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**

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		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**

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		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**

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		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**

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			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**

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	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			

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	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**

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			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**

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		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**

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	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)**	

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	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			

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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**

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	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**