Leicester, Leicestershire and Rutland Clinical Quality Audit

A RETROSPECTIVE CLINICAL QUALITY AUDIT ACROSS PRIMARY, SECONDARY AND COMMUNITY CARE (SUMMER 2017)

APPENDICES

July 2018

FINAL

Table of Contents

Appendix 1 – Methodology and approach

Methodology

The objective of the review method was to identify strengths and weaknesses in the provision of healthcare across the patient pathway from pre-admission to post-discharge including end of life care. This would provide information about what can be learnt about the systems where the provision of healthcare goes well, and identify points where there may be gaps, problems or difficulty in the provision of that care. The project specification required a review process that was:

- Both qualitative and quantitative;
- Assessed the quality of care and attempted to identify the factors that made care exceptional or deficient in order to provide learning; and
- Identified and defined opportunities/themes for improvement particularly across interfaces within the joint health economy to provide improved pathways of care for patients.

The project specification also envisaged that the main themes would fall into four domains:

- Timelines – that there were appropriate responses to patient needs;
- Monitoring of clinical care – that appropriate escalation occurred;
- Communication – both internally and externally to organisations within LLR; and
- Patient safety.

The methodology would highlight both areas of good and substandard practice. Key outcomes of the review should include;

- identification of areas of good practice with learning that can be disseminated out to the whole health economy, and
- identification of areas of substandard practice with recommendations for key actions to address these deficits.

Assessment tool

The project specification required a balance between a quantitative audit and a qualitative judgement of the overall quality of care delivered.

Mazars worked with steering group members and adapted the Royal College of Physicians (RCP) assessment tool for the review. The RCP tool has been adopted for use by the National Mortality Case Record Review (NMCRR) programme,[1] which aims to develop and implement a standardised way of reviewing the case records of adults who have died in acute hospitals across England and Scotland. The aim is to improve understanding and learning about problems and processes in healthcare associated with mortality, and also to share best practice. Mazars adapted this so that it would cover pre-admission, inpatient care and subsequent care post-discharge to end of life.

The RCP tool uses a Structured Judgement Review (SJR) approach. The structured judgement review (SJR) methodology has been validated and used in practice within a large

[1] The NMCRR programme is a national collaborative project led by the Royal College of Physicians (RCP) in partnership with Yorkshire and Humber Academic Health Science Network's (AHSN's) Improvement Academy and Datix.

NHS region.[2] It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible. SJR blends traditional, opinion-based, review methods with a standard format, requiring reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

Information Governance

Due to the number of organisations involved, the information governance requirements of this review were complex. Over a period of months, a Privacy Impact Assessment (PIA) was developed, in conjunction with Clarity, the CCGs, the Information Governance Leads of each of the Trusts and the Commissioning Support Unit (CSU) on behalf of primary care.

The PIA covered:

- Description of data to be used;
- Justification for using the data;
- The legal basis for using the data in this way;
- Who can access the data;
- How the data will be linked to other sources;
- Confidentiality and security measures for transferring the data;
- Confidentiality and security measures for storing the data;
- How long the data is retained;
- Governance measures in place; and
- Data flows.

Once agreed, the PIA was signed by the Caldecott Guardians in each of the LLR organisations.
Individual data sharing agreements were also required for each GP practice. The wording of the agreement was agreed with the CSU and gaining agreement was organised by each of the three CCGs.

Software

Mazars engaged Clarity Informatics Limited (Clarity) to provide an online software solution to enable a retrospective objective quality review of deceased patients' notes across secondary, community and primary care. Clarity was already familiar with using the RCP assessment tool for mortality reviews and was using its AssureRCR software solution for such reviews in other parts of the country.

Clarity's role was to:

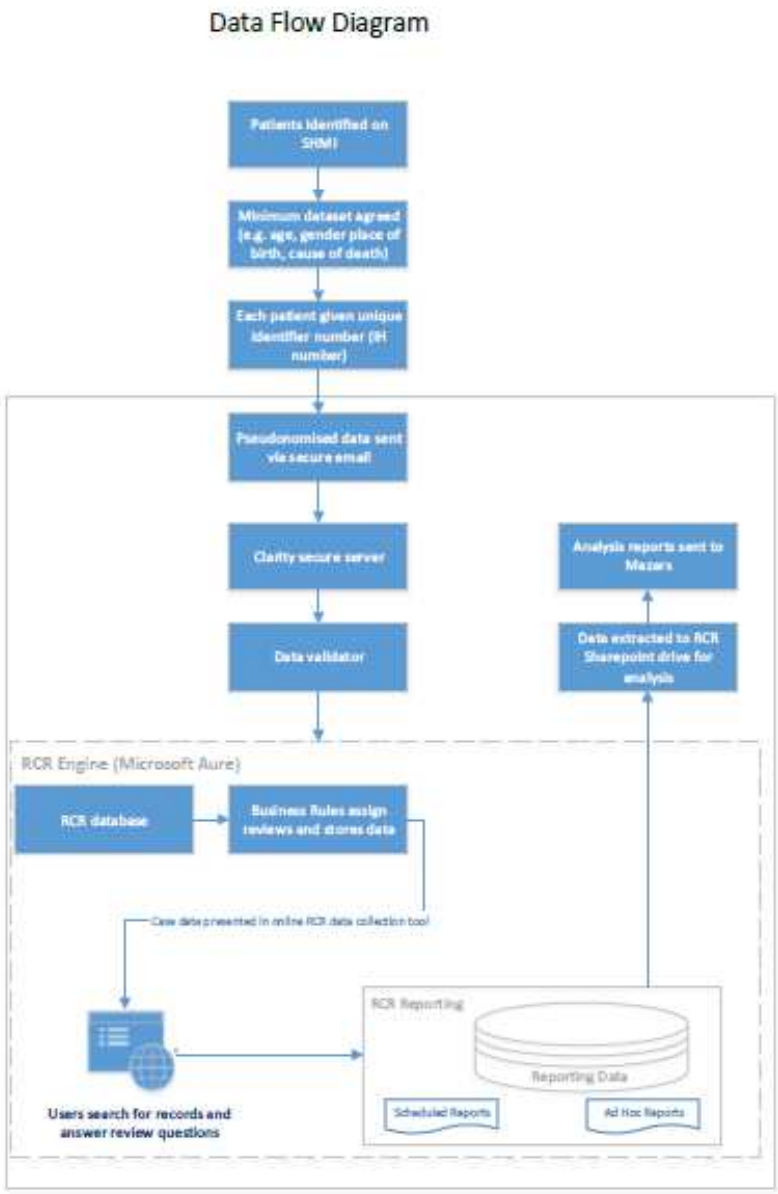
- Provide an online solution to carry out case record reviews and to refine the case review form following the pilot phase of the project;
- Provide the means for upload of all relevant hospital and community extract data (PAS data);
- Process the received data and present the case records in the online software solution (AssureRCR);
- Assign each case record a retrospective case review form;

[2] Royal College of Physicians 2016: Using the structured judgement review method**.** A clinical governance guide to mortality case record reviews

- Allow a panel of reviewers access to AssureRCR;
- Provide training for the reviewers; and
- Provide Mazars with suite of reports for them to query the data, analyse and produce the final report on the findings.

The flow of data of a minimum data set and necessary fields for the review is set out below. Information was not patient identifiable at this stage with a unique identifier created to create an individual pre-populated form ready for each case to be reviewed.

Diagram 1 Data Flow diagram



Review process

Set up

The import of hospital data into the Clarity system was an integral part of the set-up of the project. The data needed to contain the appropriate data fields, be in the correct format and needed to be tested before the reviews could begin. The final agreed list of data fields is shown below:

Table 1 Data fields provided

Discharge Hospital Code
GP name
GP Practice
Age at death (years)
Sex
Ethnic Origin
Admission Date
Day of admission
Time of admission
Admission Pathway
Spell First Primary Diagnosis
Primary Diagnosis in Last Episode
Discharge date (if applicable)
Time Died/ Discharged
Length of Spell Nights
Date of death
Day of death
Time of death
Number of days between admission and death
Specialty team at time of death
Type of admission (emergency or elective)
Recorded cause of death

The data provided was anonymised with all identifying fields removed from the data download. In order to identify cases for review a unique identifier was created for each patient which was cross-referenced to hospital records on site. Patient's details were then used during the on-site period to identify the correct community and GP records on line.

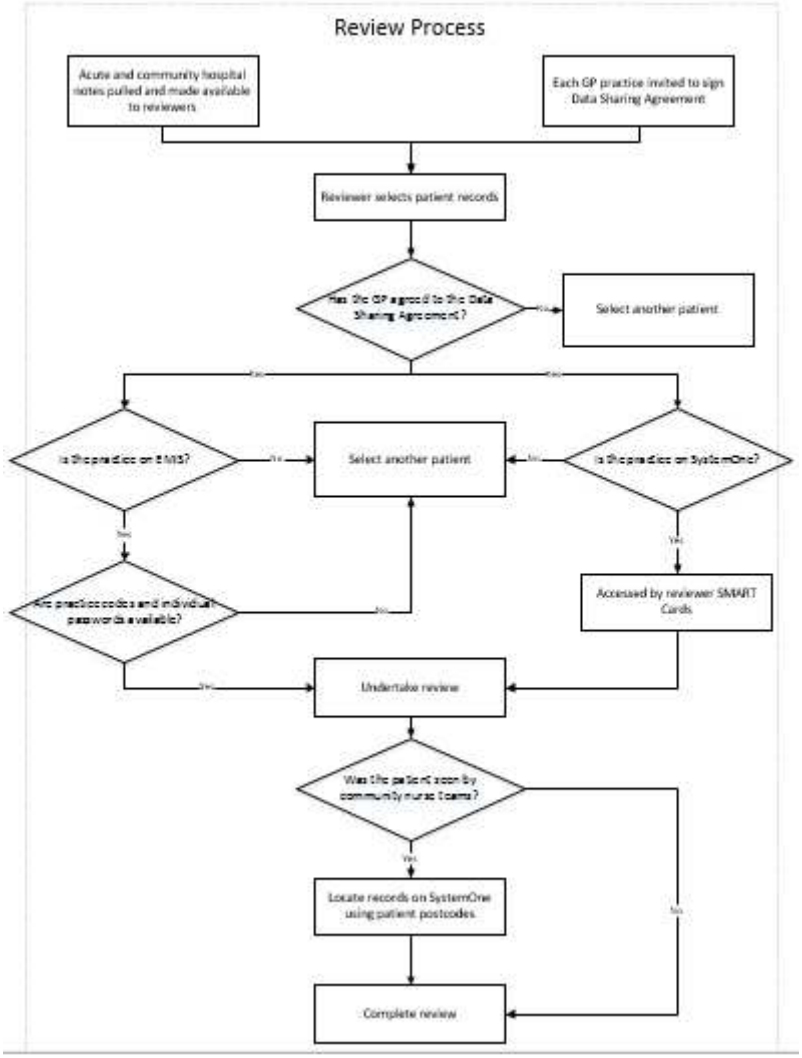
Another part of the setup of the review process was availability and access to records. These included all the paper notes of those who had died in acute or community hospitals and access to electronic hospital systems, for example, Emergency Department notes (EDRM) and observations (Nerve Centre).

Access to GP records, for those who had signed the data sharing agreement, was either through SystemOne or EMIS. The first required SMART card access and the latter required each reviewer to be locally set up by the EMIS practices and given separate login details.

Access to community nursing records was via SystemOne and required either SMART cards or individual reviewer logins.

We did not have access to hospice notes or Nursing or Residential care home notes.

Diagram 2 Review Process flowchart



Relatives' feedback

An important part of this project was to enhance the review process by taking into account the views of the relatives of the deceased patients. For those who died in the acute hospital, the Trust's Medical Examiner contacted the next-of-kin by phone shortly after the death of their relative as part of the Trusts existing processes and for the patients in this cohort asked them a short series of questions (see Appendix 2.) The Trust's Bereavement Service followed the same process for talking to relatives for those patients who died in community settings.

The relatives' anonymised feedback was uploaded into the software, using the unique IH number. This meant that the reviewers could take account of this information as part of their reviews.

Consistency

An Improvement Academy review of the use of the RCP[3] tool acknowledges the fact that all review methods are based on opinion - on individual judgement. The research shows that

[3] Hutchinson A, McCooe M & Ryland E. 2015. A guide to safety, quality and mortality review using the structured judgement case note review method. Bradford, The Yorkshire and the Humber Improvement Academy

where clinical judgement in case note review is concerned, there is about a 70% agreement between clinicians from the same specialty. Therefore it is not unusual, when choosing to use pairs of reviewers, for some aspects of scoring on the same case to differ between the two reviewers. To support consistency for the LLR review, Mazars:

- Issued the reviewers with guidance on using the SJR method for undertaking reviews;[4]
- Provided on-line training to familiarise the reviewers with the online assessment form;
- Provided onsite training for the team at the beginning of the review, led by someone experienced in SJR and using a series of case studies for the review team to work though;
- Undertook a pilot review of a number of records as a team of reviewers to identify and provide insight into issues of differing judgements;
- Ensured that a multidisciplinary team of reviewers were working onsite at the same time to discuss cases together; and
- Provided a second reviewer for any cases where there were questions arising from a first review, assessing very low scores and/or a specialist input was requested from one of the review team.

[4] Hutchinson A. March 2017. Using the structured judgement review method: A guide for reviewers**.** National Mortality Case Record Review Programme (England version).

Appendix 2 - Review Form

LLR draft review form

Introduction

The first part of this document is an exact replication of the Royal College of Physicians (RCP) data collection form,[5] excluding the avoidability of death section, which is outside the scope of this review. Additional sections have been added to cover the specific requirements of the whole system approach of the LLR Clinical Quality Audit. For ease of identification, the additional sections, specific to this project (discharge and readmission), are written in blue font. These follow the same Structured Judgement Review (SJR) methodology as the RCP form.

The second section lists the additional areas that have been raised as being of interest to LLR – either verbally, in the service specification or from the last review in LLR. All but one of these are now covered by this review tool. The exception is patient safety and a decision needs to be made about whether this will be picked up within the review tool or should have a new section.

Structure Judgement Review vs other methods

The structured judgement review (SJR) review methodology has been selected as the validated and used in practice within a large NHS region. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible. Structured Judgement Review blends traditional, opinion-based, review methods with a standard format, requiring reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase*. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The object of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.

One requirement of the LLR Clinical Records Audit specification is to identify good as well as poor quality care. An important feature of the RCP method is that the quality and safety of care is judged and recorded whatever the outcome of the case and that good care is judged and recorded in the same detail as that care which has been problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learned from analysis of high quality care.

As part of the planning phase of this project, other assessment methodologies were considered and reflected in this form, according to the specific requirements of LLR. The first part of the document also includes a series of questions (also written in blue font) in addition to the RCP form, which are specific to LLR. These are:

- The inclusion of a risk question about dementia;
- The inclusion of a risk question about mental health;

[5] Royal College of Physicians (March 2017): Using the structured judgement review method data collection form (England version) - National Mortality Case Record Review Programme

- The inclusion of questions about problems identified re: discharge, readmission and communication with relatives and carers; and
- A lessons learned section, which provides an opportunity to highlight positive lessons learned and identify negative lessons learned about the three themes identified in the previous LLR review – communication, escalation and ceilings of care. A drop-down list uses lists from the Torbay mortality tool and Clarity Informatics' Trust assessment tool.

The Learning Disabilities Mortality Review (LeDeR) Programme[6] was considered but discounted for as being too complex for a review of this size and scope.

Assuring consistency among the review team

An Improvement Academy review of the use of the RCP[7] tool acknowledges the fact that all review methods are based on opinion - on individual judgement. Research shows that where clinical judgement in case note review is concerned, there is about a 70% agreement between clinicians from the same specialty. Therefore it is not unusual, when choosing to use pairs of reviewers, for some aspects of scoring on the same case to differ between the two reviewers. To assure consistency for the LLR review, Mazars plans to:

- Ensure that a multidisciplinary team of reviewers are working onsite at the same time to discuss cases together;
- Provide onsite training for the team and a pilot review of 40 records to identify and address any issues of differing judgements in advance of the main review period;
- Provide a second reviewer for any difficult cases identified.

The previous version of this draft review form was shared with Dr Noel O'Kelly and shared and discussed with Professor Sudip Ghosh both Clinicians within LPT on 11th April 2017. Their suggestions have been incorporated into this version of the draft tool. Primary Care partners have reviewed and agreed the template

[6] University of Bristol (2015) School for Policy Studies Learning Disabilities Mortality Review (LeDeR) Programme

[7] Hutchinson A, McCooe M & Ryland E. 2015. A guide to safety, quality and mortality review using the structured judgement case note review method. Bradford, The Yorkshire and the Humber Improvement Academy

REVIEW FORM – DETAILS FROM CASE REVIEW

Reviewer Details

1. Reviewed by

2. Reviewer grade

3. Review start date

Case information

4. Date of death

5. Please enter the Hospital arrival time

6. Please enter the arrival time at ED if appropriate

7. Case category

    In-hospital/Community/Home

8. Where in the community did the death occur?

    Unanswered/Home/Community Hospital/Nursing / Care home/Hospice/Other

9. How many days after discharge did the patient die?

10. Admitting specialty

11. Discharge specialty

12. Spell HRG Code

RISK FACTORS AND PHASES OF CARE

Risk Factors

13. Did the patient have a learning disability?

    No indication of a learning disability

    Yes - clear of possible indications from the case records of a learning disability

14. Did the patient have confusion/memory problems at any point in their hospital stay?

    No

    Yes - clear diagnostic definition of the confusion/memory problems

    Yes - but without clear diagnostic definition

15. Did the patient have a significant mental illness *(other than confusion/memory problems options above)?*

No

Yes - clear diagnostic definition of the mental illness

Phase of care: Preadmission

16. Please record your explicit judgement about the quality of care the patient received and whether it was in accordance with current good practice….

17. Were any admission avoidance schemes used or considered?

Not clinically indicated

Scheme used

Scheme considered

Scheme considered and not used

Scheme not considered

18. Please rate the care received by the patient during this phase:

Not applicable; 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = excellent

Phase of care: Admission and initial management

19. Please record your explicit judgement about the quality of care the patient received and whether it was in accordance with current good practice….

20. Please rate the care received by the patient during this phase:

Not applicable; 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = excellent

Phase of care: Ongoing care

21. Please record your explicit judgement about the quality of care the patient received and whether it was in accordance with current good practice….

22. Please rate the care received by the patient during this phase:

Not applicable; 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = excellent

Phase of care: Care during a procedure (excl IV cannulation)

23. Please record your explicit judgement about the quality of care the patient received and whether it was in accordance with current good practice….
24. Please rate the care received by the patient during this phase: Not applicable; 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = excellent

Phase of care: Perioperative care

25. Please record your explicit judgement about the quality of care the patient received and whether it was in accordance with current good practice….
26. Please rate the care received by the patient during this phase: Not applicable; 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = excellent

Phase of care: Discharge

27. Please record your explicit judgement about the quality of care the patient received and whether it was in accordance with current good practice….
28. Please rate the care received by the patient during this phase: Not applicable; 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = excellent

Phase of care: Readmission

29. Please record your explicit judgement about the quality of care the patient received and whether it was in accordance with current good practice….
30. Please rate the care received by the patient during this phase: Not applicable; 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = excellent

Phase of care: End of life care

31. Please record your explicit judgement about the quality of care the patient received and whether it was in accordance with current good practice….
32. Please rate the care received by the patient during this phase: Not applicable; 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = excellent

Phase of care: Overall assessment

33. Please record your explicit judgement about the quality of care the patient received and whether it was in accordance with current good practice….
34. Please rate the care received by the patient during this phase:

Not applicable; 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = excellent

35. Please rate the quality of the patient record

Unanswered; 1 = very poor; 2 = poor; 3 = adequate; 4 = good; 5 = excellent

ASSESSMENT OF PROBLEMS IN HEALTHCARE

Assessment of Problems In Healthcare

36. Were there any problems with the care of the patient? Yes/No

Problem Types

37. Problems in assessment, investigation or diagnosis *(including assessment of pressure ulcer risk, VTE risk, history of falls)* Yes/No

38. Did the problem lead to harm? Yes/No/Probably

39. Problem with medication/IV fluids/Electrolytes/oxygen *(other than anaesthetic)?* Yes/No

40. Did the problem lead to harm? Yes/No/Probably

41. Problem related to treatment and management plan? *(including prevention of pressure ulcers, falls, VTE)* Yes/No

42. Did the problem lead to harm? Yes/No/Probably

43. Problem with infection control? Yes/No

44. Did the problem lead to harm? Yes/No/Probably

45. Problem related to operation/invasive procedure? *(other than infection control)* Yes/No

46. Did the problem lead to harm? Yes/No/Probably

47. Problem in clinical monitoring? *(including failure to plan, to undertake, or to recognise and respond to change)* Yes/No

48. Did the problem lead to harm? Yes/No/Probably

49. Problem in resuscitation following a cardiac arrest or respiratory arrest? *(including cardiopulmonary resuscitation (CPR))* Yes/No

50. Did the problem lead to harm? Yes/No/Probably

51. Problem with care following discharge? *(including communication between professionals, transfers of care, delays to support to remain at home, lack of equipment)*Yes/No

52. Did the problem lead to harm? Yes/No/Probably
53. Problems in re-admission care *(including communication between healthcare professionals, transfer of care, delays in support to stay at home)*? Yes/No 54. Did the problem lead to harm? Yes/No/Probably
55. Problem of any other type not fitting the categories above? Yes/No 56. Did the problem lead to harm? Yes/No/Probably

LESSONS LEARNED

Overall Lessons learned

57. Are there any lessons to be learned from this review? Yes/No

Positive Lessons Learnt

58. Are there any positive lessons to be learned from this case? Yes/No 59. Please describe the positive lessons learned ….
60. Are there any positive lessons to be learned about communication between staff or with relatives? • Attitude of staff • Capacity assessment required on learning disability patients • Clear management plan present • DNACPR in place, valid and followed • Good communication with family • Good coordination of clinical care / senior input / advanced decision making • Good quality of documentation • Other • Patient's stated wishes were followed • Quality of handover • None • Unanswered 61. If Other selected please enter further information
62. Are there any positive lessons to be learned about escalation? • EWS recorded • Good standard of care over weekend • No delay in treatment/surgery • Palliative care instituted in timely manner • Patient fall escalated appropriately • Physiological observations / deterioration escalated appropriately • Rapid readmission following earlier (inappropriate?) discharge • Referral to critical care timely • Test results / tests being undertaken timely

- Timely and appropriate clerking

63. Are there any positive lessons to be learned about ceilings of care?

- Appropriate admission from nursing home / community hospital / community setting
- Appropriate bed (non ICU) available
- Appropriate referral to Critical Care
- Appropriate tertiary referral / repatriation
- Appropriate transfer/repatriation from Community Hospital
- Appropriately aggressive treatment
- No wait in A&E for a bed
- Treatment of complex medical patient on surgical ward
- None
- Unanswered

Negative Lessons Learnt

64. Are there any negative lessons to be learned from this case?

Yes/No

65. Please describe the negative lessons learnt

66. Are there any negative lessons to be learned about communication between staff or with relatives?

- Attitude of staff
- Capacity assessment required on learning disability patients
- DNACPR not in place or invalid or ignored and CPR undertaken
- Lack of clear management plan
- Other
- Patient's stated wishes not followed
- Poor communication with family
- Poor coordination of clinical care / lack of senior input / advanced decision making
- Poor quality of documentation
- Quality of handover
- None
- Unanswered

67. If Other selected please enter further information

68. Are there any negative lessons to be learned about escalation?

- Delay in instituting palliative care
- Delay in referral to critical care
- Delay in test results / tests being undertaken
- Delay in treatment/surgery due to staff shortages/equipment failure
- Delayed discharge into community/lack of appropriate supportive care package
- Delayed or poor clerking
- Incomplete physiological observations / deterioration not escalated

- Lack of EWS
- Patient fall not escalated appropriately
- Possible poorer standard of care over weekend
- Rapid readmission following earlier (inappropriate?) discharge
- None
- Unanswered

69. Are there any negative lessons to be learned about ceilings of care?

- Availability of appropriate bed (non ICU) compromising care
- Inappropriate admission from nursing home / community hospital / community setting
- Inappropriate referral to Critical Care
- Inappropriate tertiary referral / repatriation
- Inappropriate transfer/repatriation from Community Hospital - delay or other problems
- Inappropriately aggressive treatment
- Long wait in A&E for a bed
- Treatment of complex medical patient on surgical ward
- None
- Unanswered

SECOND REVIEW

70. Does this case need a second review?

Yes/No

71. Please provide details of the reason for a second review

RELATIVES

Relatives comments

72. Were there CONCERNS with the care received at UHL? Yes/No

73. Please provide details of the UHL concerns

74. Were there COMPLIMENTS with the care received at UHL? Yes/No

75. Please provide details of the UHL compliments

76. Were there CONCERNS with the care received at LPT? Yes/No

77. Please provide details of the LPT concerns

78. Were there COMPLIMENTS with the care received at LPT? Yes/No

79. Please provide details of the LPT compliments

80. Were there CONCERNS with the care provided by GP? Yes/No 81. Please provide details of the GP concerns
82. Were there COMPLIMENTS with the care provided by GP? Yes/No 83. Please provide details of the GP compliments
84. Were there CONCERNS with the care provided by another organisation? Yes/No 85. Please provide details of the organisation 86. Please provide details of the concerns
87. Were there COMPLIMENTS with the care provided by another organisation? Yes/No 88. Please provide details of the compliments
89. Were there concerns regarding PREADMISSION? Yes/No
90. Were there concerns DURING ADMISSION? Yes/No
91. Were there ONGOING concerns? Yes/No
92. Were there concerns regarding END OF LIFE CARE? Yes/No
93. Were there concerns regarding DISCHARGE PLANNING? Yes/No
94. Were there concerns regarding ATTITUDE? Yes/No
95. Were there concerns regarding COMMUNICATION? Yes/No
96. Were there concerns regarding ENVIRONMENTAL FACILITIES? Yes/No
97. Were there concerns regarding DIAGNOSIS? Yes/No

Review questions

98. Problems in communication with relatives and carers? Yes/No 99. Were there any concerns or compliments? Yes/Probably/No 100. Please enter any comments

This report ("Report') was prepared by Mazars LLP at the request of West Leicestershire Clinical Commissioning Group for and on behalf itself and of East Leicestershire & Rutland Clinical Commissioning Group, Leicester City Clinical Commissioning Group ("Authority'), University Hospitals of Leicester and Leicestershire Partnership NHS Trust and terms for the preparation and scope of the Report have been agreed with them. The Report was prepared solely for the use and benefit of the Authority and to the fullest extent permitted by law Mazars LLP accepts no responsibility and disclaims all liability to any third party who purports to use or rely for any reason whatsoever on the Report, its contents, conclusions, any extract, reinterpretation, amendment and/or modification. Accordingly, any reliance placed on the Report its contents, conclusions, any extract, reinterpretation, amendment and/or modification by any third party is entirely at its own risk.