University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 6 September 2018

	Trust Board paper I

Report Title:	**Quality and Outcomes Committee – Committee Chair's Report** (formal Minutes will be presented to the next Trust Board meeting)
Author:	Helen Stokes – Corporate and Committee Services Manager

Reporting Committee:	**Quality and Outcomes Committee**
Chaired by:	Col (Ret'd) Ian Crowe – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Eleanor Meldrum – Acting Chief Nurse
Date of meeting:	30 August 2018

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

This report provides a summary of the key public issues considered at the Quality and Outcomes Committee on 30 August 2018:

- **Nursing and Midwifery quality and safe staffing report (June 2018)** – the report provided triangulated information relating to nursing and midwifery quality of care and safe staffing, and highlighted those wards triggering a 'level 2 concern' and 'level 1 concern' in the judgement of the Acting Chief Nurse and Corporate Nursing team. Although 1 more ward had triggered a 'level 3' concern in June 2018 than the zero in May 2018, fewer wards had triggered either level 1 or 2 concerns. The Acting Chief Nurse detailed ongoing work to review the structure and function of a number of surgical wards, noting the very challenging casemix in those areas and recognising the pressures upon the service. Capacity issues continued to be of concern generally (which the Acting Chief Nurse considered was illustrated by the report), and it was recognised that weekends and out-of-hours periods presented particular challenges. QOC agreed with the Acting Chief Nurse that a visible senior/ Executive-level presence (both medical and nursing) was invaluable in showing support for staff, especially at night.

  The Acting Chief Nurse intended to review the format of the monthly safe staffing report, to ensure that the metrics more closely reflected the physical observation and intelligence data provided to the Corporate Nursing team, and that the nursing vacancy data provided to QOC and the People Process and Performance Committee (PPPC) was appropriately aligned (and reflected all appropriate workforce sectors). The QOC Chair emphasised the need for momentum in reviewing how establishments were applied in the most appropriate way to meet the needs of the patient and the ward. The QOC Chair also noted the importance of being able to recruit to those establishments, and the Acting Chief Nurse outlined continuing work on different ways of working. QOC members also commented on the need to review the care environment provided by the Trust, and how this related to the care available to patients once discharged. QOC members also queried how the Trust was supporting its staff ahead of winter 2018, and queried whether staff were aware – and able to take appropriate advantage – of the UHL health and wellbeing strategy initiatives available to them. In response to queries from the Patient Partner representative on QOC, the Medical Director advised that UHL's reconfiguration plans would ease pressure on the existing LRI surgical stepdown ward.

- **Update on Carbapenem-Resistant Organisms (CRO)** – a detailed discussion took place on the CRO outbreak within the Trust, noting the measures in place and the actions taken to manage the situation. Taking assurance from Public Health England's positive feedback on UHL's management of the outbreak, QOC noted that this issue would also be covered in the Chief Executive's monthly report to the September 2018 Trust Board. A detailed report would be provided to EQB and QOC once the outbreak was declared closed.

- **Monthly highlight report from the Director of Safety and Risk** – QOC considered a suite of reports covering:- (i) the updated never event action plan; (ii) safety governance and culture; (iii) capillary blood has reporting; (iv) 2017-18 Serious Incident themes; (v) the patient safety report for July 2018; (vi) the complaints performance report for July 2018, and (vii) safety walkabouts.

  The patient safety report set out an assessment of UHL's position and practices in relation to the findings of the January 2018 national independent review of Liverpool Community Health NHS Trust. The QOC Chair welcomed this information and noted that despite the assurance provided by that assessment, UHL was not complacent and was reviewing any interventions thought necessary (further update to the September 2018 QOC). The Patient

Partner representative on QOC queried how Patient Partners could play a more proactive role in gauging awareness of Never Events. With regard to the complaints performance report, QOC sought assurance that appropriate processes/triggers were in place across elective specialties to flag multiple cancellations and ensure that patients were appropriately followed up – assurance would be sought accordingly from the Director of Performance and Information.

- **Acting on Results update** – the Medical Director advised that the update was for noting only, and confirmed that the Acting on Results work formed part of the wider e-hospital project reported to PPPC. Although noting the nature of the update this month, the QOC Chair reiterated his wish for this item to remain on the QOC agenda.

- **Fractured neck of femur update** – clinical colleagues from anaesthetics and elective orthopaedics attended to update QOC on plans to improve performance within the fractured neck of femur service, recognising the very significant challenges faced by that service. The clinicians attending for this item considered that the care pathway itself was appropriate, and that a joint clinical ownership plan between the MSS and ITAPS Clinical Management Groups – with dedicated and consistent input – was crucial to improving performance. A 2-week pilot would begin in October 2018 providing more anaesthetics and surgical continuity, and looking to run longer weekend operating sessions than was currently the case. To further change mindsets, the Medical Director noted a recent decision to treat fractured neck of femur patients as emergencies, which was welcomed. QOC recognised the need for a cultural and behavioural change, supported the actions outlined, and emphasised the need for any solution to be a sustainable one.

- **the quarterly report on learning from deaths** – the report set out UHL's crude and adjusted mortality rates for the first quarter of 2018-19 – the crude mortality rate for that period was 1.1% with no undue variations. UHL's HSMR was 94, and its SHMI 97. The report also updated QOC on UHL's processes for learning from deaths, and advised that 96% all adult deaths had been reviewed by UHL's Medical Examiners in 2017-18. That figure was 94% for quarter 1 of 2018-19, expected to rise to over 95% in quarter 2. As previously reported, the main themes emerging from Medical Examiner (ME) review related to end of life care and communication around DNACPR decisions. Where the ME review identified potential for learning, or the bereaved raised concerns about clinical management, cases were referred on for further internal review using the national mortality review template – in 2017-18 9 deaths had been considered to be 'more likely than not' due to problems in care (death classification 1). In a further 27 instances, problems in care had been considered 'unlikely to have contributed to the death' (death classification 2) – those two classifications amounted together to 1.7% of all UHL deaths. The quarterly report also noted the completion of the LLR clinical quality audit by Mazars, as referred to below.

  The quarterly learning from deaths report is appended to this meeting summary, for review by the Trust Board.

- **LLR clinical quality audit** – the Medical Director briefed QOC on the findings of the LLR clinical quality audit, undertaken as a follow-up to the 2014 Learning Lessons to Improve Care review. The audit findings were also being presented to CCG Boards. As detailed in the clinical quality audit, the quality of care was rated as adequate, good or excellent in 84% of cases – the Medical Director considered that the audit showed that the LLR system had been focusing on the right actions since the Learning Lessons to Improve Care report and was working on the improvements required for patients across LLR. The clinical quality audit contained 23 recommendations, and the Medical Director highlighted the need for a better system response to frail older patients and a need for appropriate, timely interventions. An LLR system-wide action plan had been developed in response to the recommendations.

  Information on the LLR clinical quality audit report is appended to this meeting summary.

- **UHL Quality Commitment 2018-19** – the Director of Clinical Quality advised that a simplified RAG rating was now in place in the 2018-19 Quality Commitment, which included a look-forward to likely year-end delivery. The QOC Chair commented on the number of red and amber ratings – although acknowledging this point the Director of Clinical Quality emphasised the need to look at the year-end forecast as well as the current quarter 1 position. QOC also noted that the Strategy team was providing additional support for a number of Quality Commitment workstreams, including the Stop the Line project; improving patient involvement in care and decision-making; embedding Red2Green methodology and senior clinician-led daily ward/board rounds, and improving the management of diabetic patients treated with insulin in all UHL areas.

- **Compliance Assessment and Analysis System (CAAS)** – this report provided a high-level overview for the CAAS metrics across a range of KPIs for estates and facilities, noting that CAAS supported both the NHS Premises Assurance Model (PAM) and the mandatory annual Estates Return Information Collection (ERIC). The Head of Estates and Property attended for this item. In discussion, QOC voiced concern over a number of fire safety issues where 'non-conformance' was indicated, and requested that a view be sought from the Director of Estates and Facilities on the particular issue of independent Board assurance re: fire management, to clarify what was required. QOC also noted the need for appropriate discussion of the CAAS report by Executive groups such

as the Health and Safety Committee prior to QOC review. Non-Executive Directors suggested it would be helpful to receive further assurance from the Director of Estates and Facilities that the fire safety assessment undertaken following the Grenfell Tower tragedy had not changed. Although noting the high-level nature of the report (as now explained by the Head of Estates and Property), the QOC Chair agreed to contact the Director of Estates and Facilities outside the meeting to discuss its format and purpose on the QOC agenda, noting QOC's view that the report should also outline intended solutions to any identified challenges.

- **CQC action plan** – the Director of Clinical Quality advised QOC regarding 2 outstanding issues on the CQC action plan, acknowledging that there was further work to do on the issue of Deprivation of Liberty Safeguards – this was a national issue, however. With regard to the second outstanding issue, QOC noted that the updated Interpreting and Translation Policy was scheduled for review at the September 2018 Policy and Guideline Committee. QOC received assurance that no actions on the action plan were closed unless there was appropriate supporting evidence accompanying them. QOC suggested that it would be helpful for future iterations to advise whether any listed changes in UHL's position against the CQC Insight indicators were as anticipated.

- **Clinical audit 2018-19 quarterly update** – in response to a query from the QOC Chair, it was confirmed that quarter 1 progress for 2018-19 was on track. QOC noted a slight shift in focus, with the Trust's clinical audit team also now becoming more involved in quality improvement projects. The QOC Chair received assurance that the Clinical Audit Improvement Awards would be appropriately publicised.

- **Schedule of external visits** – given that the previously-identified issues persisted, the QOC Chair requested that a member of the Estates team be involved in the forthcoming LRI aseptic suite visit, to clarify the storage constraints. The QOC Chair also emphasised the need to mitigate known non-compliance issues as far as possible ahead of such visits.

- **Cancer quality outcomes dashboard** – as requested at the May 2018 QOC, Dr D Barnes UHL Cancer Centre Clinical Lead introduced the updated cancer quality outcomes dashboard, now reworked to align more closely to the format of the CQC Insight report. Although welcoming the dashboard, QOC agreed that further work was needed to understand the data in terms of UHL's underlying performance – the author agreed that trend information would be key to this, and noted his intention to include UHL's interquartile position in the end of year iteration (to be presented to the May/June 2019 QOC once available). In response to a query from the Patient Partner representative on QOC, the Medical Director agreed to consider the most appropriate way in which to share such data with patient groups, noting the need to include appropriate explanatory context and narrative.

- **QOC Annual Workplan 2018-19** – noted.

- **Minutes for information** – Executive Quality Board minutes 3.7.18; Executive Quality Board actions 7.8.18; Executive Performance Board minutes 24.7.18.

Matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

1. quarterly learning from deaths report (as per the report appended to this summary);
2. Learning Lessons to Improve Care (as per the report appended to this summary).

Items highlighted to the Trust Board for information:

1. the update on the Carbapenem-resistant organisms outbreak.

Matters referred to other Committees:

None

Date of next meeting:	27 September 2018

MORTALITY REPORT

Authors: Deputy Medical Director, Head of Outcomes & Effectiveness; M&M Information and Project Manager
Sponsor: Medical Director

Executive Summary

Background and Context

UHL's crude and risk-adjusted mortality rates, and the work-streams being undertaken to review and improve review these, are overseen by the Trust's Mortality Review Committee (MRC), chaired by the Medical Director.

MRC also oversee UHL's framework for implementing "Learning from Deaths" which includes our Medical Examiner Process, Bereavement Support Service; and Specialty Mortality Reviews using the nationally developed Structured Judgement Review tool.

One of the Learning from Deaths requirements is 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.

The locally commissioned LLR Learning Lessons to Improve Care (LLtIC) Clinical Quality Audit (looking at the care provided to patients who died either in LPT or UHL or within 30 days of discharge from UHL) has now been completed.

Questions

1. What are the data telling us around UHL's mortality rates and what actions are being taken to improve these?
2. What has been the Learning from Deaths in 2017/18 and in Quarter 1 of 2018/19 and are we meeting the national mortality reporting requirements?
3. What were the findings of the LLR LLtIC Clinical Quality Audit and what are the next steps?

1. UHL's Mortality Rates and Actions

A summary of UHL's mortality rates, both risk adjusted and crude, are set out in the slide deck (Appendix 1).

UHL's overall crude mortality for 2017/18 was 1.2%. Our monthly mortality rate increased to 1.5% in December in line with previous years' seasonal variation. For Quarter 1 of 18/19 our overall crude rate was 1.1% which is again similar to previous years.

UHL's latest published SHMI is 97 (covering the time period January to December 2017) and our HSMR was 94 (for same time period). Both these numbers are within the expected range.

There have been several actions undertaken to reduce mortality as part of our Quality Commitment over the past 3 years. The work on recognition and appropriate management of the deteriorating patient, with a particular focus on sepsis has been one of the 2017/18 priorities. In 17/18 we have seen a reduction in the SHMI for patients admitted with a sepsis diagnosis and the pneumonia SHMI continues to be below 100 (88)

2. UHL's 'Learning from Deaths' Process and Publication of Data

UHL's 'Learning from the Deaths of Patients in our Care' Framework is underpinned by the:

- Medical Examiner Process, in collaboration with Bereavement Services
- Specialty Mortality & Morbidity Meetings and Structured Judgement Review Process
- Bereavement Support Service
- Serious Incident Reporting and Investigation Process

In 17/18 the MEs screened 3112 (96%) of all adult deaths (includes some community deaths where deceased brought to UHL's mortuary). Our internally set target of screening 95% of deaths was achieved in Quarters 1, 2 and 3 but an increase in number of deaths in December caused a backlog and 91% of cases were screened in Q4 of the year. 17/18 has now been closed from a screening point of view. 94% of the 18/19 Quarter 1 deaths have been screened to date and the expectation is that over 95% will be screened before the next reporting period.

Where MEs identify potential for learning, through screening of the case notes and speaking to the certifying doctor, or the bereaved raise a concern about clinical management, the case is referred to the Specialty M&M for full Structured Judgement Review (SJR) using the national mortality review template.

935 deaths were referred for either a clinical review or SJR in 17/18 with 523 deaths being referred for SJR. Our internally set target is that 75% of SJRs should be completed within 4 months of death and 100% within 6 months. Our current performance is 80% of SJRs requested in 17/18 have been completed. This figure will increase as not all SJR details have been collated due to capacity constraints within the Corporate M&M Admin team. MRC will discuss how to manage the end of year outstanding SJRs at the September MRC.

Following completion of a Structured Judgement Review, where problems in care are identified, the death will then be discussed at the Specialty M&M meeting and death classification agreed. There have been 6 deaths considered to be more likely than not due to problems in care (Death Classification = 1) since previously reported (9 in total for the whole year). All have been discussed with the Patient Safety Team and are in the process of being reviewed against the Serious Incident Framework.

To date, 27 cases have been given a death classification of 2 (problems in care but unlikely to have contributed to the death) All cases given a DC of 1 or 2 have been or will be discussed at the MRC.

No further theming has been undertaken since the last report and it is proposed that this be done once a year. The main theme identified so far by the ME process continues to be around the timing of discussion and decision making of do not attempt cardiopulmonary resuscitation

(DNACPR) and recognition of patients approaching end of life in both primary and secondary care.

This is reinforced by the fact that most concerns raised by the bereaved, to either the Medical Examiners or Bereavement Support Nurse (BSN), relate to the last few days of life or the death and often because of communication difficulties. Where concerns can't be resolved by the ME, or the bereaved would like a better understanding about clinical management plans or decisions made about end of life care, the BSN will facilitate a meeting with the clinical team.

The continuing challenge is to ensure that the learning identified as part of our Learning from Deaths process, and other sources of learning such as patient safety incidents and investigations leads to sustainable improvement within the organisation. A number of the themes link in with existing work streams or boards and as agreed at the time of the previous MRC report, the themes are to be picked up by relevant existing workstreams.

3. LLR Clinical Quality Audit

The final report of the Mazars mortality clinical audit findings has been shared with the core members of the LLR Learning Lessons to Improve Care (LLtIC) Clinical Taskforce and a covering summary document and LLR action plan is being drafted in collaboration with our LLR partners. The report is being presented to public Trust Boards at the end of August (CCGs) and September (UHL and LPT) and is now available on the CCG websites.

The audit looked at the care provided both within UHL and other LLR organisations and included:

- All deaths in UHL or Leicester Partnership NHS Trust (LPT) Community Hospitals from 21st June to 20th July 2017
- All community deaths in the 30 days after discharge from UHL from 21st July to 20th August 2017.

The overall quality of care across the LLR system was rated as adequate, good or excellent in 84% (148) of cases. Good or excellent ratings were given in 91 (51.4%) cases overall. However, 16% of the patients in the cohort were considered to have received poor or very poor care.

The LLtIC task force has concluded that this is a crucial report for the LLR system and once published should be shared widely to ensure that the learning is fully embedded in work across the system.

The full Mazars Report and LLR response and action plan is a separate Agenda item.

Input Sought

Members of the Board are requested to receive this report and appendix and to:

- Be advised that significant work has been undertaken to ensure UHL's mortality rates are closely monitored and that any patient groups with a higher HSMR or SHMI are being reviewed and learning and action taken where applicable;

- Note the progress being made with screening of adult deaths by the Medical Examiners and completion of Structured Judgment Reviews by Specialty M&Ms

- Be advised that capacity issues are affecting progress with the Learning from Deaths programme both corporately and at specialty level that additional resources have been approved and the Recruitment process is in progress..

- Be assured that where deaths have been considered to be 'more than likely due to problems in care' these have been investigated by the Patient Safety Team.

- Note the LLR wide review findings and proposed actions; and be advised that the UHL Bereavement Support Nurses' details have been included in the LLR Press Releases.

APPENDIX 1

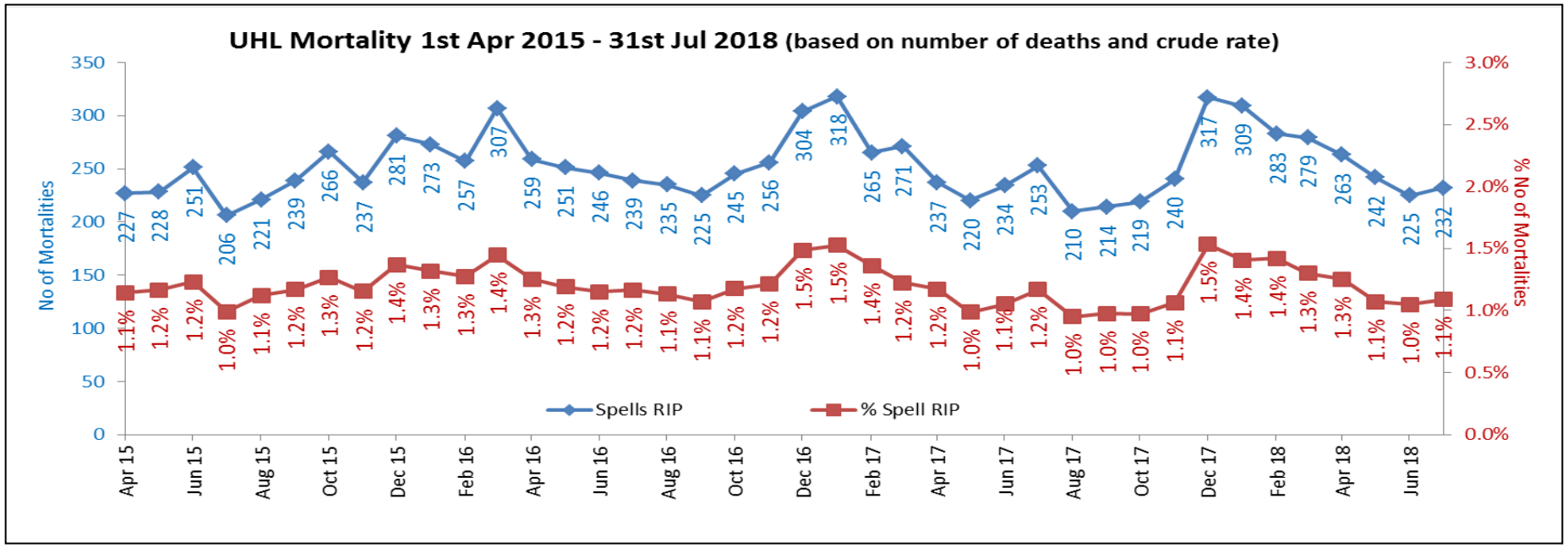
UHL Mortality Report Slide-deck

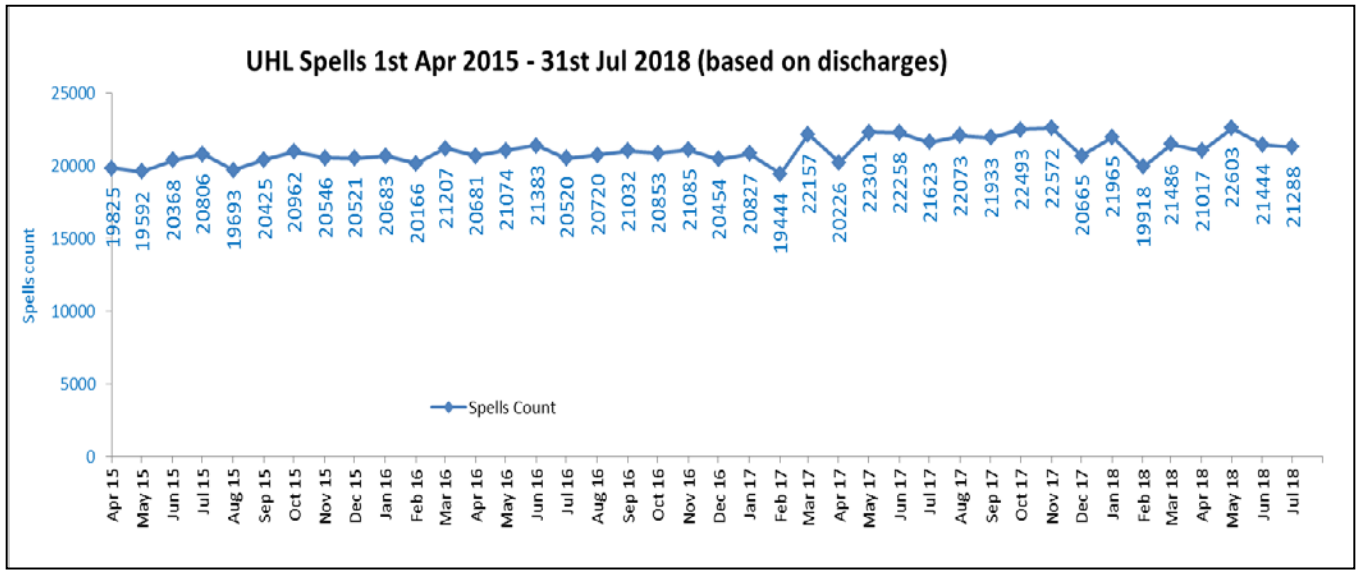
Head of Outcome & Effectiveness, Quality Project Manager and Deputy Medical Director
Sponsor: Medical Director
Aug 2018

What are UHL's current overall crude and risk adjusted mortality rates?

Crude mortality:
i.e. number deaths and proportion of discharges where death is the outcome

How many people died in the Trust between April 2015 and July 2018 and what is the Trust's crude mortality rate? (excluding ED data)





What is the data telling us?

- UHL's crude mortality rate continues to show the seasonal variation
- The 17/18 'Winter peak' was slightly earlier than in previous years and the number of deaths/mortality rate has now come down to usual summer levels

Please note:

- The number of discharges for July 18 may change due to late data recording on the system

UHL's Elective vs Emergency Mortality data

Discharged During…	Emergency Discharges Deaths % Rate	Elective IPs Discharges Deaths % Rate	Daycase Discharges Deaths % Rate	Total Discharges Deaths % Rate
FY 2018/19 (Apr to Jul)	45,545 928 2.0%	6,901 34 0.5%	33,906 0 0%	65,045 730 1.1%
FY 2017/18	136,664 2943 2.2%	20,314 71 0.3%	102,535 1 0%	259,513 3015 1.2%
FY 2016/17	129,047 3043 2.4%	21,340 71 0.3%	99,846 0 0%	250,233 3114 1.2%
FY 2015/16	128,524 2913 2.3%	21,622 77 0.4%	94,630 3 0%	244,776 2993 1.2%
FY 2014/15	122,456 2932 2.4%	22,252 65 0.3%	91,181 0 0%	234,889 2997 1.3%

What is the data telling us?

- UHL's 17/18 overall crude mortality rate of **1.2%** is similar to the last 3 years
- The emergency crude rate is slightly lower than previous years and the number of deaths if fewer than in 2016/17 but the lower rate is mainly due to the increase in the number of emergency admissions.

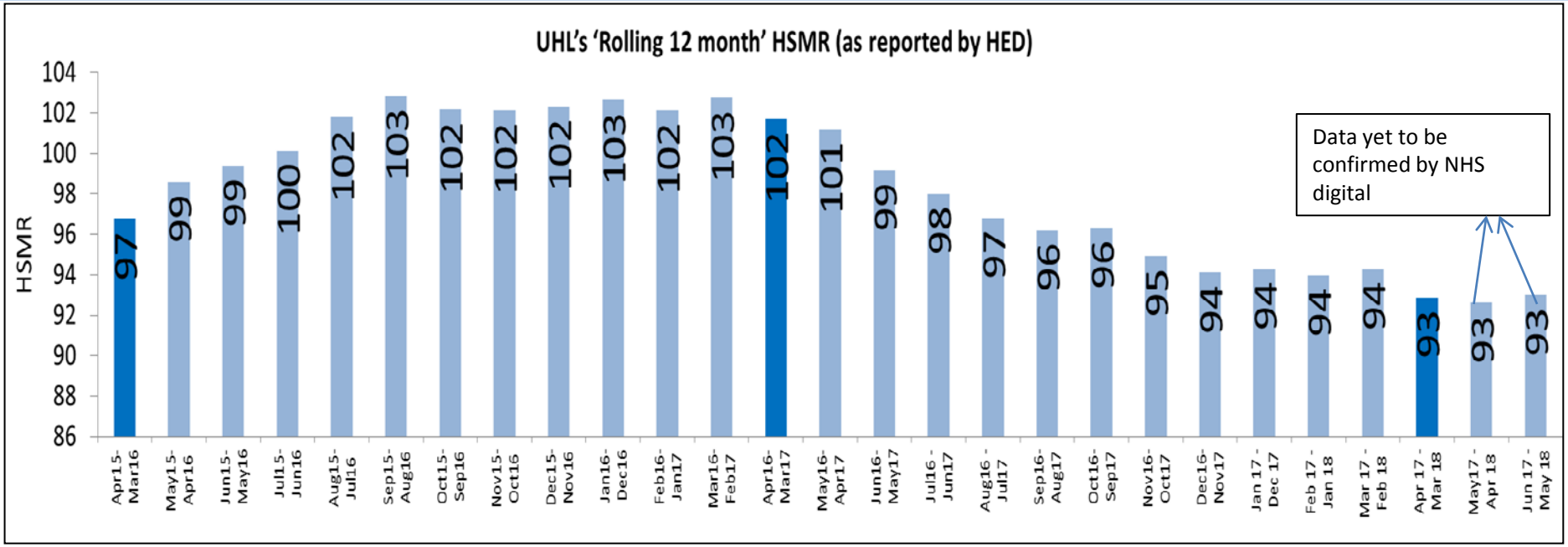
HSMR:
Hospital Standardised Mortality Ratio

HSMR is risk adjusted mortality where patients die in hospital (either in UHL or if transferred directly to another NHS hospital trust) **over a 12 month period within 56 diagnostic groups** (which contribute to 80% of in-hospital deaths).

The HSMR methodology was developed by the Dr Foster Unit at Imperial College (DFI) and is used as by the CQC as part of their assessment process, however the 'rolling 12 month' data presented in the next chart is taken from the Hospital Evaluation Dataset (HED) as their HSMR has been more recently rebased against all other trusts.

NOTE: Following upload of new national data, both HED and DFI 'rebase' their HSMR dataset and therefore Trusts may see a change in their previously reported HSMR.

What is the Trust's current Hospital Standardised Mortality Ratio (HSMR)?



What is the data telling us?

The latest 'rolling 12 month' HSMR in the HED tool covers the period June 17 to May 18 and UHL's HSMR is 93

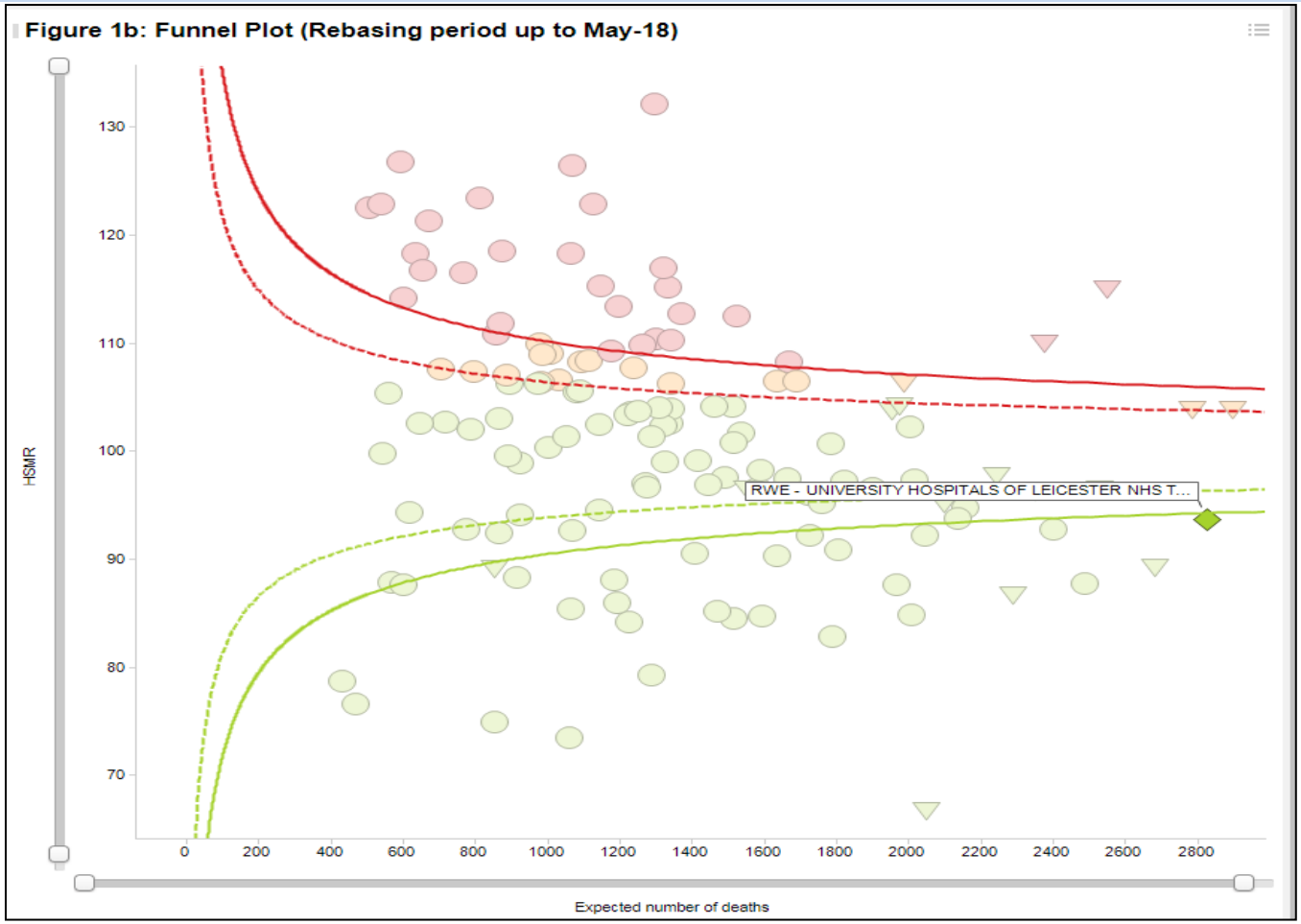
This is the lowest HSMR for UHL since 2014. UHL's 17/18 HSMR, as reported by Dr Fosters' is 92.

UHL's HSMR was above 100 for the financial year 2016/17 (as reported by HED and DFI) but was still within the expected range compared to all trusts.

Financial Year	HSMR (HED)	HSMR (DFI)
2014/15	95	95
2015/16	97	95
2016/17	102	102
2017/18	93	92

Note: NHS digital had technical issues in submitting data to HED & Dr Fosters for the last few months. HED have advised that the predicted scores for HSMR will be confirmed in August based on NHS digital final submission

How does UHL's HSMR* compare with other trusts? (Jun 17 – May 18)
*Data taken from HED



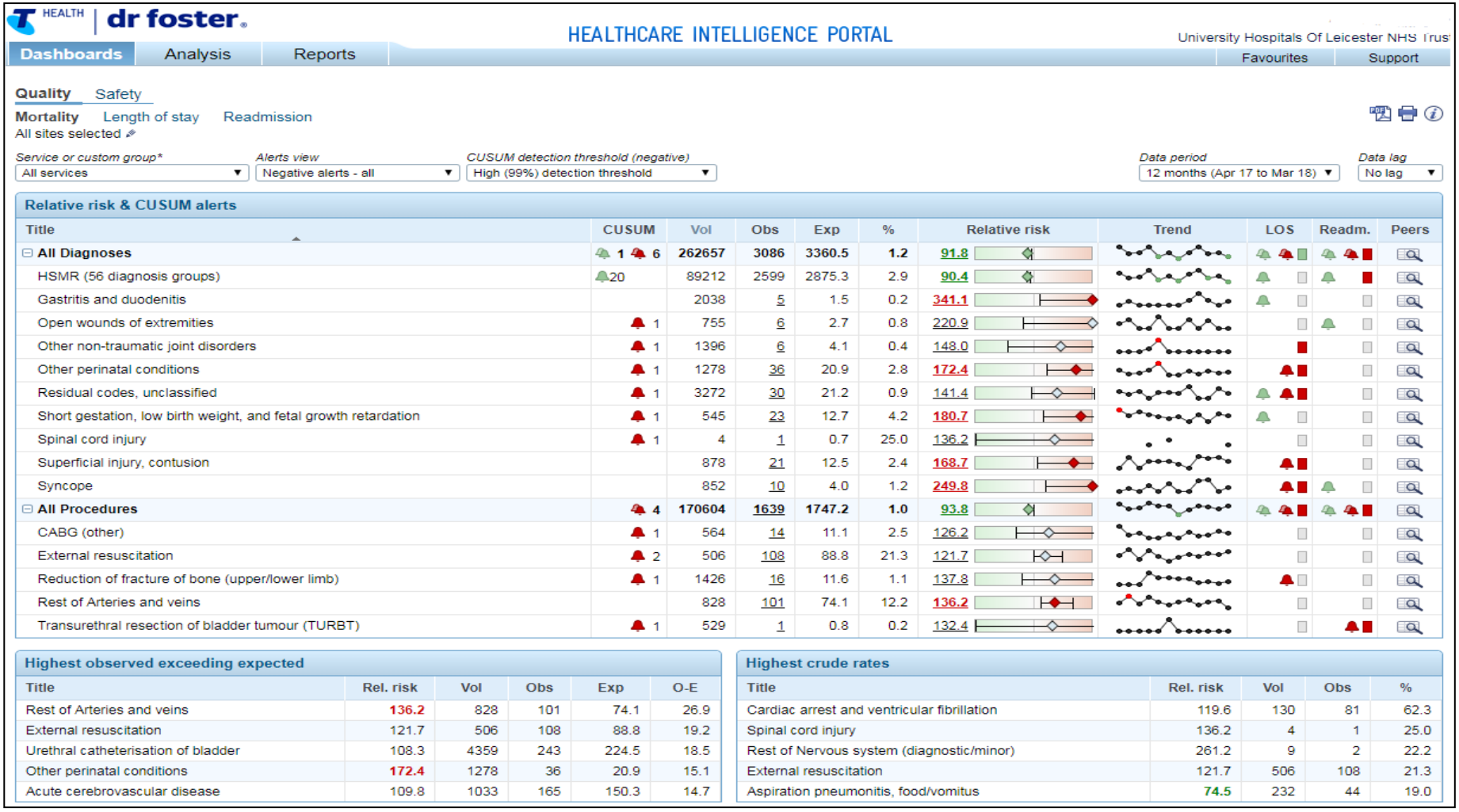
What is the data telling us?

UHL's latest HSMR is 93 and is better than most of our 'peer trusts' (similar sized trusts).

- 8 Trusts' HSMR have dropped since FY 2016/17 and 6 of them are above 100
- UHL has improved from 102 to 93 and is in the top 5 amongst its peers

Note: NHS digital had technical issues in submitting data to HED & Dr Fosters for the last few months. HED have advised that predicted scores for HSMR will be confirmed in August based on NHS digital final submission

Dr Foster's Healthcare Intelligence Portal Dashboard for UHL – (as of 30.07.18)



HEALTH | dr foster

HEALTHCARE INTELLIGENCE PORTAL

University Hospitals Of Leicester NHS Trust

Dashboards | Analysis | Reports | Favourites | Support

Quality | Safety

Mortality | Length of stay | Readmission

All sites selected

Service or custom group*: All services | Alerts view: Negative alerts - all | CUSUM detection threshold (negative): High (99%) detection threshold | Data period: 12 months (Apr 17 to Mar 18) | Data lag: No lag

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 6	262657	3086	3360.5	1.2	91.8				
HSMR (56 diagnosis groups)	20	89212	2599	2875.3	2.9	90.4				
Gastritis and duodenitis		2038	5	1.5	0.2	341.1				
Open wounds of extremities	1	755	6	2.7	0.8	220.9				
Other non-traumatic joint disorders	1	1396	6	4.1	0.4	148.0				
Other perinatal conditions	1	1278	36	20.9	2.8	172.4				
Residual codes, unclassified	1	3272	30	21.2	0.9	141.4				
Short gestation, low birth weight, and fetal growth retardation	1	545	23	12.7	4.2	180.7				
Spinal cord injury	1	4	1	0.7	25.0	136.2				
Superficial injury, contusion		878	21	12.5	2.4	168.7				
Syncope		852	10	4.0	1.2	249.8				
All Procedures	4	170604	1639	1747.2	1.0	93.8				
CABG (other)	1	564	14	11.1	2.5	126.2				
External resuscitation	2	506	108	88.8	21.3	121.7				
Reduction of fracture of bone (upper/lower limb)	1	1426	16	11.6	1.1	137.8				
Rest of Arteries and veins		828	101	74.1	12.2	136.2				
Transurethral resection of bladder tumour (TURBT)	1	529	1	0.8	0.2	132.4				

Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Rest of Arteries and veins	136.2	828	101	74.1	26.9
External resuscitation	121.7	506	108	88.8	19.2
Urethral catheterisation of bladder	108.3	4359	243	224.5	18.5
Other perinatal conditions	172.4	1278	36	20.9	15.1
Acute cerebrovascular disease	109.8	1033	165	150.3	14.7

Highest crude rates

Title	Rel. risk	Vol	Obs	%
Cardiac arrest and ventricular fibrillation	119.6	130	81	62.3
Spinal cord injury	136.2	4	1	25.0
Rest of Nervous system (diagnostic/minor)	261.2	9	2	22.2
External resuscitation	121.7	506	108	21.3
Aspiration pneumonitis, food/vomitus	74.5	232	44	19.0

What is the data telling us?

- 'Coronary atherosclerosis and other heart disease' and 'Cardiac Arrest' are no longer showing as CUSUM alerts.
- 'Gastritis & Duodenitis' and 'Syncope' have a higher relative risk but are not alerting
- These diagnosis groups will be reviewed at the next MRC.

SHMI:
Summary Hospital Mortality Index
ie risk adjusted mortality where patients die either in UHL or within 30 days of discharge
(incl those transferred to a community trust)

The SHMI is published on a Quarterly basis by NHS Digital (previously the HSCIC).

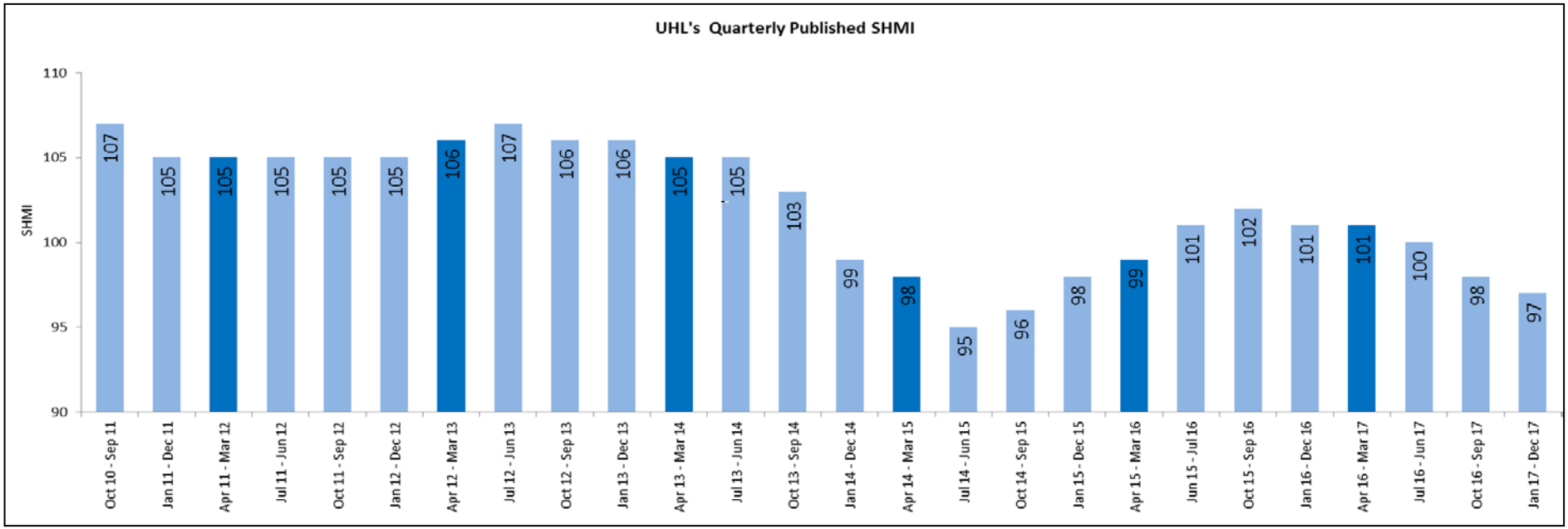
UHL subscribes to the University Hospitals of Birmingham's "Hospital Evaluation Dataset" Clinical Benchmarking tool (HED) which uses HSCIC methodology to replicate SHMI. This then allows us to review our SHMI pre publication.

NOTE:
Although HED rebase their SHMI database following uploading of new data, the unpublished SHMI value is usually 1 or 2 below the final NHS Digital published SHMI

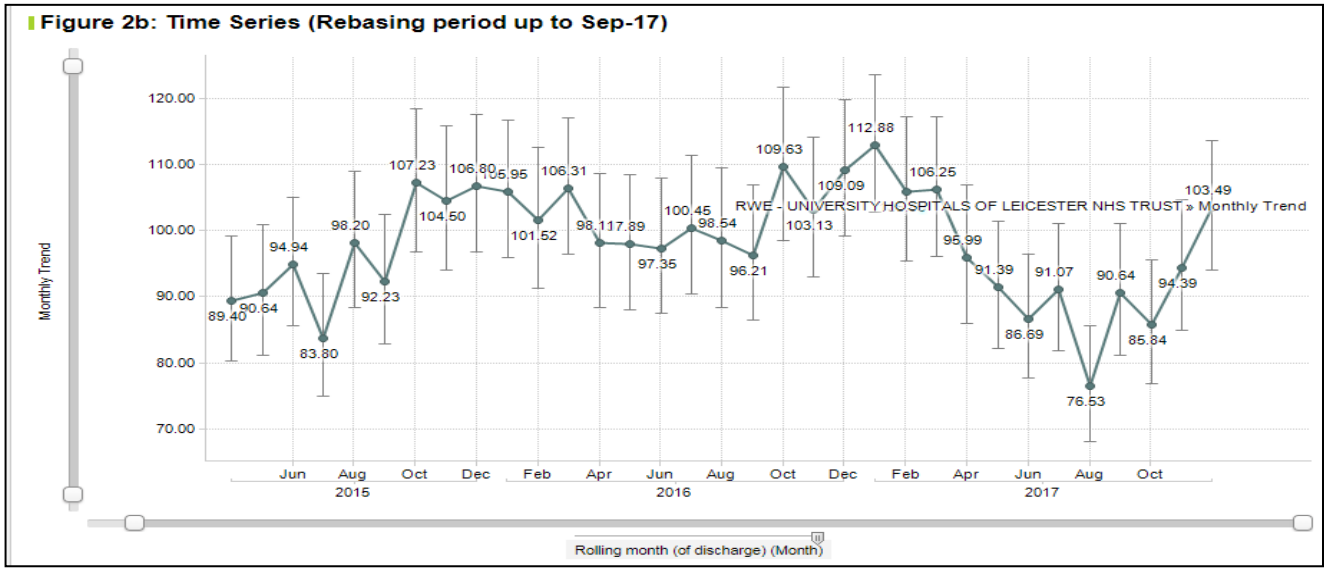
Due to the SHMI involving 'out of hospital deaths' the reporting timeframe is a month behind that for the HSMR.

Note: NHS digital had technical issues in submitting data to HED & Dr Fosters for the last few months. HED have advised that predicted scores for HSMR will be confirmed in August based on NHS digital final submission

What is the Trust's current Summary Hospital Mortality Index (SHMI)?



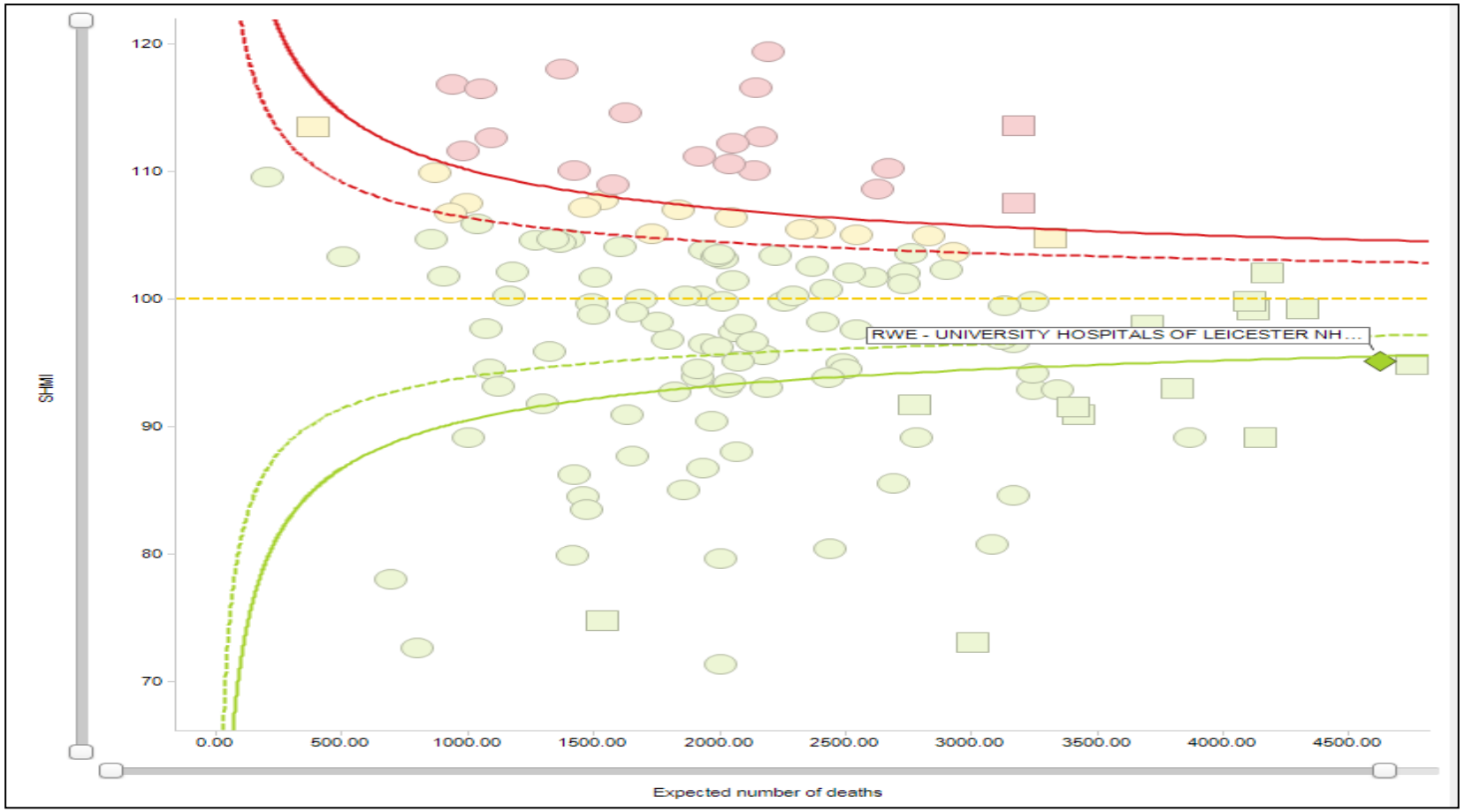
UHL's monthly SHMI (as reported by HED) Apr 15 – Dec 17



What is the data telling us?

- UHL subscribes to HED which uses HSCIC methodology to replicate the SHMI (unpublished SHMI)
- Last month we reported that UHL's latest unpublished SHMI for Jan to Dec 17 was 95.
- UHL's published SHMI for the same time frame is now available from NHS Digital and is 97.
- The monthly SHMI has been below 100 from Apr to Nov 2017

How does UHL's SHMI – as reported by HED - compare against all Trusts (Jan 17 to Dec 17)



What is the data telling us?

UHL's published SHMI for the period Jan 17 to Dec 17 is 97 which is within expected limits..

Learning From the Deaths of Patients in our Care

What does "Learning from Deaths" involve?

- The National Guidance on Learning from Deaths includes a requirement for Acute Trusts to publish on a quarterly basis via Trust Board papers and in the annual Quality Accounts:
  - total numbers of in-hospital deaths from 1st April 2017
  - numbers of deaths fully reviewed as part of the relevant Specialty M&M process (using the Structured Judgement Review tool (SJR) which is part of the National Mortality Case Record Review programme)
  - number of deaths assessed as having been more likely than not to have been caused by problems in care
  - evidence of learning and action that is happening as a consequence of this information
- **There are certain categories of deaths where a full review is automatically expected (ie children; patients with Learning Disabilities, Severe Mental Illness, following an elective procedure**).
- **Full reviews should also be undertaken where**
  - family, carers or staff have raised a concern about the quality of care provision;
  - there is the potential for learning and improvement
  - There is a CUSUM alert for a diagnosis group or a Quality Improvement initiative
- **Case record review** can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work. Review also identifies good practice that can be spread.
- **Investigation** is more in-depth than case record review as it gathers information from many additional sources. The investigation process provides a structure for considering how and why problems in care occurred so that actions can be developed that target the causes and prevent similar incidents from happening again.
- **Death due to a problem in care** is one that has been clinically assessed using a recognised method of case record review, where the reviewers feel the death is more likely than not to have resulted from problems in care delivery/service provision

UHL's "Learning from Deaths" Framework

- **Medical Examiners (MEs)** – (Currently 14 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

- **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

- **Bereavement Support Nurse (BSN**)– 'follow up contact' for bereaved families of adult patients, liaises with both the MEs and Clinical Teams

- **Patient Safety Team (PST)** – Investigation where death considered to be due to problems in care

- **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

April 17 to March 18

PLACE OF DEATH	ADULT	CHILD	NEONATE	ALL DEATHS
IN PATIENT	2918	25	83	3026
ED	221	14	0	235
COMMUNITY	97	3		100
	3236	**42**	**83**	**3361**

What is the data telling us?

- UHL is one of England 'top 5' trusts for activity and also for the number of deaths.
- The table above shows the number of patients included in UHL's "Learning from Deaths" Process 17/18
- "Neonates" includes all stillbirths and babies who are born in UHL and died on an obstetric ward or the neonatal unit or who are born in another hospital and transferred to our Neonatal Unit.
- "Children" includes all children between 0 and 16 years (i.e. includes babies not considered to be a "Neonate")
- "Community" includes deaths incorporated into the Medical Examiner process, where deceased are brought to UHL's Mortuary for Death certification purposes

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

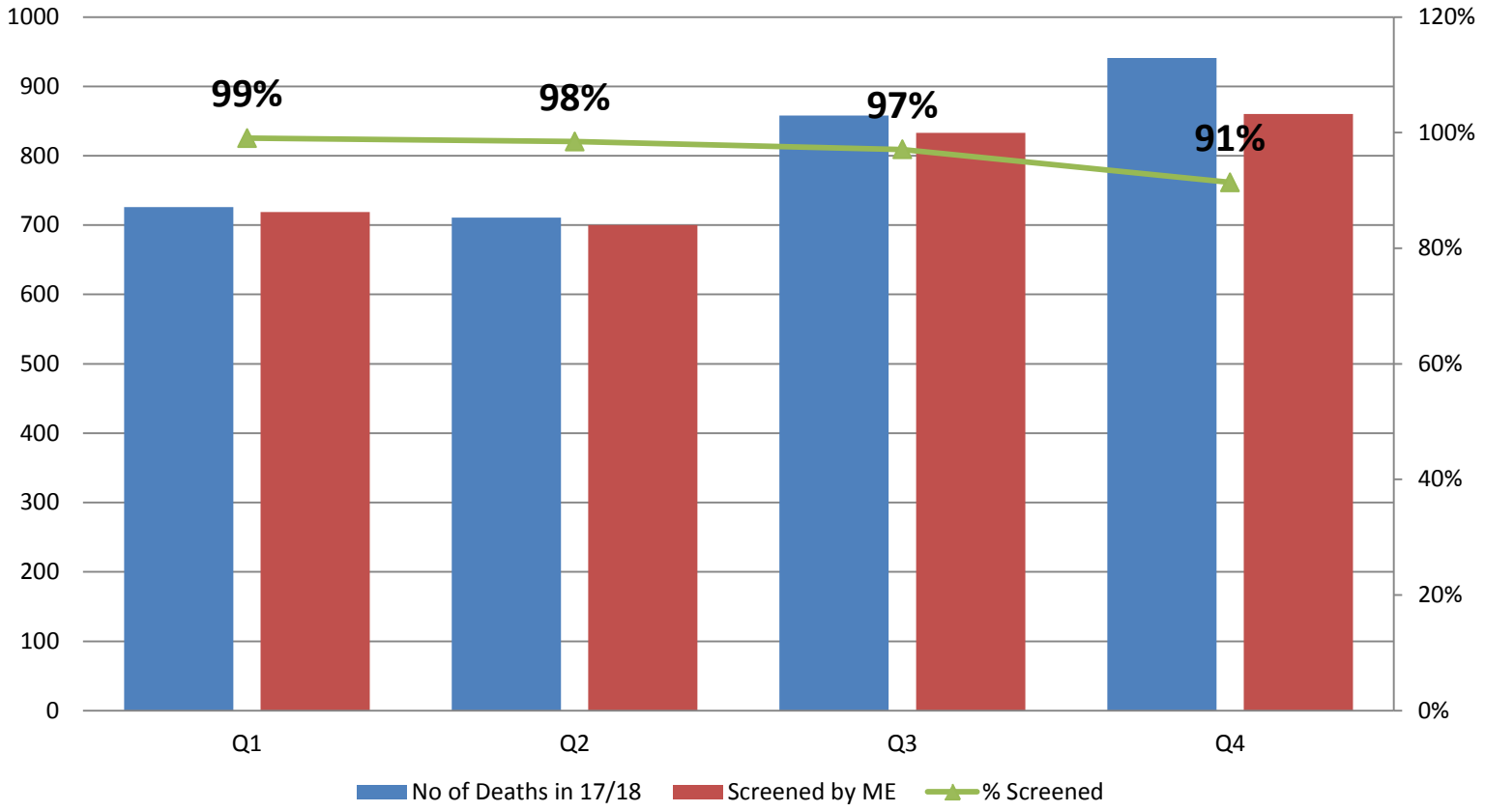
April to June 18

PLACE OF DEATH	ADULT	CHILD	NEONATE	ALL DEATHS In Q1
IN PATIENT	681	7	35	723
ED	65	1		66
COMMUNITY	35	1*		36
	781	**9**	**35**	**825**

What is the data telling us?

* Child transferred from UHL and died at Rainbows and Children's Services chose to undertake a Structured Judgement Review.

Number / % of Adult Deaths Screened by the MEs (April 17 to Mar 18)

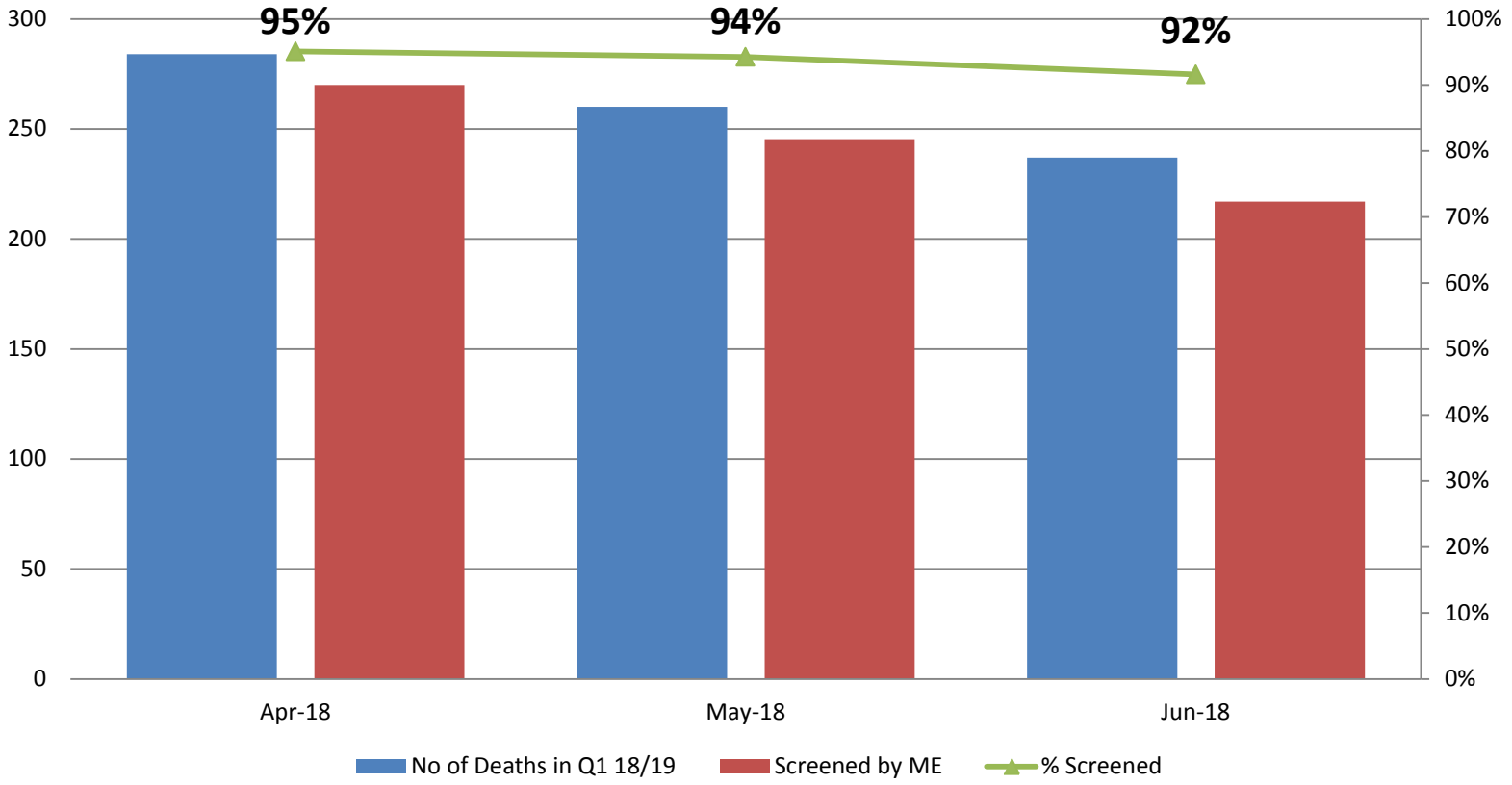


What is the data telling us?

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

In 2017/18 our Medical Examiners have screened 3112 (96%) of all adult deaths (includes some community deaths where deceased brought to UHL's mortuary) which was above target for the year. However we did not achieve our target in Quarter 4 due to the increase in number of deaths from during the winter months. This year's activity is now closed.

Number / % of Adult Deaths Screened by the MEs during 18/19 Quarter 1 (April to June 18)



What is the data telling us?

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

Medical Examiners have screened 781 (94%) of adult deaths during Quarter 1. Most cases that have not been screened are those that have been referred to the Coroner and we are working on a pathway to speed up screening of these cases.

Retrospective screening continues of May and Junes' deaths and it is expected that the 95% target will have been met when next reported.

What happens where MEs think further review required?

- **MEs refer cases for:**
  - Structured Judgement Review through Specialty M&M (**12% of adult deaths in 17/18)**
  - Clinical Review by Consultant responsible for patient care or Matron/Ward Sister **(13% of adult deaths in 17/18)**

- **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 about patient's prognosis, deterioration
    - Previous discharge arrangements

- During 17/18 a process has been established with the EMAS, LPT and CCG Quality & Safety Leads for feeding back where relatives raise concerns about care provided outside UHL, or the MEs think there may be learning for other organisations,
- **Feedback has been sent for 140 cases in 17/18 to:**
  - Ambulance Trust (EMAS); Mental and Community Hospitals (LPT); Primary Care; Other Non LLR Trusts and the Private Sector
  - Relates to: Ambulance Delays; Care Home not contacting GP soon enough; Lack of End of Life Care in Nursing Home; Difficulty in contacting the GP; Earlier Referral by GP; Care in Mental Health and Community Hospitals.

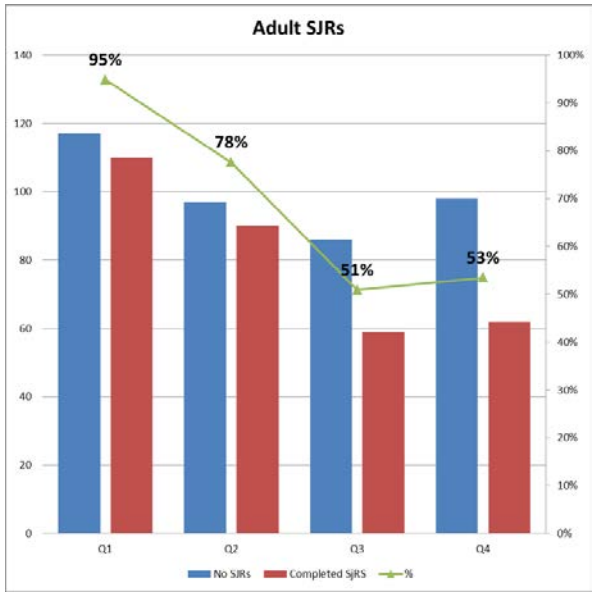
Number of Deaths and Further Review in 17/18

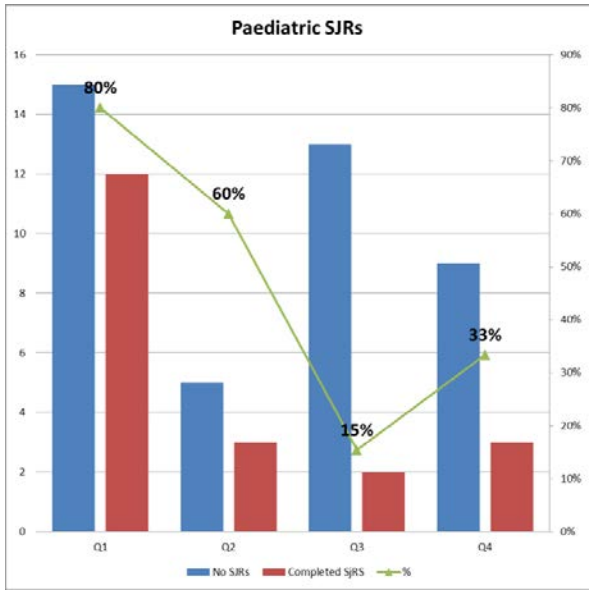
	Q1	Q2	Q3	Q4	All
ME Screened - No further review (Adult)	520	466	611	616	2213
Structured Judgement Review (Adult & Paed)	153	129	114	127	523
ME screen and Clinical Review	58	107	117	130	412
ME screen and Feedback	6	6	3	7	22
ME screen and Theme already identified and action in place	14	11	11	8	44
ME screen and Follow up by Bereavement Support	5	12	7	4	28
Referred to Patient Safety Team				1	1
All	**756**	**731**	**863**	**893**	**3243***

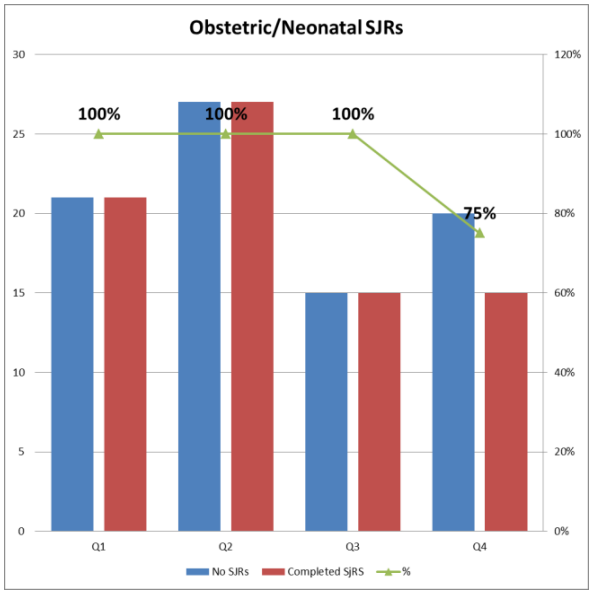
What is the data telling us?

*Not all Community Deaths will have been screened and the above numbers include children and neonates, all of whom have automatic speciality M&M reviews
Most deaths screened by the Medical Examiners are not considered to need a further review.
In total, 523 SJRs were requested in 17/18.
257 SJRs were requested by the Medical Examiner after screening the case notes and 25 more because of concerns raised by the Relatives.
224 SJRs requested were in line with the National Learning from Deaths requirement: Child deaths (42); Perinatal deaths (83); death after elective procedures (56), patients had a Learning Disability (25) and patients with Serious Mental Illness (18)
17 further cases were subject to SJR because of a CUSUM alert (3), speciality M&M choice (13) and patient safety referral (1)
216 Clinical Reviews requested by Medical Examiners and 196 because of concerns raised by relatives

17/18 UHL Adult, Child and Neonatal Deaths Referred for Structured Judgement Review and Number / % Completed







What is the data telling us?

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.

Overall 93% of Quarters 1 & 2 SJRs have now been completed and 65% of those requested for Quarters 3-4 deaths have also been completed. This gives an overall performance of 80% for the year which is below target. It is expected to improve as outstanding SJRs are completed.

The Perinatal Mortality Review Group have reviewed 95% of 17/18 deaths.

The majority of Paediatric SJRs not yet undertaken are ED deaths which have all be referred to the LLR Child Death Overview Panel.

121 SJRs have been requested in Quarter 1 of 18/19 to date and performance data will be presented when available.

What are UHL's Death Classification Criteria and Next Steps?

Following review of phases of care and confirmation as to whether any problems in care led to harm, deaths are classified in line with the criteria below and action taken accordingly:

Category	Rationale	Next Steps
1*	Problems in care thought more likely than not to have contributed to death	Upon initial classification of DC = 1 (i.e. by Reviewer, M&M Lead or at MDT M&M): Confirm Category as applicable. Check if reported as Patient Safety Incident (PSI). **If not already on Datix as Moderate, Major or Death graded incident, M&M Lead to ensure reported as PSI with Major Harm on Datix** . Reporter to advise PSI identified thru SJR Review/M&M. MDT M&M to Escalate to MRC for further review via Mortality Mailbox and **Confirm learning and actions.** MRC review and confirm Death Classification and details of learning/actions Patient Safety Team review against the NHSI Serious Incident Framework and **undertake SI Investigation if meets criteria.**
2*	Problems in care but unlikely to have contributed to death	Upon initial classification of DC = 2 (i.e. by Reviewer, M&M Lead or at MDT M&M): Confirm Category as applicable. **Check if reported as PSI If not consider if requires reporting as PSI.** SJR findings to be reported to MRC via Mortality Mailbox. Update SJR proforma. **Confirm learning and actions.**
3*	Problems in care but very unlikely to have contributed to death	Discuss at M&M meeting. **Confirm learning and actions** and Patient Safety Implications. Update SJR proforma with M&M discussion and send to Mortality Mailbox
4**	No problems in care	**Confirm if any learning** and disseminate accordingly. Update SJR proforma if discussed at M&M meeting and send to Mortality Mailbox
5**	Good or Excellent Care.	**Confirm if any learning /sharing of best practice** and disseminate accordingly. Update SJR proforma if discussed at M&M meeting and send to Mortality Mailbox

* **MUST** be discussed at Specialty M&M ** Death Classification can be 'signed off' by M&M Lead

17/18 Death Classifications where SJR Completed

DEATH CLASSIFICATION	REASON FOR REQUESTING SJR									
	ME	Rels	Child	El Proc	LD	SMI	Cusum Alert	Specialty	PST	Total
1	5	1	2	1						**9**
2	16	1	7	1	1	1				**27**
3	85	6	12	6	10	6	1	2		**128**
4	74	12	52	12	1	6	1	8	1	**167**
5	19	1	23	14	11	2		1		**71**
1 or 2 tbc	2				1					**3**
3 tbc	7			2				1		**10**
4 or 5 tbc	1		8	2		1				**12**
All	**209**	**21**	**104**	**38**	**24**	**16**	**2**	**12**	**1**	**427**

What is the data telling us?

- 6 cases have been given Death Classification of 1 since the previous Quarterly report. All were discussed at the Mortality Review Committee on 7th August and all have been discussed with the Patient Safety Team. Further detail was requested for 3 cases. Details of actions arising from this group of patients will be reported in the next EQB update.
- Actions will be tracked by MRC for all cases given a Death Classification of 1 or 2.

Key Themes from the Learning from Deaths Programme in 17/18 (to date)

The table below summarises the areas of learning identified from the ME screening process , completed clinical reviews , Specialty M&M reviews and Bereavement Support follow up.

Theme	Sub themes
End of Life (EoL) / Do Not Resuscitate Orders) DNACPR	Delayed recognition of End of Life; DNACPR not in place early enough; Invalid DNACPR; EoL care in place but continued active treatment; Fluids not given when patients on EoL care
Communication – mainly with Relatives	Mainly relates to relatives' concerns, includes communication relating to prognosis, deterioration, death or being able to contact ward/consultant
Discharge / Admission	Previous discharge – perceived appropriateness, expectations re prognosis, effective planning of post discharge care or follow up; medication Admission – perceived appropriateness; emergency pathway (ED/GPAU)
Clinical Monitoring	Includes in-patient observations, ward round reviews, out-patient follow up; transfer between sites; senior review/setting of 'ceilings of care', handover and transfer between specialties and sites
Acting on Results	Investigations – both following up and acting on results
Nursing Care	Responding to Buzzers, Feeding, General Care and Staff Attitude
Sepsis	Earlier recognition, timely delivery of sepsis care bundle; risk of fluid overload
Escalation	Escalation of EWS or escalating for senior review or higher level of care
Medication	Delays, Toxicity, Omissions of Critical Medicines
Others	Pain Management (7); CT - Delays/AKI (5) Chest Drain/Pneumothorax (5) Pathways (8) Diabetes Management (4)

Top Themes and Structure for Addressing Issues

It has previously been agreed that identified learning from both the Medical Examiner and Specialty M&M process should be fed into existing work-streams and reported to relevant oversight committees

17/18 Review findings are still being collated.

Theme	Group overseeing actions
Recognition of End of Life (EoL) / Do Not Resuscitate Orders) DNACPR	Resuscitation Committee End of Life Care Board
Communication – mainly with Relatives	Individual M&M meetings and M&M Leads Forum
Appropriateness of Admission	UHL, LPT and Social Services Integrated Care Team Leaders
Discharge / Re-admission	UHL, LPT and Social Services Integrated Care Team Leaders
Clinical Monitoring	Deteriorating Adult Patient Board
Acting on Results	Acting on results work stream
Nursing Care	Heads of Nursing/Matrons
Sepsis	Sepsis Working Group/Deteriorating Adult Patient Board
Escalation	Deteriorating Adult Patient Board
Nutrition and Hydration	Deteriorating Adult Patient Board Nursing Executive Team
Medication	Medicines Optimisation Committee
Others	Heads of Service, Corporate Teams as applicable

How is UHL engaging with bereaved families and carers

Bereavement Support Service

- **Follow up contact by the Bereavement Support Service is offered to the bereaved relative/carer for all UHL adult deaths**.
- Contact is made by the Bereavement Support Nurse (BSN) 6-8 weeks after the death

- Contact offered either by the Ward staff or Bereavement Services. Where death referred to the Coroner, the BSN contacts the family directly
- **62% (1979)** of bereaved relatives requested follow up contact by the Bereavement Support Nurse
- BSN managed to speak to **61%** of those relatives (letter/email sent to the remaining where the Bereavement Support Nurse was unable to speak to the family on the phone)
- Further information / follow up was requested by **264** families as part of the follow up contact
- Meetings with the clinical team/s were facilitated for **93** families
- Signposting to bereavement services for 264 people eg CRUSE, LOROS, Sharma Women's Centre, Child Bereavement UK was given to bereaved relatives/carers

Learning from Deaths in our Care - Next Steps

- Continue monitoring UHL's risk adjusted mortality rates (HSMR and SHMI) and undertake more detailed reviews where applicable
- Scope potential for benchmarking with other Trusts and Health Economies with similar patient demographics and organisational structures
- Improve timeliness of ME Mortality Screening in respect of Coroner Referrals and LGH/Glenfield cases
- Improve process for collating, theming and analysis of Mortality Screening and Specialty Review data
- Ensuring dissemination of learning and appropriate actions being taken
- Develop and disseminate Learning from Deaths Bulletin
- Work in collaboration with other Trusts to identify ways of improving our Learning from Deaths process
- Improve support for Specialty process
- Prepare for the impending National Medical Examiner process

Learning Lessons to Improve Care Clinical Quality Audit

Sponsor: UHL Medical Director Paper H

Executive Summary

The following paper provides LLR NHS Trust Boards and CCG Governing Bodies with a report covering the findings and subsequent actions from the Learning Lessons to Improve Care (LLtIC) Clinical Quality Audit. The audit aimed to identify how we could improve the quality of care for patients across our system as a follow up to the original LLtIC audit in 2014.

The LLtIC Clinical Task Force has reviewed the report on behalf of the organisations that they represent and our view is that this report identifies the progress made since the last report and the areas where further work is required. This report demonstrates that the system has been focusing on the right actions and is working on the improvements required for our patients across LLR.

The overall quality of care for the cohort of patients audited across the LLR system was rated as adequate, good or excellent in 84% (148) of cases. Good or excellent ratings were given in 51% (91) cases overall; 16% (29) of the patients in the cohort received poor or very poor care. This audit identified areas for improvement in respect of the care of the frail older person and particularly those patients at the end of life and this needs to be used as a driver for improving the scale and pace of system actions.

The findings demonstrate how many frail, older patients are being cared for appropriately and admitted when there is a deterioration. However in 143 cases, the need for admission could have been avoided. The measures include care in community hospitals and nursing homes, focussed support for families caring for elderly relatives at home and a recognition of more responsive and joined up care by each part of the system. The audit demonstrates that the cumulative effects of these factors disproportionally affect the frail older person.

The report needs to be read in context of the work recently commenced to focus on frailty across the system and the recommendations build on the work of the Better Care Together Work stream. However, the examples of poor and very poor care cited in this report should be seen as a call to action to organisations in LLR to ensure that we step up our efforts to improve care for this vulnerable group of patients by focussing on the key strategic areas for improvement, namely:

- Advance Care Planning and DNA CPR,
- Frailty – particularly the community offer for frail older people to prevent admission and support discharge.

Input Sought

QOC is requested to:

- RECEIVE the report
- APPROVE the supporting action plan and consider the implications for implementing the actions

Learning Lessons to Improve Care
Clinical Quality Audit – August 2018

Report to LLR NHS Trust Boards and CCG Governing Bodies

1. INTRODUCTION

In the summer of 2014, University Hospitals of Leicester, and Leicestershire Partnership Trust and West Leicestershire, East Leicestershire and Leicester City Clinical Commissioning Groups published the LLtIC report. The report detailed the findings of a clinical audit commissioned by health organisations in Leicester, Leicester and Rutland to examine the quality care provided to a particular group of patients that died, and the action plan to address the areas of improvement identified.

The LLtIC Clinical Taskforce (CTF) was set up with the purpose of establishing system-wide clinical leadership across LLR health organisations to ensure that patient issues identified from the Learning Lessons to Improve Care audit were addressed across the whole patient pathway and implemented by the system.

A Joint Action Plan focussing on five themes was developed to focus on:

- System wide clinical leadership to ensure that patient care issues were addressed across the health community
- Patient and staff engagement, listening and action
- Effective care across interfaces between providers of health services
- Transforming emergency care in our wards, hospitals and communities
- Transforming End of Life Care (EoLC)

In August 2016 the CTF reported on the progress of the joint Action Plan confirming that all actions had been implemented and committed to undertaking a further clinical quality audit. Trust Boards and Governing Bodies agreed that the context for the audit had changed since the initial report and therefore agreed that a new methodology was appropriate. These factors included local initiatives such as the improved Morbidity and Mortality Reviews in UHL and LPT and the UHL Medical Examiner model as these improved the ability to learn from reviews into the care of patients. The National agenda had also changed significantly since the decision to undertake the Next Stage Review was made with regards to the National Mortality Case Record Review Programme and the Learning from Deaths Framework.

It was agreed that a retrospective case note review would be undertaken and the cohort of patients to be reviewed would be all adult deaths in a defined month in UHL and those who have died in the 30 days after discharge from UHL (SHMI Cohort) including deaths in community hospitals and primary care. Relatives of the cohort of patients would be contacted make them aware of the audit and ask for their experiences of the care provided.

As a result of the agreement the CTF tendered for a partner to develop an audit tool and undertake the Clinical Quality Audit. In April 2017 Mazars was commissioned to be this partner, their experience in national programmes of work such as Southern Health NHS Foundation Trust for NHSE provided assurance that they would be an excellent partner for this work. This review was the first of its kind using Structured Judgement Review methodology across systems instead of individual organisations.

2. FINDINGS FROM MAZARS REPORT

Scope

Conventional structured mortality reviews often concentrate on the final episode of care and are typically focused on secondary care. The aim of this review was to provide a more system-wide view of quality of care across organisations for patients in the last weeks of their life by reviewing patients' notes across secondary, community and primary care. The audit was retrospective and undertaken shortly after the month of death. The period chosen meant that the audit focussed on the following cohort of patients:

- All deaths in University Hospitals of Leicester (UHL) from 20th June to 21st July 2017
- All deaths at Leicester Partnership NHS Trust (LPT) Community Hospitals from 20th June to 21st July 2017
- All deaths in the Community within 30 days of being discharged from UHL between 21st June and 20th July 2017 (to include deaths in LPT Community Hospitals where previously in UHL).

(This excluded babies and children and deaths on mental health wards.)

The audit was also designed to include feedback from relatives of the deceased patients. This was undertaken via the Medical Examiner's office and the UHL Bereavement Support Nurses team.

The full cohort that was applicable to the audit amounted to 319 deaths (the full cohort) during the period described above. We reviewed case records from 181 patients (57%) in total with 177 cases being given an overall care rating (the reviewed cohort). We used an adapted Structured Judgement Review (SJR) methodology for the audit with the adaptions being agreed in advance with the audit Steering Group. The full detail of the case note review methodology is provided in Appendix 1.

The main addition to the conventional review method was to add a pre-admission phase and post discharge / readmission care. This meant that the overall care rating was an overall assessment of the care across the system and was made up of all the phases throughout the patients care. The phases were:

- Preadmission
- Initial Management and Admission
- Ongoing Care
- Care During a Procedure
- Perioperative Care
- Readmission
- Discharge
- End of Life

By reviewing all phases we have been able to identify some key themes for the Learning Lessons Taskforce to consider that affect the overall pathway as well as issues relating predominantly to specific phases of care.

Mazars' Reflections:

This review was the first of its kind using Structured Judgement Review methodology across systems instead of individual organisations. It required considerable engagement and agreement between all parties to facilitate the audit. This effort by all parties should be applauded. Approaches to relatives, access to hard copy records, access to electronic records and systems, provision of secure logins and facilities required co-operation between a wide number of organisations and individuals and were organised by the LLR organisations. The engagement and co-operation of primary care staff, medical records teams and information governance leads were key to success. There was much to be learnt from the process from all parties to facilitate such a review in future. Process, engagement and mixed review teams are all key. Lessons included:

- identifying the period for review in advance is critical for the scope
- dedicated engagement from medical examiners and bereavement support nurses to talk to relatives
- collating and storing hard copy records well in advance and ordering them for easy access
- support to ensure information governance protocols were adhered to and patient identifiable data is protected (no patient identifiable data was downloaded or removed from site)
- secure access to EMIS and SystemOne is complex and upfront engagement with primary care is beneficial
- dedicated medical reviewers with experience in SJR and experience of acute care combined with primary care physicians enables a whole system perspective of good practice across the pathway. A mixed team facilitates a more robust pathway assessment.
- adapting the SJR methodology to suit a pathway review and agreeing with all parties, and a protocol for raising concerns throughout the audit if needed.

Making a judgement across a system of care is subjective and based on the specific review teams' perspective. It is well documented that various teams rate care differently. Having one team reviewing all cases we consider has gone some way to mitigating this to provide a fair and reasonable assessment of each case and the themes arising for the purposes of overall improvement.

The audit team included 2 Consultants experienced in SJR in acute care including a Critical Care Consultant and a Consultant Physician. We had a GP on the team too which was also invaluable in providing primary care input and insight and assessing the quality of care in primary care. The combined team collaborated with 3 nursing reviewers to provide a combined perspective on the quality of care when further team discussion was required. This also enabled a second review to take place where either specialist knowledge was required or an individual team member required a second opinion.

It was agreed at the outset that should any case cause immediate concern this would be raised directly on site. Specific cases that highlighted the need for local review outside the audit were also highlighted. This ensured additional case reviews were carried out where appropriate.

Overall quality of care
The overall quality of care across the LLR system was rated as adequate, good or excellent in 84% (148) of cases. Good or excellent ratings were given in 91 (51.4%) cases overall.

Relatives' views and patient/family engagement and communication
Relatives were predominantly complimentary of the care in all phases. It was notable that the issues that relatives raised were often concerns that would not have been recorded separately in the case records and indicates the value of the combined approach to review in identifying areas for improvement.

Cumulative impact on quality of care when access is delayed for elderly patients
The most significant theme arising was the cumulative impact of care for the elderly and in particular those with confusion/memory problems. Whilst the cohort had an average age of 77 years, the very elderly (those over 81) tended to fare worse across the system in overall terms.

Initial Management and Admission
It was notable that this phase of care was the most positive phase of care. There was a predominantly emergency route of access to UHL within this cohort. We did not audit waiting times although we comment above on this and some long waits were observed. However, we observed rapid sepsis assessment, prompt administration of antibiotics and IV fluids, liaison with microbiology and timely access to radiology and CT scanning. We observed 2 specific issues in relation to the need to have clear protocols to stabilise patients needing transfer to another hospital (including UHL) and the complexity of the emergency care records bundle.

Clinical monitoring
Pre-alerts from EMAS to A&E for stroke, cardiac and sepsis cases were good. The pre-alerts focussed on these specific conditions and enabled timely assessment for these critical situations. Sepsis assessment was clearly an uppermost consideration when infection was apparent.

Quality of records
We observed a clear relationship between the quality of care records (largely based on the hard copy records at UHL) and the quality of care. Record quality was markedly better where care was also rated highly and vice versa.

Discharge and support at home
On discharge fast track arrangements appear to be effective in 62% of cases where fast track was part of the discharge process. However, there are specific issues regarding DNACPR arrangements and a lack of weekend cover for approval which caused delays and uncertainty in some cases

Whilst occupational therapy/physiotherapy support to get a patient assessed for discharged was efficient with an ability to get equipment in place when needed, community physiotherapy not always provided post discharge for those needing to mobilise which was due to a lack of prioritisation by therapy services.

End of Life Care
A lack of clear advance care planning and End of Life plans presented a challenge for ambulance services deciding whether to transfer or not when patients deteriorated. DNACPR decisions were sought in the majority of cases; however we highlight a number of cases where this did not occur.

3. ADDITIONAL SYSTEM ANALYSIS.

In line with the agreed methodology, 11 cases were referred for further review by UHL. 2 patients had died post discharge from UHL and so had not been through the UHL Learning from Deaths process; the remaining 9 were in-hospital deaths. All 11 cases were reviewed by the Deputy Medical Director (DMD) and Head of Outcomes & Effectiveness (HOE). Their review looked at both the Trust's "Learning from Deaths process" and also whether appropriate learning and actions had already been identified and taken in respect of clinical care.

- Of the 9 in-patient deaths, all had been through the Trust's Medical Examiner Screening process and the Medical Examiner had referred 5 cases for further review (4 for Structured Judgement Review as part of the Specialty M&M process and 1 for Clinical Review by the Consultant responsible for the care of the patient).
- Of the 4 cases not referred for further review by the Medical Examiner, this was considered appropriate for 2 cases, possibly a missed opportunity for the 3rd and the 4th should have been referred.

The issues identified from these cases are congruent with the findings of the Mazars's work.

- Handover / Transfer communication
- Advanced Care Planning, earlier DNACPR or recognition of End of Life car
- Other learning related to documentation of observation and escalation and patient's weight in respect of medication,
- 2 cases had already been reported and investigated as patient safety incidents but not considered to be Serious Incidents.

6 of the 11 cases were forwarded to the Clinical Taskforce for further review by primary care where they were reviewed by the Clinical Chairs and Chief Nurse/Director of Nursing for the relevant CCGs.

- 3 of the cases matched the above systemic themes and therefore no further action was identified.
- 1 case was referred to the Learning Disabilities Mortality Review (LeDeR) Programme as a referral had not already taken place
- 2 cases have been discussed with the practices for further learning

Actions being taken

1. The Lead Medical Examiner and HOE are responsible for the ongoing monitoring of the ME process and feeding back where any areas for learning identified.
2. In respect of the two main themes identified by both the Mazars Reviewers and also the DMD/HOE and Specialty M&M:
    a. Earlier recognition of End of Life Care and DNACPR is being taken forward as a UHL-wide imitative with oversight from the End of Life & Palliative Care Board and the Resuscitation Committee.
    b. Improving the quality of handover and implementation of the NerveCentre Handover module is one of the UHL's Quality Commitment Priorities for 18/19 and is being overseen by the Deteriorating Adult Patient Board.

It is reassuring to note that UHL's Learning from Deaths process had already identified potential learning for all but 2 of the cases referred by Mazars.
End of Life and Handover were the main issues by Mazars in this group of patients. Both have been identified as key themes from the wider 'Learning from Deaths' process (and other quality and safety data) and are being taken forward as trust-wide initiatives. Embedding both the Learning from Deaths process and ensuring actions are taken forward accordingly will continue during 18/19.

4. COMPARISON OF ISSUES WITH 2014 LLTIC REPORT

Although the methodology for the LLtIC Audit in 2014 and this Clinical Quality Audit differ, it is important to ascertain whether the themes identified are similar. Throughout the development of the Clinical Quality Audit advice sought from national leaders in learning from death methodologies. The advice received advised the CTF to expect similar themes as those identified in 2014 as they were the 'wicked issues' facing all organisations and systems. The following table summarises the themes form the two reports:

Themes from 2014 audit	**Themes from 2018 audit**
DNAR orders	Cumulative impact of delays on frail older people
Clinical reasoning	Admission avoidance for very elderly and EoL patients, particularly late at night
Palliative care	Advance Care Planning
Clinical management	DNACPR orders, including DoLS assessments
Discharge summary	Prevention of dehydration
Fluid management	Management of UTIs
Unexpected deterioration	Clinical monitoring • Fluid balance • Diabetes • Warfarin management • Weight management

Themes from 2014 audit	Themes from 2018 audit
Discharge	Inter-site transfers & ward moves
Severity of illness	Discharge
Early Warning Score	
Antibiotics	
Medication	

It is important to note that both reviews identified areas for improvement in respect of the care of the frail older person and particularly those patients at the end of life, but, learning from others suggests that these will probably always continue to be one of the top themes of any review looking deaths.

On the positive side, the second review demonstrates that the work undertaken to improve recognition of severity of illness and escalation of the deteriorating patient has started to have an impact with use of the Early Warning Score being an area receiving positive comments by the Mazars auditors. The most positive phase of care being that of initial management and admissions, but this finding needs to be understood in the context of options for admission avoidance.

5. RECOMMENDATIONS AND ACTIONS

The Mazars' report identifies 23 recommendations groups into four key areas:

A. Pathways
B. Clinical Management
C. Process Issues
D. Future Analysis.

An action plan has been developed to address all of the findings and recommendations from the Mazars report, this is attached as Appendix B. It is important to recognise that, many of the action required are already in place through the Better Care Together work stream but need to embed them into day to day practice. Despite this, there are still areas where improvements can be made and the associated action plan ensures that these new actions are allocated to the relevant BCT work stream.

Many of the recommendations focus on the specifics care issues identified by the reviewers and are matched with specific actions. By reviewing all phases we have been able to identify some key themes for the CTF to consider as the **key strategic areas for improvement**;

- Advance Care Planning and DNA CPR,
- Frailty – particularly the community offer for frail older people to prevent admission and support discharge.

In addition to the work already in place as identified in the action plan (Appendix B), the leaders of the health economy should consider the following:

- It is essential that the newly established Out of Hospital Board receive this report to ensure that the actions for that programme will address the findings.

- The LLR system needs to consider how best to implement ReSPECT (*ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning).*

6. CONCLUSION

This is a crucial report for the LLR system and should be shared widely to ensure that the learning is fully embedded in work across the system.

It is important to recognise that the overall quality of care across the LLR system was rated as adequate, good or excellent in 84% (148) of cases. Good or excellent ratings were given in 91 (51.4%) cases overall. But this means that 16% of the patients in the cohort received poor or very poor care.

The report underlines the importance of the system approach to frailty which is now being addressed through the Frailty Task Force and the work of the BCT work streams, particularly Integrated Locality Teams and Home First. Many of the actions identified in the action plan are already included in the BCT work streams and any new actions can be embedded into these to ensure that we have a system response to the findings from the audit.

Across the system, organisations have improved mechanisms for learning from deaths and, whilst both UHL and LPT have developed Learning from Deaths processes and are working collaboratively, there is still work to do in respect of implementing the Learning from Death framework within primary care and to develop processes for ongoing cross-organisational learning.

This report should be seen as a call to action to organisations in LLR to ensure that we step up our efforts to improve care for this vulnerable group of patients by focussing on the key strategic areas for improvement; Advance Care Planning and DNA CPR, Frailty and the community offer for frail older people to prevent admission and support discharge.

The Full Report and Methodology Appendices are available on the Leicester Hospitals website:

https://www.leicestershospitals.nhs.uk/aboutus/performance/publications-and-reports/llr-clinical-quality-audit-report/

Leicester, Leicestershire and Rutland Learning Lessons to Improve Clinical Quality Audit 2017

MAZARS FINDINGS AND ACTION PLAN
August 2018

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
A. Pathways	1. Examine the cumulative impact on the timeline for frail, elderly patients when admission is required and identify key pinch points to shorten the elapsed time to ward admission.	**Frailty Task Force** Better identification of frail and multi-morbid patients Identify support offer/interventions that need to be rapidly in place across the frailty pathway and various settings of care in order to support independence, continuity of care, minimise the need for acute hospital admission and minimise inpatient length of stay (acute and community) **A&EDB** Admission avoidance measures EMAS conveyance of GP referrals –	Review actions across multiple workstreams to ensure that any delays to patient admission are minimised	**Frailty Task Force**	**October 2018**

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
		dedicated team Assessment units co-located in ED Formalising Emergency Frailty Unit in UHL UHL Frailty Flying Squad to identify cohort of patients on arrival to ED Medical in-reach to ED			
	2. Examine admission avoidance schemes to establish whether criteria are suitable for very elderly and end of life patients including care coordination, hospice at home, management of acute illness and support to nursing homes.	**Home First** Time limited care co-ordination for patients who are unstable/acutely unwell/ require crisis recovery Care Home subgroup – focus on training for care home to support admission avoidance **Integrated Locality Teams** Care co-ordination by the locality MDT for patients who are multi-morbid/frail/complex	Review admission avoidance schemes to establish whether criteria are suitable for very elderly and end of life patient. Ensure that pathways are effective and understood across the system	**Frailty Task Force**	**Oct 2018**

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
		A&EDB Implementation of admission avoidance schemes **End of Life** Development of home based Integrated palliative Care Team to reduce the need for hospital admission **Community Service Redesign Project** Development of community services to support admission avoidance **Medicine's optimisation** Actions to support medicine's optimisation for frail and multi morbid patients			
	3. Promote a concerted effort to improve advance care planning to support decision making for admission, retaining patients in their preferred place of death and preventing unnecessary admission.	Focus on advance care planning in included in the following workstreams: **End of Life –** engaging partners	Greater engagement with EMAS Improve the quality of Advance Care Plans	**Frailty Task Force**	**Sept 2018** **Mar 2019**

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
		across the system **IM&T** – access to summary care records	Ensure all organisations have access to SystmOne Implementation of ReSPECT – embedding the requirements of ReSPECT into Advance Care Plans	 **Frailty Task Force**	**Oct 2018** **Mar 2019**
	4. Promote improved Advance Care Planning across the system in primary care and on discharge from secondary or community provision.	**UHL** Implementation of GREAT – actions to improve discharge communication re End of Life from secondary to primary care	Implementation of ReSPECT – embedding the requirements of ReSPECT into Advance Care Plans	**Frailty Task Force**	**Mar 2019**
B. Clinical Management	5. Identify actions to support the prevention of dehydration in the frail elderly patient.	**Home First** Staff training in care homes	Focus on raising the general awareness of the public regarding hydration – potentially linked to MECC End of Life training to focus on hydration.	**Prevention** **End of Life**	**Oct 2018** **Dec 2018**

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
			Advance Care plans to include management of patients in the final stages of life.		
	6. Identify actions to support the management of UTIs in the frail elderly patient.	**Infection Prevention** Management of CAUTIs	Support the training of staff across the system in the identification and management of UTIs	**Clinical Leadership**	**Dec 2018**
	7. Clinical monitoring issues to focus on include: a. Fluid balance management and recording on wards b. Diabetic management and glucose monitoring/recording throughout the pathway c. Warfarin management including as part of falls risk assessments,	a. Progress in UHL & LPT since original LLtIC report – further work required in UHL b. CQC action plan in UHL addressing actions regarding diabetes. UHL Diabetic Nurses reviewing patients with hypo and hyperglycaemia c. EPMA alerts for	Version 5 of Nerve Centre to include fluid balance monitoring – pilot in progress Nursing risk assessments to be included on Nerve Centre EObs roll out in Nerve Centre	**UHL** **UHL** **UHL**	**Mar 2019** **Mar 2019** **Mar 2019**

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
	monitoring and the additional risks presents on prescribing antibiotics	antibiotic for patients on warfarin in UHL LLR Falls assessment includes risk factors for warfarin			
		LLR Polypharmacy reviews for frail/multi morbid patients	Focus on correlation with medications	**Medicine's optimisation Programme Board**	**Oct 2018**
	d. Weight management and monitoring particularly in relation to correct medication dose	d. MUST assessments in UHL & LPT	Compliance with guidelines	**UHL & LPT**	**Sept 2018**
	e. Clearer recording of decision making at end of life in regards to completing observations and taking blood glucose reading	e. Guidelines in place in UHL	Priority education area for LPT	**LPT**	**Dec 2018**
	f. Examining the provision of adequate community therapy services to support mobilisation on discharge in particular, in patients at risk of pressure sores,	f-i **Community Services Redesign Project** Aiming to deliver better integrated services that reflect the			

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
	with amputations and at risk of developing chest infections. Look at the prioritisation of therapy provision in community post discharge to ensure waiting times are minimised for elderly patients requiring mobilisation	evidence base for best practice community services (including the community hospitals)			
	g. Examining the availability of TPN in community hospitals	Not currently an issue in LPT			
	h. Securing adequate provision of syringe drivers in the community	h. Hospice at home reviewing availability of syringe drivers in the community			
	i. Considering the provision of IV fluid and IV antibiotic administration in community hospitals.	i. Already in place			
	8. Stabilisation protocols for transfers to other units (including Glenfield Hospital) should be agreed.		Internal group established to review management of transfers between UHL sites – actions to be identified an	**UHL**	**TBC**

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
			implemented		
	9. Cumulative effect elapsed time for elderly patients' admissions should be reviewed further to include: a Management of fluid balance throughout the admission journey b Monitoring of blood glucose throughout the admission journey c Reducing late night admissions and identifying any consequent risk factors facing the older patient d Examining access to primary care assessment at weekends and early in the working day	**A&EDB** Admission avoidance measures EMAS conveyance of GP referrals – dedicated team to ensure earlier admission from General practice **AEDB** Clinical Navigation hub, City hubs, Acute visiting service are all increasing access to primary care in the community	Communications to all agencies to ensure importance of hydration, blood glucose monitoring and pain relief at all points of a patient's journey Roll out of NHSE extended access requirements	**Frailty Task Force** **Primary Care**	**Oct 2018** **April 2019**
	10. Review the support available to ambulance service staff faced with decision making for admission at End of Life	**End oL** Improved use of green bags in patients homes to include all	Implementation of ReSPECT – embedding the requirements of	**Frailty Task Force**	**Mar 2019**

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
		information/medication **IM&T** – access to summary care records	ReSPECT into Advance Care Plans		
C. Process Issues	11. Weekend issues to focus on include: a. Fast track approval processes to ensure decisions are not delayed at weekends b. Blood taking and blood results being available to GPs/out of hours cover at weekends in community hospitals	**A&EDB** a. Focus on pre-empting weekend discharges End to end CHC team to ensure fast track discharges are appropriate **End of Life** Implementation of Integrated Palliative Care Team to ensure weekend discharges are managed	a. CCG Director on-call to approve fast track applications out of hours b. Ensure DHU access to SystmOne for GPs in community hospitals	**A&EDB** **IM&T**	**Oct 2018** **Oct 2018**
	12. Ensure DoLS assessments are completed and authorised and capacity assessments are completed for all relevant patients including where DNACPR or best interest	UHL and LPT have worked to ensure that capacity assessments are completed prior to DNACPR decisions	Implementation of ReSPECT	**Frailty Task Force**	**Mar 2019**

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
	decisions are required.				
	13. Criteria for fast track CHC funding should be reviewed to ensure that inappropriate barriers do not prevent appropriate discharge e.g. DNACPR or perception of lack of imminent death.	**A&EDB** End to end CHC team to ensure fast track discharges are appropriate **EoL** Implementation of Integrated Palliative Care Team to ensure patients are discharged to a specialist team, where appropriate			
	14. Examine ways to reduce the need to change GP practice registration at end of life and consider options for maintaining continuity at end of life.	**EoL** Focus on supporting people to die in the usual place of residence **UHL/LPT** Discharge letters accompany patients to the new discharge location	Improved communication between GP practices when patients move Advice for care home regarding communication with new GP	**Primary Care** **Home First (Care Home subgroup)**	

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
	15. Confirm palliative care coding reflects palliative care accurately.		Review variable practice within Trusts in terms of SHMI coding to understand the extent of palliative care in the system	**End of Life**	**Mar 2018**
	16. Clarify the arrangements for seeking and accessing a Marie-Curie service by UHL on discharge.	**EoL** Implementation of Integrated Palliative Care Team to ensure patients are discharged to a specialist team, where appropriate			
	17. Examine ways to prevent ward moves for patients at end of life.	**UHL** Working to limit moves to assessment ward to base ward. Metrics in place for Emergency care and EoL Board **Home First** Ensuring that patients are able to access community services, where appropriate, reducing the need for step down facilities			

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
D. Future Analysis	18. Undertake to get a better understanding of the use of health care services at the end of life amongst the ethnic population.		Public Health to review findings to identify whether any further actions are required	**Clinical Leadership Group**	**Oct 2018**
	19. Examine end of life care for people with dementia and their families to secure greater understanding of the specific needs of those caring for relatives at home. This should inform future admission avoidance schemes across health and social care services.	**Mental Health** LLR Dementia Strategy in development	Dementia workstream to review findings and ensure that end of life care is factored into workstream actions	**Mental Health**	**Mar 2019**
	20. Examine access to hospice care including those with dementia to establish if there is a need for greater capacity and choice.	**EoL** Hospice at Home provides support to all patients, including those with dementia. LOROS Specialist Palliative Care Nurses provide outreach in the community	LLR Integrated Palliative Care Team to review findings in relation to patients with dementia	**End of Life Programme Board**	**Mar 2019**
	21. An approach to clinical governance reviews should be agreed and an agreed model for information sharing	**UHL/LPT** Learning from deaths reviews are being	Discussion with NHSE regarding the West Midlands Concordat	**Clinical Leadership Group**	**Oct 2018**

AREA	RECOMMENDATION	CURRENT ACTIONS	NEW ACTIONS	STP/BCT WORKSTREAM OWNERSHIP	TIMESCALE
	if future joint reviews are planned between the CCG, providers and GP practices (including nursing homes or other care settings if possible). Agree a protocol to facilitate future audits by enabling access to GP records (and hospice and care home records) as part of the Learning from Deaths policy.	rolled out across UHL and LPT, with joint investigations where appropriate	for Learning form Deaths Review that includes primary care to ascertain whether this can be developed across LLR or Central Midlands		
	22. Monitor community deaths to establish if the observation of high levels of deaths on Mondays is replicated in other periods and to understand any specific characteristics.		Public Health to review findings to identify whether any further actions are required	**Clinical Leadership Group**	**Oct 2018**
	23. An evaluation of the audit process by all parties to seek to improve the process for learning across the NHS and locally should be undertaken.		Process and findings to be shared at Central Midlands Quality Surveillance Group	**Clinical Task Force**	**Oct 2018**
E. Additional actions	24. Support for carers across the whole community for frail and end of life patients	Carers Strategy in place across health and Social Care organisations	Findings to be reviewed to ensure that learning is factored into developments for carers	**Carers Strategy Lead**	**Dec 2018**