A Rapid Review of the Safety and Quality of Care for Acute Adult Patients in NHS Lanarkshire

Executive Summary

December 2013
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Executive summary

This executive summary highlights the key findings from the report on the Rapid Review of the safety and quality of care for acute adult patients in NHS Lanarkshire.

Introduction

The Rapid Review was triggered in August 2013 by the publication of mortality data for January to March 2013. These mortality data can be taken as a trigger to look for potential quality problems and showed Monklands Hospital continuing with a higher than predicted Hospital Standardised Mortality Ratio (HSMR), a pattern first noted in February 2012. There was also concern about the mortality ratios at Hairmyres and Wishaw hospitals which, at the point of initiating the review, had both been reported as having a high HSMR at some point in the last 18 months.1

In light of this, in August 2013, the Cabinet Secretary for Health and Wellbeing commissioned Healthcare Improvement Scotland to undertake a Rapid Review of the safety and quality of care for acute adult patients in NHS Lanarkshire. The review focused on those factors which could impact on the HSMR.

Structure of review

The review team and the expert advisory group have a wide membership including doctors, nurses, experts in healthcare and data analysis, NHS leaders, junior staff and members of the public. Over 30 individuals have contributed as members of both groups.

The review team heard people’s experience of their care and the views of staff working in NHS Lanarkshire. The review team carried out detailed on-site announced and unannounced visits and studied a large amount of written information.

The review team considered the experiences of patients, family and staff as being central to the process and the review.

Although the Rapid Review was triggered by concerns about mortality rates, it has involved a detailed and broad assessment of the key factors relating to safety and quality of care in the three acute hospitals. The review team has:

- heard the experiences of over 300 patients and carers
- listened to the views of over 200 members of staff
- visited over 40 clinical areas and reviewed the records of 152 patients, and
- considered a substantial amount of written information and data.

It is important to recognise that the remit of the Rapid Review was limited to the key factors that might affect the HSMR and did not review the full spectrum of acute care in NHS Lanarkshire.

1 The subsequent inclusion of late data has brought Hairmyres and Wishaw Hospitals HSMR down and with this new information these hospitals have not been a significant outlier at any point over the last 18 months.
Findings

The review team found a range of areas for improvement in all three hospitals, but particularly at Monklands and Hairmyres hospitals.

The review team has made 21 recommendations which should be seen together rather than individually. The report outlines these recommendations, including the need for stronger focus and leadership in implementing robust safety measures and in the redesign of services.

The recommendations seek to help NHS Lanarkshire meet its ongoing commitment to a safer and higher quality system of care.

Understanding the HSMR

NHS Lanarkshire needs to significantly improve the timeliness of its discharge summaries and of its national data returns.

There are significant delays in producing final discharge summaries and issues about the accuracy of some of those that are produced.

The review team identified substantial delays in the submission of important patient activity data to the national data body. This impacts on the availability of NHS Lanarkshire’s quality and performance data. The review team identified this as a significant performance issue which NHS Lanarkshire needs to address.

Patient and carer experience

The review team found that there is considerable variation in the quality and system of care being delivered within all three hospitals.

Many patients spoke very highly about the care they received.

However, the review team also heard about instances where patients and their families had experienced poor quality care. At times, it was due to inadequate staffing levels and poor working conditions.

NHS Lanarkshire needs to take further action to develop a culture where every opportunity is taken to learn from mistakes with the aim of improving patient care.

Some patients and carers told the review team that they had had difficulty getting their concerns heard. Whilst there were some examples of excellent practice, NHS Lanarkshire was not consistently, and appropriately, sensitive in the handling of the complaints it received. There was too much concern with meeting target response times and the responses were not always sufficiently person-centred.

The review team also found that staff did not always report or escalate risks to the delivery of safe patient care because they did not believe that management would take action. It is vital that health staff at all levels of the organisation are actively engaged in reporting and fixing problems which impact on the quality and safety of patient care, and they understand their responsibility to bring concerns to the attention of management.

The safety of patient care

NHS Lanarkshire needs a more robust approach to identifying and supporting patients whose clinical condition is deteriorating.
NHS Lanarkshire has already taken a range of actions to ensure staff have the necessary skills and knowledge to recognise a patient whose condition is deteriorating, but needs to go significantly further in implementing improvements in this area. The review team found a need for more focused attention on supporting clinical teams to test and implement practical changes to working practices. Parallel to this, action needs to be taken to address some of the issues that are impacting on the availability of staff to implement the evidence-based practice such as reliable implementation of the Modified Early Warning Scores and the Sepsis 6 bundle.

**NHS Lanarkshire needs to strengthen the support for their quality improvement work.**

The review team found that awareness of the Scottish Patient Safety Programme was low in the majority of areas it visited, with little evidence that staff were consistently applying improvement techniques, although there were exceptions. Some elements of the programme, specifically Executive Safety Walkrounds, are not in place and other key patient safety interventions need to be reliably implemented.

**Workforce – Medical staffing**

There is a need for robust and swifter action to ensure more sustainable medical staffing. To deliver this, NHS Lanarkshire needs to advance and implement credible plans to deliver a sustainable model of care.

The review team found some medical staffing levels were inadequate, particularly in relation to senior staff out of hours and at weekends. The review team recognised that this is a complex problem to which national shortages in some specialties, and the challenges of ensuring robust medical staffing across the three hospitals are contributing. It cannot be fixed just by spending more money on doctors, even if the money and staff were readily available.

**NHS Lanarkshire needs to ensure robust procedures are in place for the development and ratification of clinical protocols.**

The review team identified specific concerns about the continuity of care and with the protocol for the management of overnight orthopaedic admissions at Hairmyres Hospital, which were not acceptable in the professional view of the review team or the expert advisory group. NHS Lanarkshire needs to ensure the safe and continuous delivery of care for all patients across the three hospitals by addressing these specific concerns.

**Workforce – Nursing staff**

NHS Lanarkshire needs to ensure nurse staffing levels are safe and adequate at all times.

The review team found there were gaps in nurse staffing levels on some wards and an imbalance between registered and unregistered nursing staff. The intended staffing levels were not always happening in practice. There was also a high use of bank staff and movement of staff between wards. This is impacting on the ability to consistently meet basic care needs and reliably carry out vital observations that would alert staff that a patient’s condition is deteriorating.

**Operational effectiveness**
NHS Lanarkshire needs to prioritise clinical and managerial time to ensure the recently agreed work with the National Acute Patient Flow Team receives the right level of local attention and support.

The review team found significant and long-standing challenges with ensuring emergency patients are admitted in a timely manner to the ward most appropriate to their needs and, once treated, are discharged in a timely manner with appropriate support. However, with an increasing evidence base that congestion in accident and emergency departments and the hospital results in poorer outcomes for patients who are admitted, this needs to change. The solutions are complex and linked to both acute hospital staffing levels and community health and social care services. The review team noted that this is an area where the Scottish Government has recently committed resources and support for NHS Lanarkshire.

Leadership and governance

NHS Lanarkshire needs to review the use of data and its reporting across the system.

The review team found that some of the data being reported to the Board did not reflect the reality in practice. This appeared to be related to a lack of understanding across all levels of the organisation about how to interpret data and use the information effectively to support improvement work. It also found that senior leaders need to more actively challenge information that indicates all is well, particularly when contradictory evidence exists.

NHS Lanarkshire needs to review and simplify its management arrangements to ensure sharper focus on accountability and delivery in each of the three hospitals.

The review team found complex management and governance structures, which were not clear to all staff and therefore led to a lack of clarity about accountability.

In conclusion

The recommendations in the report will need all of the key stakeholders to engage constructively in discussions and reach solutions in partnership. Some of these stakeholders are internal whilst others are external to NHS Lanarkshire. It is essential that they work together to find the optimal solution for improving the safety and quality of acute healthcare for the people of Lanarkshire. The review team does not underestimate the challenge, but is clear that improving the quality of care is dependent on all of the stakeholders working together.

The review team found a service where clinicians and managers are working hard to do the right thing, sometimes in a difficult environment.

This is an important message to emphasise. Across all levels of the organisation, the review team found dedicated and hard working individuals who are committed to delivering the highest standard of healthcare to the people of Lanarkshire.

The review team expects that the recommendations made in the report will be used to provide guidance and support for those working in NHS Lanarkshire to help them to deliver the necessary improvements.
We can also provide this information:

- by email
- in large print
- on audio tape or CD
- in Braille (English only), and
- in community languages.

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