties. These events will bring together carers, volunteers, patients, charities and clinicians to talk about what constitutes quality end of life care when a patient reaches the stage when medical intervention is not in their best interests and how they can all work better together to make sure that they have the right conversations with patients and their families, no matter how difficult those conversations might be. It will also be urging all frontline doctors and nurses to discuss prognosis and future care plans for patients with serious illnesses at a much earlier stage.

Improvements in end of life care are already being seen. Since April 2013, more than 1,000 patients on the palliative care register in their last twelve months of life have benefitted from having an Emergency Healthcare Plan (EHP). As a result, 85 per cent of patients who had a care plan died in their place of choice and their wishes were carried out – almost double the national average of 45 per cent.

Dr Kevin Harris, UHL Medical Director, and Professor Mayur Lakhani CBE, GP Chair of West Leicestershire CCG, have apologised to patients and their families on behalf of their colleagues across the system. They said:

"We take this report very seriously. As doctors we want to do much more for our patients and it is essential that we have a high quality local joined up health care system. On the evidence of this review, we have let some people down. For this, we want to apologise to the families of all 89 patients whom the review found to have received substandard care and assure them that we are going to work tirelessly with our colleagues to make substantial and lasting improvements to the local health system."

Dr Harris and Prof' Lakhani have written to the relatives of all 381 patients, whose notes were reviewed, to explain the purpose and outcomes of the review.

The local healthcare community has also recently published its five year plan, "Better Care Together", which aims to ensure much more integrated services which work better for patients. Implementation of this plan begins this year.

Dr Ron Hsu and Ms Lucy Douglas-Pannett, the study's authors, said:

"We commend the local NHS organisations for commissioning this independent case records review by public health specialists and would like to thank the 49 local doctors and nurses who volunteered to review the cases for us. We used a review methodology which looked at the whole patient journey involving general practice, acute hospitals and community services, rather than just the acute hospitals.

"Whilst the reviewers found cases of excellent care delivered by doctors, nurses and other clinicians in the local NHS, there was a worryingly wide variation in care which included care considered to be 'unacceptable'. There was evidence of fractured care, dysfunctional processes and lack of joined up thinking throughout the NHS in Leicester, Leicestershire and Rutland.

"We recognise that doctors, nurses, other clinicians and managers in the local NHS have been struggling to fix the emergency care pathway as individuals rather than as part of a system. We urge all those working in the local NHS to work collaboratively to modernise and improve the emergency care pathway experienced by the patients whose cases we reviewed, so that doctors, nurses, other clinicians, managers and the people in Leicester, Leicestershire and Rutland can be proud of the care the NHS provides."

Toby Sanders, Managing Director of West Leicestershire CCG, and John Adler, CEO of UHL NHS Trust, added:

"We have a responsibility to create a better functioning, joined up, system of care. There is much more to do, so through *Better Care Together* we will work as partners to accelerate our plans for integrated care and to support our clinicians to deliver high quality patient care."

Dr Aly Rashid, Medical Director for NHS England (Leicestershire and Lincolnshire), said:

"If the reviews of patient care of the last few years teach us anything, it is that the NHS should not allow itself to be too easily assured or reliant on just looking at high level measures of care quality. This quality review asked difficult questions. It went looking for problems as a means of improving the overall quality of care across the Leicester, Leicestershire and Rutland health service. As such I think the CCGs and the provider Trusts should be recognised for the transparent and open way that they are sharing the findings. It is clear to me that there is significant and important work to do in response to the review and I will be supporting the local health economy to take action to improve services and quality for patients."

Mary Dixon-Woods, Professor of Medical Sociology at the University of Leicester, commented:

"'Hard Truths', the government's response to the Francis Inquiry, called for a "problem-sensing" approach to patient safety rather than the "comfort-seeking" approaches of the past. We know from research that organisations that actively seek discomfiting information are those that have safety at the heart of what they do. It is those organisations that are creating cultures of candour and openness and it is those organisations that are best placed to make improvements. This report is an excellent example of exactly that. It has got to the bottom of a problem, generated learning, and been transparent. Care for patients will now get better. I hope many other NHS organisations follow the same path."

Many of the issues described by the review were already recognised locally and nationally as key areas for improvement and as such in many instances action is already being taken. Nonetheless the review has shown where, as a whole local health system, effort should be focused. As well as improvements to emergency and end of life care, action is also being taken in other areas highlighted in the quality review:

- There were occasions when the severity of a patient's condition was not recognised as early as it ought to have been, both in hospital and in the community. The clinical teams have therefore been working to increase the knowledge and skills of staff in the community and in hospital to ensure that they have the policies and guidelines in place to support their practice.

- Particular attention has been paid to ensuring that when a patient undergoes a test, that the results are acted upon in a timely manner, that ward rounds

are conducted in a way that identifies risks, actions and future plans for the patient's care and that a senior clinical review takes place.

- Clinical teams have improved the awareness of staff through training programmes to ensure that they monitor fluid intake effectively, provide intravenous fluids when they are needed and escalate concerns regarding poor fluid intake promptly.

- The review identified that the way that patients are discharged out of hospital care needs to be improved, particularly in relation to the communication processes to enable care to be continued in the community. Improvements have been made to the discharge documentation to ensure that information about diagnosis, complications and actions after discharge is clear.

Kevin Harris, UHL's Medical Director, added:

"This review is unique. There have previously been hospital case note studies but never such an exhaustive study of the whole patient journey from primary to secondary and intermediate care. Although that means that we have nothing to compare this with in order to judge the health system in Leicester, Leicestershire and Rutland, it nevertheless gives us a chance to improve care for local patients. We set out to find problems and we found them, so we are now better positioned to address those system-wide issues."

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Notes to Editors:

1. Methodology: The review was devised and organised by Dr Ron Hsu (Consultant in public health) and Ms Lucy Douglas-Pannett, (Public health speciality registrar). The review selected patients who were admitted as an emergency to Leicester Royal Infirmary and who died either:

• In hospital following an attempt at resuscitation

• In hospital after a period of time in Intensive Care

• In the community following discharge.

Of the patient records considered, 64% of the patients died in hospital and 36% died post discharge. The key numbers…

381 (100%) – total patient notes sample

89 (23%) - below an acceptable standard

292 (77%) - at least an acceptable standard (of which)

119 (31%) - had lesson to learn

2. The review and supporting documents are available from the websites of UHL NHS Trust or Leicestershire Partnership NHS Trust. (www.leicestershospitals.nhs.uk or http://www.leicspart.nhs.uk/Library/PublicpapersAtoXJuly2014.pdf - Paper M, page 146)

3. Interviews will be arranged with Dr Kevin Harris and Prof Mayur Lakhani by the UHL NHS Trust communications team on 0116 258 8644

4. *'Better Care Together' is the local NHS' integrated 5 year plan, details of which can be found at www.bettercareleicester.nhs.uk/

5. The next of kin of those patients whose case notes were reviewed have been contacted. Any other members of the public who would like to speak to someone about the review are invited to contact the **Patient Advice and Liaison Service, (PALS) for Leicestershire Partnership Trust on 0116 295 0830 or 0116 295 0831 or the University Hospitals of Leicester PALS service on 08081 788337**

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