Cover report to the Trust Board meeting to be held on 7 March 2019

Trust Board paper L

Report Title:	**Quality and Outcomes Committee – Committee Chair's Report** (formal Minutes will be presented to the next Trust Board meeting)
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Reporting Committee:	**Quality and Outcomes Committee**
Chaired by:	Col (Ret'd) Ian Crowe – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Carolyn Fox – Chief Nurse
Date of meeting:	28 February 2019

Summary of key public matters considered by the Committee and any related decisions made:

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 28 February 2019:

- **Mortality Report** – UHL's crude and risk-adjusted mortality rates and related workstreams were overseen by the Trust's Mortality Review Committee (MRC) chaired by the Medical Director. MRC also maintained oversight of UHL's framework for implementing 'Learning from Deaths', which included the Trust's Medical Examiner Process, Bereavement Support and Specialty Mortality Reviews using the nationally developed Structured Judgement Review Tool. One of the requirements relating to 'Learning from Deaths' was for Trusts to submit nationally and publish mortality data on a quarterly basis including the number of deaths reviewed / and or investigated, the number of those found to be more than likely due to problems in care and details of learning and actions taken to improve the care of all patients. QOC received this latter-referenced data as part of the report presented by the Deputy Medical Director, **a copy of which is appended to this report for receipt and noting by the Trust Board (entitled 'Learning from the Deaths of Patients in our Care').**

  UHL's crude mortality rate 18/19 to date (end December) was 1.1% and, whilst the usual seasonal increase in December and January had been observed, both months were below previous year's figures. UHL's latest published SHMI was 96 (covering the 12 months July 2017 to June 2018) and HSMR was also 95 for the same time period. Both these numbers were within the expected range. The next published SHMI for UHL would increase to 99, but would still remain within the expected range. The reasons for the increase in SHMI were being investigated by the MRC, but preliminary review had not identified any particular emerging themes or new contributing patient or diagnostic groups. The Committee were also particularly requested to note the following: (1) significant work had been undertaken to ensure that UHL's mortality rates were closely monitored and that any patient groups with a higher HSMR or SHMI were being reviewed and learning and action taken, where applicable (2) the progress made with screening of adult deaths by the Medical Examiners and completion of Structured Judgement Reviews by Specialty M & Ms (3) capacity issues continued to affect progress with the Learning from Deaths programme and (4) actions had been agreed in response to the recommendations made by Internal Audit which should be completed by the end of June 2019.

  Particular discussion took place regarding the application of learning from DC1 case identified. The Deputy Medical Director and Director of Safety and Risk were requested to confirm outwith the meeting, reporting back to the next QOC meeting, as to whether UHL had discussed this matter with the other Trust involved, in terms of identifying further learning opportunities.

  A further discussion took place regarding an emerging theme relating to the cross-site transfer of patients with more than one clinical problem. The Medical Director and Mr Jameson, Deputy Medical Director, were requested to submit a high level report to the next QOC detailing the Trust's plan to address issues relating to management of cross site transfer of patients, with a detailed paper then to be submitted to a future QOC meeting describing proposals (including reference to policies and SOPs).

  In concluding discussion on this item, the QOC Chair recognised the significant progress made to date, as described within the report presented, and acknowledged the slight rise in the mortality indices, albeit understanding the reasons for this. The contents of this report were received and noted.

- **VTE Prevention Task and Finish Group – Update –** the Committee received and noted the contents of a second update report from the VTE Prevention Task and Finish Group which had been meeting since early December 2018. The Committee was asked to: (1) note the immediate actions taken in response to a second Coroner's Regulation 28 Prevention of Future Deaths report relating to VTE and (2) note the work being undertaken by the VTE Prevention Task and Finish Group. In presenting this report, Dr Marshall, Deputy Medical Director, noted the significant progress made since the publication of this report (relating to the undertaking of audits, the distribution of a learning bulletin, a review of patient information given at times of admission and discharge etc.), all of which would be the subject of a further report to the next Executive Quality Board meeting on 5 March 2019 and, thereafter, at the next Quality and Outcomes Committee meeting on 28 March 2019. Particular discussion took place regarding (a) the need for consistency in terms of the advice (both written and verbal) given to patients upon admission and discharge and potential means by which such consistency could be achieved, including the fostering of a trust-wide culture such as that already observed in the Women's and Children's CMG in relation to VTE prevention (b) progress towards the achievement of quality standard 5 (c) relevant links to the Quality Strategy and (d) the fact that all known incidents relating to VTE had been taken into account in the progression of this workstream.

- **Delays in Sending Vascular Clinical Correspondence –** the Clinical Director (RRCV) attended QOC to brief the Committee in relation to the identification, in January 2019, that a number of clinical letters pertaining to patient interventions, both in-patients and out-patients, had not been sent onto their intended recipients. The report presented detailed the outcome of the investigation into this matter and the action taken in response, both in terms of addressing the delayed letters (and any consequences of this delay) and means by which to prevent a recurrence, both within this particular specialty and across the wider CMG. This incident had highlighted system failures in the CMG's administrative processes at a number of levels; individual, team and IT system. The investigation had been completed and actions had been implemented to correct the issues identified. Administrative typing backlogs were being monitored across all specialties with Respiratory and Cardiology backlogs continuing to be an issue, albeit the reasons for this were known. In discussing this matter, the Committee considered issues relating to (a) effective communication with GPs, as well as with patients (b) ensuring that staff felt empowered to raise issues of concern, where required, alongside the wider issue of general staff behaviour and communication processes (c) facilitating an effective means by which patients could contact the Trust and ensuring that patients were briefed as to the relevant contact point and (d) consideration of the potential need to take a wider look at administrative processes across the board.

- **Distribution of Cardiology Imaging Results –** the Clinical Director (RRCV) also briefed QOC regarding the identification, on 21 January 2019, that paper copies of cardiac MR (magnetic resonance), CT (computerised tomography) and Plain Film (chest and abdominal) imaging results had not been received by the Cardiology Administrative team by internal post. The first scan not received dated back to 28 November 2018. It was noted that all of these scans had been reported electronically by Radiology, however the Consultant Cardiologists used the paper report as a prompt to review the tests in the absence, currently, of a robust system to track what tests had been ordered. As a consequence, this had resulted in Consultants not acting upon results in a timely manner. The report presented detailed the outcome of the investigation into this matter and the action taken in response, both to address any potential delays in the treatment of individual patients and to prevent a recurrence of such a situation in future. In discussion on this item, the Chief Executive undertook to consider the matter of administrative processes with the Executive Board (point (d) in the paragraph above also refers) and report back on this accordingly. He also undertook, as part of this discussion, to consider a single point of access for patients to use when needing to seek assistance from the Trust.

- **Nursing and Midwifery Quality and Safe Staffing Report – December 2018 -** the report provided triangulated information relating to nursing and midwifery quality of care and safe staffing, and highlighted those wards triggering a level 3, 2 or 1 concern in the judgement of the Chief Nurse and Corporate Nursing team. In December 2018, 1 ward had triggered a level 3 concern (this was 1 more than in November 2018), there were 7 wards triggering a level 2 concern (this was the same as in November) with 22 wards triggering a level 1 concern (this was the same as in November). Particular discussion took place regarding staffing challenges in relation to ward 22 LRI (a CHUGGS ward) and the means by which it was intended to try and overcome these, as addressed in an individualised action plan. Mr Caple, Patient Partner, also fed back regarding the outcome of a session held for patients in January 2019 at which they provided feedback about their experiences on ward 22, the majority of which had been quite complimentary about the care received and understanding of the pressures placed on staff, albeit expressing the view that communication could be improved between ITAPS and CHUGGS. Note was also made, in discussion, of the continued monitoring of vacancies within the Children's Hospital. The Chief Nurse proposed that future reports to this Committee focused on fill rates, narrative, vacancy data and hot topics, with the scorecard element of the report moved into the Performance Review meetings, which was agreed by the Committee. Note was also made of the need to celebrate success and particular discussion took place regarding an impending celebration relating to the introduction of Nursing Associates.

- **Monthly Highlight Report from the Director of Safety and Risk –** the Director of Safety and Risk particularly highlighted the following issues in her monthly report: - (1) a review of the quality of serious incident investigations and improvement work intended for 2019/20 in this respect (2) emergency department winter pressure and patient safety concerns (3) themes from the GP Concern Transferring Care Safely Process and how these were being addressed and (4) a focus on complaints in neurology. Mr Jameson, Deputy Medical Director, was requested to liaise with the Medical Director and Clinical Director of ESM to ensure that QOC received an appropriate update on this matter. In presenting her report, the Director of Safety and Risk also made particular reference to the SPC Charts and the in-depth review of these which was undertaken within the Patient Safety Team. Particular discussion took place regarding the positive approach to patient and family involvement within UHL and means by which this could potentially be further improved (e.g. by sending draft reports to patients for comment prior to publication of the final version). Members received and noted the contents of this report.

- **Monthly Report from the Director of Clinical Quality** – this report, presented by the Chief Nurse in the absence of the Director of Clinical Quality, provided the Committee with (1) a CQC update, including details of the next CQC Provider Engagement meeting and a copy of the latest CQC Insight Report and a summary of the action being undertaken to address outlier or deteriorating indicators and (2) the quarter 3 update for the Quality Commitment. Key risks / issues identified within the quarter 3 position were (a) a large number of competing priorities for IT hardware / mobile devices (b) a number of workstreams dependent on the roll out of IT systems and (c) embedding standardised processes remained inconsistent. Development of the 2019/20 Quality Commitment was underway. Also noted was a recent meeting with the new CQC team and the fact that their initial feedback would feature in the next update report. The contents of this report were received and noted.

- **Never Event Report** – the Committee received and noted the contents of the final investigation report into a Never Event relating to use of the wrong femoral nail (i.e. use of a left sided nail instead of a right sided nail). The Chief Executive undertook to discuss this matter in detail at the Executive Quality Board meeting due to be held the following week, specifically in relation to the necessity for all staff to follow agreed processes.

- **Reports for information –** QOC received and noted the following reports for information: (1) Clinical Audit Quarterly Report for quarter 3 2018/19 (2) Learning from Claims and Inquests for quarter 3 2018/19 and (3) Data Quality and Clinical Coding. The QOC Chair highlighted the excellent work undertaken by Trust staff in relation to submissions made for the Clinical Audit Improvement Competition and congratulated the winners.

- **Minutes for Information –** QOC received and noted the Executive Quality Board (EQB) Minutes from 8 January 2019, EQB actions from 5 February 2019 and Executive Performance Board Minutes from 29 January 2019.

Matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

- Learning from Deaths Data (as attached to this summary).

Matters referred to other Committees:

- None.

Date of next meeting:	28 March 2019

Appendix 3

Learning From the Deaths of Patients in our Care 18/19 Q1-3

February 2019
Medical Examiner Screening
Specialty Structured Judgement Reviews
Bereavement Support Follow Up

UHL's "Learning from Deaths" Framework

- **Medical Examiners (MEs)** – (Currently 12 MEs working 1 PA a week). ME process includes all ED and Inpatient adult cases – MEs support the Death Certification process and undertake Mortality Screening – to include speaking to the bereaved relatives/carers and screening the deceased's clinical records. Where Screening identifies potential areas for learning by the clinical team(s), the case will be sent to the relevant Specialty for further review.

- **Specialty Mortality & Morbidity Programme (M&M)** – involves full Mortality Reviews (SJRs) where meet National criteria (see previous slide) or are referred by the ME or members of the Clinical Team. M&M meetings confirm Death Classification, Lessons to be Learnt and taking forward agreed Actions

- **Clinical Teams** – involves reviewing care of patients where families have raised concerns about the end of life care or other patient experience issues

- **Bereavement Support Nurse (BSN)**– 'follow up contact' for bereaved families of adult patients, liaises with both the MEs and Clinical Teams where families have unanswered questions. Also sign posts bereaved relatives to appropriate support agencies where unmet bereavement needs identified.

- **Patient Safety Team (PST)** – where death considered to be due to problems in care, will review against the Serious Incident reporting framework and take forward as an investigation where applicable.

- **Mortality Review Committee (MRC)** – oversee the above and support cross specialty/trust-wide learning and action

Deaths covered by UHL's "Learning from the Death" process

Quarters 1 – 3 (April to December 2018)

	Q1	Q2	Q3	All Deaths
Adult	**781**	**737**	**810**	**2328**
Inpatient	691	635	717	2043
ED	55	60	53	168
Community**	35	42	40	117
Child	**9**	**12**	**8**	**29**
Inpatient	7	8	6	21
ED	1	4	1	6
Community	1		1	2
Neonate	**36**	**13**	**15**	**64**
Inpatient	36	13	15	64
All Deaths	**826**	**762**	**833**	**2421**

What is the data telling us?

* Q1 - Child died at Rainbows Q3 – Child died at QMC. Speciality undertook SJR.

** Not all Community deaths will go through the full screening process. Therefore 'Screening Performance data' will only include Inpatient and ED Deaths.

Paediatric / Neonatal Deaths – Quarters 1 to 3

What is the data telling us?

There have been 91 'Child' or 'Neonate' ED/In-patient deaths in Q1-3

64 were babies either born/stillborn in UHL and died on the Labour ward/Neonatal Unit (Neonates)

15 babies (0-1 yr) were either born in UHL and transferred to Cardiac surgery or were transfers into UHL from other hospitals or admitted to the Paediatric Intensive Care Unit from Home

There were 6 babies (0-1 yr) who died in the Emergency Department

There were 6 children admitted to the LRI via ED and died in Intensive Care

Two further deaths have been reviewed as part of the UHL LFD programme although one was a baby who died at Rainbows and the other a child who died at QMC

Medical Examiner Process and Specialty Reviews

At the present time the Medical Examiner process – death certification and screening - only applies to adult deaths.

The proposed national roll out of the Medical Examiner process includes paediatric and neonatal deaths.

Preliminary discussions have been held with the W&C Clinical Director to consider how MEs could support the death certification process of children and babies and how to ensure there were no 'unintended consequences'.

In the interim all paediatric and neonatal deaths are subject to a Structured Judgement Review by the relevant Specialty M&M. They are also reviewed by the LLR Child Death Overview Panel (CDOP).

63 Reviews have been completed for Q1-3 deaths

There were 4 deaths where there were problems in care but unlikely these contributed to death
– 2 related to recognised but rare complications of procedures;
- 2 related to Growth Scan (1) and to CTG monitoring (1) – both have been subject to further investigation as a Moderate Patient Safety Incident

Actions have been agreed for all 4 cases which have are on track or have been completed.

Adult Deaths – ED or InPatients*
Number and % Screened by a Medical Examiner in Q1-3
(April to December 18)

	Adult Deaths	Screened	Not Yet	No*	% Screened
Q1	746	732	0	14	98%
Q2	695	687	4	4	99%
Q3	770	711	59		92%
Q1-3 Total	**2,211**	**2130**	**63**	**18**	**95.9%**

What is the data telling us?

UHL target is 95% of all Adult Inpatient or ED Deaths to be 'screened'

There were 2,328 adult deaths which were processed by the Bereavement Services Office during Q1-Q3

Of these, 105 were 'community death' where the deceased's body was brought to the UHL Mortuary for Death Certification purposes
90% of community cases were also screened by the Medical Examiner

During Q1-3, there were 2,211 deaths in either ED (168) or In-Patient (2,043). T

Of these 2,130 (95.9%) have been screened by the Medical Examiner to date.

What happens where Medical Examiners (ME) think further review required?

- **MEs refer cases for:**
  - Structured Judgement Review through Specialty M&M**)**
  - Clinical Review by Consultant responsible for patient care or Matron/Ward Sister
  - Follow up by Bereavement Support Nurse
  - Feeding back to Non UHL organisations
- **Structured Judgement Reviews are requested where the Medical Examiner thinks there is potential for learning in respect of:**
  - Clinical management
  - Delays or omissions in care
  - Meets the national criteria for SJR (death post elective surgery, patient had a Learning Disability, Severe Mental Illness)
- **Clinical Reviews are requested where concerns are raised by the bereaved about:**
  - Pain management; end of life care, DNACPR
  - Nursing care, such as help with feeding; responding to buzzers
  - Communication with patient/relatives about patient's prognosis, deterioration
  - Previous discharge arrangements
- **Bereavement Support Nurse follow up will be requested where**
  - The relatives appear to be particularly distressed - to signpost to 'bereavement counselling services'
  - Say they have questions or concerns about the care provided but do not feel ready to talk about them
- **Feeding back to Non UHL Organisations**
  - Process established with the EMAS, LPT and CCG Quality & Safety Leads for feeding back where relatives raise concerns about care provided outside UHL, or MEs think there may be learning for other organisations,

Number of Adult Deaths and Further Review Q1-3

Further Review details	Q1	Q2	Q3	All
No further review	545	502	521	1,568
Structured Judgement Review*	82	75	73	230
Clinical Review	95	87	82	264
Feedback	46	53	54	153
Theme already identified and actions in progress	1	2	4	7
Follow up by Bereavement Support	9	7	9	25
Referred to Patient Safety Team / SI Investigation	3	4	1	8
All (includes Community Deaths where screened)	**781**	**730**	**744**	**2,255**

What is the data telling us?

***Some deaths may be referred directly for SJR without ME screening if meets National Criteria**

70% of Q1 to Q3 deaths screened by the Medical Examiner were not considered to need further review.

10% of deaths have been referred for Structured Judgement Review by the Specialty M&M – this includes deaths meeting the national criteria

12% of deaths were referred for Clinical Review by the clinical team looking after the patient

7% of deaths have been referred for Feedback only – mostly relates to staff attitude, communication issues

18/19 Q1-2 Adult Deaths Referred for Structured Judgement Review or Clinical Review – Progress Update

	Completed	In progress	%	ALL
Clinical Reviews				
Q1	51	44	53%	95
Q2	21	66	24%	87
SJRs				
Q1	66	16	80%	82
Q2	35	41	45%	75

Following discussion with the Specialty M&M Leads, an internally set target for completion of SJRs was agreed as: 75% within 4 months of death and 100% within 6 months.

80% of SJRs for Q1 Adult deaths have been completed to date – which is below the 100% threshold.

45% of SJRs for Q2 Adult deaths are known to have been completed but capacity issues within both the Corporate and Specialty teams mean that more SJRs may have been undertaken but not yet collated.

Progress updates have been sought on all outstanding SJRs.

Specialties with most SJRs requested in Q1-3 were:

Geriatrics – 33
Gen Surg (LRI) -22
Acute Medicine – 21
Gen Surg & HPB (LGH) -20
Cardiac Surgery – 15
Cardiology 16

Death Classifications for Q1-Q2 Adult Deaths where SJR Completed

DEATH CLASSIFICATION	REASON FOR REQUESTING SJRS FOR ADULT DEATHS IN Q1 & Q2						
	ME	Rels	El Proc	LD	SMI	Specialty	Total
1		1					1
2	10		1	1			12
3	20	4	2	1	1		28
4	13	2	9	2	1	3	30
5	6	1	6	2	4	2	21
All	**49**	**8**	**18**	**6**	**6**	**5**	**92**

What is the data telling us?

- 1 case has been given a Death Classification of 1 by the Specialty M&Ms – Cardiology and Cardiac Sugery – problems in care related to delays with referral from a another hospital and also once arriving at UHL . The death has been investigated by the Patient Safety Team. Need for a TAVI Co-ordinator identified as the key action.
- 12 cases were given a Death Classification of 2 by the Specialty M&M. Learning points were:

• **Delay in transfer to CCU**	• **Review of Hb in dialysis patients receiving EPO**
• **Staff need to be very careful with relevant blood results. Serum Calcium blood tests on admission**	• **Recognising and treating Type 2 Respiratory failure and familiarity with NIV at the LRI**
• **Xray reviews – should be reviewed on admission and when reaching base wards**	• **Interpretation of abnormal findings on CXR and positioning of NG tube**
• **Sub-optimal management of PD meds**	• **Access to gastroenterology advice out of hours**
• **Knowledge and communication / treatment of Atrial Fibrillation**	• **Patient on surgical ward at LGH - should have had Medical review**
• **Regular blood tests in relation to fluid management/obstructing type problems**	• **Fluid management of hypernatraemia** **Recognition of delirium**

How is UHL engaging with bereaved families and carers

Bereavement Support Service

- The Bereavement Support Service (Adult) offers bereaved families/carers the opportunity to talk about what matters to them regarding their bereavement and offers information and support and signposting to bereavement counselling and other support organisations as required
- **Follow up contact by the Bereavement Support Service is offered to the bereaved relative/carer for all UHL adult deaths**.
- Contact is offered either by the Ward staff or Bereavement Services. Where death referred to the Coroner, the BSN contacts the family directly
- Contact is made by the Bereavement Support Nurse (BSN) 6-8 weeks after the death

- **1071 families of deceased patients in Q1 – Q2 requested** follow up contact by the Bereavement Support Nurse
- BSN managed to speak to **74% (796)** of bereaved relatives (of patients who died in Quarters 1-2) who requested telephone follow up (a letter or email is sent to the remaining where the Bereavement Support Nurse was unable to speak to the family on the phone)

Feedback from Bereaved Relatives where the Patient died in Quarter 1-2

BSS signposted 214 families for bereavement support

Signposting to bereavement services included CRUSE, LOROS, Sharma Women's Centre, Child Bereavement UK

52% of bereaved families provided feedback on EoL care.
8% amongst them said their experience was either Poor or Very Poor.
100% of this group had the opportunity for a further follow-up

Feedback about Quality of Care	Number/%
Overall Standard of EoL care rated as **GOOD**	321 (42%)
Overall Standard of EoL care rated as **GOOD**	172 (23%)
Overall Standard of EoL care rated as **UNABLE TO COMMENT**	141 (19%)
Overall Standard of EoL care rated as **SATISFACTORY**	65 (8%)
Overall Standard of EoL care rated as **POOR**	36 (5%)
Overall Standard of EoL care rated as **V.POOR**	25 (3%)

Meetings with the clinical team/s were arranged for **12** families who said care had been poor or very poor.