# 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<br>• Fluid balance<br>• Diabetes<br>• Warfarin management<br>• 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/