Appendix '3'

# Improving Lancashire's outcomes (Draft)

## Summary paper

**February 2012**

AQUA Observatory

## Summary

It is estimated that across England the NHS treats 1 million people every 36 hours. Many of these people have their lives saved or improved because of the care they receive from dedicated NHS staff. The NHS is there when we need it most providing round the clock, compassionate care and comfort. It plays a vital role in ensuring that as many of us as possible can enjoy good health for as long as possible – one of the things that matters most to us and to our family and friends.

However, there is always more that we could and should do to provide care of the highest quality and holds true at every level of the system. High quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual. It also needs to improve health outcomes.

As we enter a period of tougher economic circumstances this focus on quality and outcomes is particularly important. There is a body of evidence to suggest that poor quality care is often inefficient care and that releasing efficiencies will lead to higher quality, innovation and prevention. Therefore, productivity should be driven by the desire to improve quality.

The Lancashire Health and Social Care system, provider and commissioner have joined forces to reframe their approach to QIPP to focus on both Improving Outcomes and saving cost. All organisations, at Board level, have agreed to 'A Strategy for improving Outcomes for the People of Lancashire health economy'. Lead by the Lancashire Improving Outcomes Partnership (LIOP) Board, this change in emphasis from saving to improvement in a way that creates more engaging, broader ownership and moves the approach from predominantly transactional one to a more Transformational.

As part of this work AQuA has been commissioned to undertake an analysis of the improvement priorities and to suggest – for further discussion and refinement – the scale of the improvement aims and the priories for action. In this context this paper sets out:

- The baseline position and trends for the Lancashire health economy at an organisational level for each of the five domains of the National Outcomes Framework.
- Areas for improvement that are quantified where possible.
- Suggested priorities for the Lancashire health economy Improving Outcomes Strategy and associated outcome measures.

## Reducing Avoidable Mortality

The evidence suggests that across the Lancashire health and social care economy there is potential to reduce the number of avoidable deaths, including taking action to prevent people becoming ill in the first place. Based on our analysis – and for further discussion and debate – suggested outcome measures lie in the following areas:

a. Reducing premature mortality from the major cause of death (i.e. cancer, cardiovascular disease and respiratory disease) saving 1500 lives by 2015 from a 2009 baseline:

    i. Implement the agreed Cardiac and Stroke strategy for Lancashire health economy with particular attention to prevention projects in that strategy.

    ii. Implement agreed cancer programmes of work with a particular attention to the national priority around prevention.

iii. Continuing to support the Advancing Quality Programme's in AMI, Heart Failure and Pneumonia.
iv. Working with AQuA and the regional Respiratory Leads to develop a new Advancing Quality Programme on COPD.
v. Implement local prevention projects across all of Lancashire health economy that have already been implemented fully in one CCG area focused on areas such as affordable warmth, smoking, alcohol liaison etc.

b. Reduce premature mortality from causes amenable to healthcare saving a further 300 lives by 2015:

    i. Tackling areas such as, perinatal deaths, whooping cough and measles, asthma (ages 0-44 years), diabetes mellitus (0-49 years), CHD (0-74 years), maternal deaths (all ages) and areas where misadventure during surgical and medical care (all ages) are considered most likely to occur. Reduced premature mortality in adults with serious mental illness will also need to be considered.

c. Reduce in-hospital mortality. All four main acute providers to Lancashire health economy have HSMRs over 100 (only one has an SHMI under 100). Working with AQuA's Reducing Mortality Team the aim should be to achieve a combination of:

    i. Reducing avoidable in-hospital mortality by a further 300 deaths by 2013/14 from the 2011 baseline.
    ii. Reduce SHMI to 100 in all providers by 31 March 2015 at the very latest.

d. Reduce levels of smoking, obesity and alcohol consumption as a result of increased surveillance of preventable 'social' factors

Achieving these improvement outcomes will mean that Lancashire health economy will close the gap for preventable deaths against the expected trend for England over the same period. Anything less would lead to a widening of that gap. They are not mutually exclusive and are chosen to reflect that improvement action to reduce avoidably mortality is a complex subject and needs to reflect a number of interlinked issues. Further reducing health inequalities should also be factored in.

## Improving the quality of life for patient with long term conditions

The evidence suggests that across the Lancashire health economy health and social care economy has potential to improve the quality of life for patients with long term conditions. Based on our analysis – and for further discussion and debate – suggested outcome measures lie in the following areas:

a. Reduce beds from emergency admissions associated with long term conditions by 300 by 2014/15 resulting in reductions from the 2011/12 baseline of:

a. Reduction in demand from long term conditions by 20%. This equates to a reduction in non-elective spells of 9000 spells.
b. Reduction in long term conditions LOS by 25%. This equates to a total reduction in LOS from long term conditions emergency spells of 1.4 days.

    This pays particular attention to implementing the principles set out by Sir John Oldham which include: Risk profiling of populations, Integrated health and social care teams and self-care. Investment in tele-health and tele-monitoring is also known to be important enablers.

It is also expected that the further work that is in hand to quantify the impact of reducing admissions from acute, chronic and paediatric conditions usually managed in primary care that are known to result in high emergency admissions will provide evidence of the potential for further bed and activity reductions.

b. Dementia beds will be reduced by at least 50 by March 2015 based on 2011 baseline with appropriate community facilities being in place.

    i. Good quality early diagnosis and intervention for all.
    ii. Improved quality of care in general hospitals by reducing LOS for patients with dementia by 1.5 days by 31 March 2013 with further reductions expected after that.
    i. Living well with dementia in care homes and the community by reducing unplanned admissions for dementia patients by 8% through the development of integrated neighbourhood teams targeting patients in the community who are assessed as being at high risk of admission.
    ii. Continue to achieve compliance with a national directive to reduce the use of antipsychotic drugs for people with dementia.

Make further improvements in Primary care management by

a. Increasing the % of relevant patients recorded on the Long term conditions QOF registers (and, possibly in time, the COF), narrowing the gap between actual and expected rates. Priority appears to be conditions relating to CHD.
b. Increasing the rates of diagnosis, initial and on-going management of patient with long term conditions so that all GP Practices are at least as good as the mean figure for the North West and/or England whichever is the highest.

Efforts should also be made to improve the quality of life (as measured by the EQ-5D, GP Practice Survey and Labour Force Survey metrics to improve the quality of life for patient with long term conditions and those that care for them. Working with Health & Well Being Boards and Local Authorities to provide employment opportunities for patients with mental health and long term conditions should form part of this work. Further reducing health inequalities should also be factored in.

## Making ill people better

The evidence suggests that across the Lancashire health economy health and social care economy has potential to make progress in reducing cases in which recovery has been interrupted by emergency admissions with those that measure positive progress in recovery provide a picture of the NHS's contribution to minimising the adverse impact of ill-health and injury upon the quality of life of those affected.

However, in reality, both the elective and the emergency care pathway needs to be considered together as both have a bearing on preventing conditions from becoming more serious. Based on our analysis – and for further discussion and debate – suggest that outcomes measures lie in the following areas:

a. Ensure effective recovery from illnesses and injuries requiring hospitalisation by:

    i. Reducing unnecessary outpatient appointments so the 5000 less clinics are held each year freeing up doctors and nurses for other clinical priorities. Greater use

of Shared Decision Making has an important part to play here as do schemes such as pharmacist home-based medication review.

ii. Reduce unnecessary admissions via A&E by the ensuring that a senior clinical opinion is given as early as possible and that access to diagnostics and testing are equitable throughout the day and night. Consideration of the effectiveness of out-of-hours primary care arrangements and the support provided to nursing homes are also important.

iii. Reducing length of stay for elective patients by a range of interventions including greater use of Enhanced Recovery and minimally invasive surgical techniques.

iv. Reducing length of stay for emergency patients by a range of interventions structured approach to discharge planning and the implementation of early Supported Discharge schemes and community-based case management for generic conditions.so that patients can return to their normal lives as quickly as possible. This is particularly important for patients with heart attacks, heart failure, hip fractures, pneumonia and COPD.

As a result the Lancashire health economy could reduce beds in the acute sector by 600 during the planning period (this is in addition to the 300 beds identified within the long term condition work stream).

## Improving the patient experience

The evidence suggests that across the Lancashire health economy health and social care economy has potential to further improve the patient experience thereby providing a positive experience of care for patients, service users and carers. Patient feedback has an important role to play in driving improvements in the quality of service design and delivery. When analysed alongside a range of additional information sources (including complaints and operational data), this data can provide local clinicians and managers with intelligence on the quality of local services from the patients' and service users' point of view.

Based on our analysis – and for further discussion and debate – suggest that outcomes measures lie in the following areas:

- Patients will be seen and cared for in clean, friendly, comfortable environments. This will mean respecting privacy, protecting meal times, delivering 'Essence of care'/Nursing High Impact actions and clinical engagement.
- Improving End of Life planning. This will include the systematic introduce gold standard pathway across Lancashire with options provided regarding respite care, interface with hospices, choice of location of death discussed with patients and their families and carers in a timely fashion.
- Access to care and waiting times. This will mean delivering the minimum level of standards set out in the NHS Constitution. This includes a range of indicators relating to timely access to care including maximum waiting time, access to GP hours and out of hours provision. Access to NHS dentistry also form a key part of this.
- Acute and chronic pain management. This will mean improving access to pain management advice and drug therapy using a family centred approach that includes where possible self- management.
- Improved information. This means continuing to improve access to health records, information at point of care and GP discharge letters. It also means ensuring that education and training is provided for clinical professionals and, by listening to

complaints that organisations take the necessary steps to ensure compliance with the proposed Duty of Candour.

The impact on quality of service provision through innovation and rolling out of best practice is expected to be very high. Some productivity gains will be accrued through use of telehealth, telecare and telemedicine.

### Safer Care

The evidence suggests that across the Lancashire health economy health and social care economy quality and outcome improvement opportunities lie in the following areas:

- A zero tolerance approach to serious harm and never events.
- Reducing the incidence of Venous Thromboembolism (VTE), CAUTI, falls and pressure ulcers in all settings, including those that occur in the usual pace of residence as well as hospitals and other temporary accommodation.
- A reduction in medical reconciliation errors tackled through a range of ways that include clearer labelling, training, governance and policies/procedures and patient information.
- A focus on the need for a safety culture delivered through awareness of the impact of hand off and other communication errors.
- Year on year reduction in rates of MRSA, C Diff, MSSA and E Coli.
- Safe guarding vulnerable adults and children

| **Reducing avoidable mortality** | | |
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| **Suggested Outcome** | **Suggested Improvement action** | **Suggested Metrics** |
| Reducing premature mortality from the major cause of death (i.e. cancer, cardiovascular disease and respiratory disease) saving 1500 lives by 2015 | • Implement the agreed Cardiac and Stroke strategy for Lancashire health economy with particular attention to prevention projects in that strategy.<br>• Implement agreed cancer programmes of work with a particular attention to the national priority around prevention.<br>• Continuing support the Advancing Quality Programme's in AMI, Heart Failure and Pneumonia.<br>• Working with AQuA and the regional Respiratory Leads to develop a new Advancing Quality Programme on COPD.<br>• Implement local prevention projects across all of Lancashire health economy that have already been implemented fully in one CCG area focused on areas such as affordable warmth, smoking, alcohol liaison etc.<br>• Tackling areas such as, perinatal deaths, whooping cough and measles, asthma (ages 0-44 years), diabetes mellitus (0-49 years), CHD (0-74 | • Under 75 mortality from all causes (YLL, SMR, DSR and crude rate).<br>• Under 75 mortality from cardiovascular disease (SMR, DSR and crude rate).<br>• Under 75 mortality rate from respiratory disease (SMR, DSR and crude rate).<br>• Under 75 mortality rate from cancer (SMR, DSR and crude rate). |

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| | years), maternal deaths (all ages) and areas where misadventure during surgical and medical care (all ages) are considered most likely to occur.<br>• Reduced premature mortality in adults with serious mental illness will also need to be considered. | |
| Reduce premature mortality from causes amenable to healthcare saving a further 300 lives by 2015 | • Tackling areas such as, perinatal deaths, whooping cough and measles, asthma (ages 0-44 years), diabetes mellitus (0-49 years), CHD (0-74 years), maternal deaths (all ages) and areas where misadventure during surgical and medical care (all ages) are considered most likely to occur.<br>• Reduced premature mortality in adults with serious mental illness will also need to be considered. | • Under 75 mortality rate from causes amendable to healthcare (SMR, DSR and crude rate).<br>• *Mortality rates for adults with serious mental illness will follow once the national definitions have been released.* |
| Reduce in-hospital mortality. | • Working with AQuA's Reducing Mortality Team the aim should be to achieve a combination of:<br>– Reducing avoidable in-hospital mortality by a further 300 deaths by 2013/14 from the 2011 baseline.<br>– Reduce SHMI to 100 in all providers by 31 March 2015 at the very latest. | • SHMI<br>• Actual number of death in hospital. |
| Reduce levels of smoking, obesity and alcohol consumption. | • Increase surveillance of preventable 'social' factors: | • Quit rates for 16+ for smoking and reductions in levels of adult obesity.<br>• Take up of NHS Health Check.<br>• The difference in life expectancy and years of life lost between the most affluence and the least affluent areas |

## Improving the Quality of life for patients with Long Term Conditions

| Suggested Outcome | Suggested Improvement action | Suggested Metrics |
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| Reduce beds from emergency admissions associated by LTCs by 300 by 2014/15 resulting in reductions from the 2011/12 baseline of:<br>i. Reduction in demand from LTC by 20%. This equates to a reduction in non-elective spells of 9000 spells.<br>ii. Reduction in LTC LOS by 25%. This equates to a total | • This pays particular attention to implementing the principles set out by Sir John Oldham which include: Risk profiling of populations, Integrated health and social care teams and self-care.<br>• Investment in tele-health and tele-monitoring is also known to be important enablers.<br>• It is also expected that the further work that is in hand to quantify the impact of reducing admissions from acute, chronic and paediatric conditions usually managed in primary care that are known to result in high emergency | • Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)<br>• Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s<br>• ALOS for chronic ambulatory care sensitive conditions (adults)<br>• ALOS for asthma, diabetes and |

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| reduction in LOS from LTC emergency spells of 1.4 days. | admissions will provide evidence of the potential for further bed and activity reductions. | epilepsy in under 19s<br>• Emergency readmissions within 28 days of discharge from hospital<br>• Investment in telemedicine/ health |
| Dementia beds will be reduced by at least 50 by March 2015 with appropriate community facilities being in place | • Good quality early diagnosis and intervention for all<br>• Improved quality of care in general hospitals by reducing LOS for patients with dementia by 1.5 days by 31 March 2013 with further reductions expected after that.<br>• Living well with dementia in care homes and the community by reducing unplanned admissions for dementia patients by 8% through the development of integrated neighbourhood teams targeting patients in the community who are assessed as being at high risk of admission.<br>• Continue to achieve compliance with a national directive to reduce the use of antipsychotic drugs for people with dementia | • Unplanned admissions for patients aged 65+ with a dementia co-morbidity by March 2013<br>• Average length of stay for patients aged 65+ with a dementia comorbidity<br>• Readmission rate for patients aged 65+ with a dementia comorbidity<br>• Increase number of patients on QOF Dementia related registers<br>• Prescribing levels and costs of anti-psychotic prescribing drugs |
| Make further improvements in Primary care management | • Increasing the % of relevant patients recorded on the Long term conditions QOF registers (and in time the COF), narrowing the gap between actual and expected rates. Priority appears to be conditions relating to CHD.<br>• Increasing the rates of diagnosis, initial and on-going management of patient with long term conditions so that all GP Practices are at least as good the mean figure for the North West and/or England whichever is the highest. | • Increase number of patients on QOF registers relating to patients with Long Term Conditions |
| Efforts should also be made to improve the quality of life (as measured by the EQ-5D, GP Practice Survey and Labour Force Survey metrics to improve the quality of life for patient with long term conditions and those that care for them | • Working with Health & Well Being Boards and Local Authorities to provide employment opportunities for patients with mental health and long term conditions should form part of this work.<br>• Further reducing health inequalities should also be factored in | • Proportion of people feeling supported to manage their condition<br>• Employment rates for people with mental health and long term conditions |
| **Helping ill people to get better** | | |
| **Suggested Outcome** | **Suggested Improvement action** | **Suggested Metrics** |
| Ensure effective recovery from illnesses and injuries requiring hospitalisation<br><br>As a result the Lancashire | • Reducing unnecessary outpatient appointments so the 5000 less clinics are held each year freeing up doctors and nurses for other clinical priorities. | • % A&E Attendances/ median time to departure from A&E (admitted) |

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| health economy could reduce beds in the acute sector by 600 during the planning period (this is in addition to the 300 beds identified within the long term condition work stream). | Greater use of Shared Decision Making has an important part to play here as do schemes such as pharmacist home-based medication review.<br>• Reduce unnecessary admissions via A&E by the ensuring that a senior clinical opinion is given as early as possible and that access to diagnostics and testing are equitable throughout the day and night. Consideration of the effectiveness of out-of-hours primary care arrangements and the support provided to nursing homes are also important.<br>• Reducing length of stay for elective patients by a range of interventions including greater use of Enhanced Recovery and minimally invasive surgical techniques.<br>• Reducing length of stay for emergency patients by a range of interventions structured approach to discharge planning and the implementation of early Supported Discharge schemes and community-based case management for generic conditions.so that patients can return to their normal lives as quickly as possible. This is particularly important for patients with heart attacks, heart failure, hip fractures, pneumonia and COPD. | • Emergency and elective length of stay<br>• Emergency readmissions within 30days of discharge from hospital<br>• Emergency admissions for acute conditions that should not usually require hospital admission, including the % of children admitted to hospital with serious lower respiratory tract infections (LRTI)<br>• % patients offered rehabilitation (indicator being developed nationally) following a stroke and fragility fractures<br>• Patient reported outcome measures (PROMS) for Hip replacement, Knee replacement, Groin hernia and Varicose veins<br>• Progress towards compliance with all Advancing Quality bundles of care<br>• Take up of Share Decision Making techniques<br>• Take up of Enhanced Recovery techniques/ % day case rates |

## Improving the patients experience

| Suggested Outcome | Suggested Improvement action | Suggested Metrics |
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| Patients will be seen and cared for in clean, friendly, comfortable environments | • Respecting privacy, protecting meal times, delivering 'Essence of care'/Nursing High Impact actions and clinical engagement. | • Delivery of the Essence of Care Benchmarks/ Nursing High Impact actions and other measures of privacy and dignity such as single sex accommodation, protected meal times, score as awarded in PEAT inspections.<br>• National staff survey results |

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| Improving End of Life planning. | • The systematic introduce gold standard pathway across Lancashire with options provided regarding respite care, interface with hospices, choice of location of death discussed with patients and their families and carers in a timely fashion. | • Take up of the Gold Standard and Liverpool Care pathways for patients nearing the end of their lives |
| Access to care and waiting times. | • Delivering the minimum level of standards set out in the NHS Constitution. This includes a range of indicators relating to timely access to care including maximum waiting time, access to GP hours and out of hours provision.<br>• Access to NHS dentistry also form a key part of this. | • Adherence with the minimum standards set out in the NHS Constitution<br>• Patient experience of a number of care settings including: GP services, GP Out of Hours services, NHS Dental Services, outpatient and inpatient care in acute, mental health can community settings |
| Acute and chronic pain management | • Improving access to pain management advice and drug therapy using a family centred approach that includes where possible self- management. | • Access to pain services<br>• Patient survey information on pain |
| Improved information. | • Improving access to health records, information at point of care and GP discharge letters.<br>• Providing education and training for clinical professionals and, by listening to complaints that organisation take the necessary steps to ensure compliance with the proposed Duty of Candour. | • Timeliness of GP discharge letters |

## Safer patient care

| Suggested Outcome | Suggested Improvement action | Suggested Metrics |
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| A zero tolerance approach to serious harm and never events | • Root cause analysis of all serious harm events and | • % serious harm<br>• % same harms repeated |
| Reducing the incidence of Venous Thromboembolism (VTE), CAUTI, falls and pressure ulcers in all settings, including those that occur in the usual pace of residence as well as hospitals and other temporary accommodation. | • Introduction of risk assessment for at risk patients,<br>• Introduction of established care bundles for VTE, catheter acquired urinary tract infections (cauti), falls and pressure ulcers. | • Delivery of the Essence of Care Benchmarks/ Nursing High Impact actions and other measures of privacy and dignity such as single sex accommodation, protected meal times, score as awarded in PEAT inspections. |
| A reduction in medical reconciliation errors | • Tackled through a range of ways that include clearer labelling, training, governance and policies/procedures and patient information | • % serious harm relating to med rec errors in all healthcare settings |
| Year on year reductions in infection rates | • Hand hygiene, early screening and isolation | • Rates of MRSA, C Diff, MSSA and E |

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| | | Coli<br>• Orthopaedic surgical site infection |
| A focus on the need for a safety culture delivered through | • Increased awareness of the impact of hand off and other communication errors | • Increases in harm reporting |
| Safe guarding of vulnerable children and adults | | • Incidence of harm to children due to 'failure to monitor' / National CAS measures<br>• Admission of full term babies to neonatal care<br>• Deaths from suicides and incidence of self harm |