East Leicestershire and Rutland Clinical Commissioning Group

University Hospitals of Leicester NHS
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 10 SEPTEMBER 2014

REPORT OF UNIVERSITY HOSPITALS OF LEICESER AND EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP

LEARNING LESSONS TO IMPROVE CARE

Introduction

1. The following paper reports the findings of a clinical audit commissioned by health organisations in Leicester, Leicestershire and Rutland to examine the quality care of patients and the action plan to address the areas of improvement identified.

2. This audit was prompted by the Summary Hospital Level Mortality Indicator (SHMI)* of University Hospitals of Leicester (UHL) being at or slightly above 1.05 since 2010/11. It must, however, be noted that this is within expected limits and the aim of the audit was to enable healthcare organisations to understand this issue better.

3. The findings of the audit, and the action plan developed as a result of the process, are being shared within the boards of all five partner local NHS organisations (East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG), Leicester City Clinical Commissioning Group (LCCCG), West Leicestershire Clinical Commissioning Group (WLCCG), UHL and Leicestershire Partnership Trust (LPT)). Each individual organisation has reviewed the findings internally and identified their own actions, and in addition the audit demonstrated the need for cross organisational actions to be implemented to improve the quality of care for patients across the system.

Rationale for the Audit

4. This clinical audit was undertaken as a proactive step by the local health organisations to better understand the quality of care across the whole patient pathway.

Audit Methodology

5. Case notes from patients who had died in 2012-13 were reviewed by teams of doctors and nurses. 381 patients were identified from the cohort of patients who had been admitted to UHL in an emergency and died in hospital following an attempt at resuscitation, or had died on the Intensive Therapy Unit or had died within 30 days of discharge from hospital after changing their post code or GP.

6. The cases were deliberately chosen as those most likely to identify any clinical issues across the healthcare system. The audit was designed to shine a light on the quality and appropriateness of care rather than clinical outcomes.

Findings

7. Of the 381 case notes audited, 208 (55%) were identified as having significant lessons to learn. Of these 89 (23%) were found to be below an acceptable standard.

   A thematic analysis of the findings identified 47 themes, the 'Top 12' being:
   - DNAR orders
   - Clinical reasoning
   - Palliative care
   - Clinical management
   - Discharge summary
   - Fluid management
   - Unexpected deterioration
   - Discharge
   - Severity of illness
   - Early Warning Score
   - Antibiotics
   - Medication

Duty of Candour

8. In order to demonstrate openness and transparency contact has been made with the next of kin of the 381 patients whose case notes were audited.

9. A call centre has been set up to allow them to talk through the care of their relative and escalate further concerns if necessary.

Five Point Action Plan

10. In response to the findings a Five Point Action Plan has been developed, the full action plan is attached with the papers. This includes the following actions:
    - Clinical Leadership and Task Force to address improvements
    - Public and Patient Involvement
    - Integrated care pathways
    - Acute care pathway review and redesign
    - End of life care transformation

Conclusion

11. This is a significant review for all Boards to consider of quality of patient care across LLR. It represent a positive step taken by the CCGs, UHL and LPT to allow the health community to make focussed improvements across the system. However, Boards should be aware that the findings could raise anxieties across many areas including patients, clinicians and the media.

12. System Leadership will play a key role in ensuring that the Five Point Action Plan will deliver the outcomes expected of it and boards should consider strategies for clinical leadership to support the delivery of safe high quality care across LLR. We need, also, to engender a culture that challenges healthcare practice and encourages patients to co-produce health care with clinicians.

13. An implementation group has been established to ensure that the actions included in the plan are implemented in line with agreed timescales. This Clinical Task Force will be co-chaired by Professor Mayur Lakhani and Dr Kevin Harris.

List of Appendices

- Appendix A - Learning Lessons to Improve Care: A joint review of the quality of care delivered to patients who died in Leicester, Leicestershire and Rutland in 2012-13. Summary Document.

- Appendix B - Leicester, Leicestershire and Rutland (LLR) Joint Mortality Review: Case Records Review (22 July 2014).

- Appendix C - Joint LLR Learning Lessons to Improve Care Action Plan.

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