

**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS  
THURSDAY 25 OCTOBER 2018**

<b>Title:</b>	<b>QUALITY PERFORMANCE REPORT</b>
<b>Responsible Director:</b>	Mark Garrick, Director of Quality Development
<b>Contact:</b>	Ann Keogh, Head of Clinical Quality Benchmarking, 13684 Imogen Acton, Head of Quality Development, 13687

<b>Purpose:</b>	To provide assurance on clinical quality to the Board of Directors and detail the actions being taken following the September 2018 UHB Clinical Quality Monitoring Group (UHBCQMG) meeting, and the Clinical and Professional Review of Incidents Group (CaPRI) meetings.	
<b>Confidentiality Level &amp; Reason:</b>	None	
<b>Annual Plan Ref:</b>	CORE PURPOSE 1: CLINICAL QUALITY  Strategic Aim: To deliver and be recognised for the highest levels of quality of care through the use of technology, information, and benchmarking.	
<b>Key Issues Summary:</b>	Updates provided on the following areas: <ul style="list-style-type: none"> <li>• Staff investigations currently underway</li> <li>• Adverse inquest conclusions</li> <li>• Executive Root Cause Analysis (RCA) meetings</li> <li>• Clinical quality indicators update</li> <li>• Board of Directors' Unannounced Governance Visits</li> </ul>	
<b>Recommendations:</b>	The Board of Directors is requested to:  <b>Discuss</b> the report on quality performance and associated actions.	
<b>Approved by:</b>	Mark Garrick	Date: 17/10/2018

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**BOARD OF DIRECTORS  
THURSDAY 25 OCTOBER 2018**

**QUALITY PERFORMANCE REPORT  
PRESENTED BY DIRECTOR OF QUALITY DEVELOPMENT**

**1. Introduction**

To provide assurance on clinical quality to the Board of Directors and detail the actions being taken following the September 2018 UHB Clinical Quality Monitoring Group (UHBCQMG) meeting and the Clinical and Professional Review of Incidents Group (CaPRI) meetings. The Chief Executive is requested to discuss the contents of this report and approve the actions identified.

**2. Investigations into Staff Performance**

There are currently 25 investigations underway in relation to clinical staff. There are also 6 non-clinical investigations underway with a patient wellbeing component.

<b>Staff group</b>	<b>Number of investigations</b>
Consultants	7
Junior Doctors	5
Nurses and Midwives	10
Allied Health Professionals	3
Nursing auxiliary / HCA	5
Non-clinical staff	1
<b>Total</b>	<b>31</b>

**3. Inquest Update**

Table 1 on the following provides an update on Inquests with adverse conclusions relating to the Trust which have taken place since 1<sup>st</sup> August 2018.

### Table 1: Adverse Inquest Conclusions

Inquests held 01/08/2018 – 30/09/2018

There were no adverse findings: Neglect or Regulation 28.

Theme	Inquest date	Directorate & Specialties	Location	Investigation	Conclusion/Status
Infected hip replacement – delay in surgery/treatment of infection	14.08.18	T&O / Div 5	BHH	SI	Accidental Death
Human Error – Non-invasive ventilation turned off	06.09.18	Ward 10. Respiratory / Div 3	GHH	SI	Natural Causes
Discharge from ED proximate to death – paracetamol OD	11.09.18	ED / Div 3	BHH	SI	Alcohol & Drug related death
Complication in gastric band surgery, surgical procedure concerns	17.09.18	Gastroenterology / Div 5	BHH	SI	Narrative Verdict – complications following gastric band for obesity

**Table 2: Upcoming Inquests**

Future inquests associated with an internal investigation or complaint: 01/10/2018 – 31/12/2018.

<b>Theme</b>	<b>Inquest Date</b>	<b>Directorate &amp; Specialties</b>	<b>Location</b>	<b>Investigation</b>	<b>Possible Conclusion / Status</b>
Failed discharge on 29.07 with high troponin, no evidence of troponin review prior to discharge	30.10.18	Acute medicine / Div 3	SH	Exec RCA	Case presented to Executive RCA meeting 10/10/18 by Divisional Management Team.
Damage to superior mesenteric vein in elective right hemicolectomy	31.10.18	Theatres/ Colorectal surgery	QEH	SI	SI concluded. for surgery – query recovery management post surgery
Fall on ward, resulting in spinal injury. Fall occurred after a symptomatic bradycardia following PCI and stent insertion.	01.11.18	Cardiology / Div 3	BHH	Falls RCA Complaint	
Haemorrhage following tracheostomy	05.11.18	HGS: Infectious diseases / Div 1 QEH: ITU / WCCC	BHH & QEH	None	Some concerns regarding the transfer from BHH to QEH – knowledge of falls. Unlikely to be causative of death
Delay in recognising deteriorating treatment/inappropriate surgery/consent	06.11.18	Gen Surgery / Div 5	GHH	SI	SI still outstanding. Inadequate clinical planning and post-operative assessment.

<b>Theme</b>	<b>Inquest Date</b>	<b>Directorate &amp; Specialties</b>	<b>Location</b>	<b>Investigation</b>	<b>Possible Conclusion / Status</b>
Subdural haematoma following fall – potential issues with post fall medical management	28.11.18	Medicine / Div C	QEH	Falls RCA	Round table falls RCA meeting 17/10/2018 With CSL and MD for consideration
Delay in acting on urgent CT scan report	No date	Outpatients / ED, Div C	QEH	For CaPRI review	

#### 4. Update on Serious Incidents (SIs) and Internal Serious Incidents (ISIs)

4.1 Table 1 below provides an update on the number of confirmed SIs, ISIs and Never Events for the period 1 August 2018-30 September 2018.

Site	Heartlands (BH)	Good Hope (GH)	Solihull (SH)	QEHB (QE)	Other	Total
Never Events	0	1	0	2	0	3
Serious Incidents	0	4	0	3	0	7
Internal Serious Incidents	3	1	0	1	0	5
<b>Total</b>	<b>3</b>	<b>6</b>	<b>0</b>	<b>6</b>	<b>0</b>	<b>15</b>

#### 5. Executive Root Cause Analysis (RCA) meetings

5.1 The Executive RCA process has been reviewed to ensure it remains fit for purpose following the merger and reflects current governance arrangements. The Executive Care Omissions RCA meetings have been in place at QEHB since 2010 and at HGS since December 2015. There are currently three meetings a month consisting of an overall UHB meeting, a QEHB meeting and an HGS meeting. The following issues have been identified with the current process:

- a need to move to cross-site and cross-specialty working
- more cases being referred (predominantly by CaPRI)
- concerns about duplication (where an incident has already been investigated as an SI or ISI).

5.2 The plan is to move to a new process from January 2019. Details of the planned revised process are as follows:

- Continue to be chaired by CEO or nominated deputy.
- RCAs from QEHB and HGS to be presented at combined UHB meeting. The QEHB and HGS RCA meetings will no longer exist. Cross site and cross divisional attendance where possible will be encouraged to assist in the organisational learning from the Executive RCA cases.
- Meeting frequency will alternate between 1 and 2 meetings a month subject to review.
- Staff must complete the Executive RCA template for all Executive RCA cases (except for SIs/ISIs or complaints) by the deadline provided by the Quality Development Team. For SIs/ISIs and complaints, staff must provide the original SI/ISI and complaints documents plus an updated action plan to avoid duplication.

#### 6. Clinical Quality Indicators (assessment and day case areas)

6.1 Following the merger, the Quality Development Team initiated a review of the key quality indicators being monitored by the four hospitals. The aim of the review is to identify and agree common clinical quality indicators across various parts of the Trust. The expected standards, methodologies and targets will need to be agreed with input from clinical teams.

6.2 Performance for clinical quality indicators will eventually be reported by site. This

piece of work will take some time to complete and will therefore be iterative. The initial focus will be on inpatient, assessment and daycase areas. Other areas such as Emergency Departments and Outpatients will also be included.

- 6.3 In September / October 2018, the Quality Development Team asked the Divisions to provide details of their assessment areas, day cases areas.
- 6.4 It has been identified that the assessment areas at HGS and QEHB may have different names and thus clinical activity. Appreciation and documentation of this is required to allow comparable indicators to be developed.
- 6.5 The plan is to compile a list of potential indicators that could be developed for these areas. Some of the suggested indicators may not be possible yet (e.g. the electronic data is not available). These indicators will be recorded for future development.

## **7. Specialty Indicators**

- 7.1 The review to collate all indicator data that is collected internally or submitted externally by HGS and QEHB to national audits and other clinical data registries is now being finalised.
- 7.2 Cross-site specialty discussions will be undertaken to agree a small number of specialty quality indicators for inclusion in future Quality Performance Reports. These discussions will also look at local data validation and feasibility of access to data prior to submission to national databases and registries.
- 7.3 A desk top review of the current QuORU (QEHB) indicators was requested and undertaken over summer 2018. This has been a very important development in allowing clinicians to engage with the development of clinical quality indicators using the large range of trust electronic data sources to easily identify and monitor areas for improvement and also allow real time monitoring of some of their national audit indicators. This allows easy continuous audit by the clinicians. Many of these linked electronic data sources such as PICS are not currently available at HGS (see Appendix B).
- 7.4 There is also transparency of data as this is available to all staff via the Intranet. This review has highlighted a number of areas for improvement which will require to be made in order to develop a new vision for this service in line with current quality improvement and data transparency. Including:
  - 1) The QuORU membership should be reviewed to include Divisional Representation.
  - 2) A comprehensive review of each indicator should be undertaken with each indicator/speciality lead at QEHB and a specialty colleague at HGS to confirm that they are meaningful quality indicators, there are clear definitions and that an appropriate goal has been set. This will form part of the overall clinical indicator work stream and utilise the individual indicator comments obtained from this review. This will also be an opportunity for sharing of good practice across the Trust.
  - 2) The Informatics Team should work with Clinicians and the QuORU Group to review the format of the data provided to clinicians to ensure

that it meets their and the Trust's requirements to allow measurement and appropriate monitoring for ongoing clinical quality improvement.

- 3) The overall Trust QuORU indicator dashboard should be revised to allow easy identification of specialties with indicators being achieved or below their goals and whether they are statistically improving or deteriorating to allow sharing of good practice and improvement methodology or target work to be undertaken.
- 5) Sharing of improvement methodology for successful indicators should be regularly captured and made available on the QuORU website.

## **8. Board of Directors' Unannounced Governance Visits**

### **8.1 Summary of September 2018 Visits**

Five wards / areas were visited at the Queen Elizabeth Hospital Birmingham on Monday 24<sup>th</sup> September 2018. A summary of the visits is provided in Appendix A.

### **8.2 Summary of October 2018 Visits**

A verbal summary will be provided to the meeting on the areas visited in October 2018.

## **9. Recommendations**

The Board of Directors is requested to:

**Discuss** the report on quality performance and associated actions.

Mark Garrick  
Director of Quality Development

## Appendix A: Summary of Board of Directors' Unannounced Visits – Queen Elizabeth Hospital Birmingham, 24<sup>th</sup> September 2018

Ward/Area	Specialty	Visit team	Summary
<b>Ward 410</b>	Trauma & Orthopaedics	Michael Sheppard, Non-Executive Director Michele Owen, Director of Nursing Mark Garrick, Director of Quality Development Gaynor Watters, Revalidation Support Manager Ben Khela, Medical Directorate Assistant	A positive visit to a busy 36 bedded Trauma ward, which was calm, professional and organised throughout the visit. The Sister in charge had only been working on the ward for a matter of months but was well aware of the ward dynamics, the missed doses and falls data and was already putting steps in place to make improvements. Feedback from patients was positive, saying that staff can't be faulted in their care. There were however some environmental issues that need to be addressed.
<b>Bournville Ward</b>	Elderly Care	Dr Javid Kayani, Deputy Medical Director Andrew McKirgan, Executive Director Harry Reilly, Non-Executive Director Mariola Smallman, Head of Medical Directors' Services	A positive visit. The ward was clean and tidy, although the layout and time of the visit (morning) meant that there was some "necessary" clutter in the corridors. Staff need to adhere to information governance standards. Support from Social Services is good generally although there are some challenges with placements (e.g. MRSA positive patient, aggression due to clinical condition). Positive feedback about staff – cheerful and friendly. Junior doctors very positive about their placements
<b>Ward 514</b>	Stroke / Medicine	Lisa Stalley Green, Executive Chief Nurse Kevin Bolger, Executive Director Strategic Operations (and External Affairs) Catriona McMahon, Non-Executive Director. James Bentley, Quality Support Manager	Overall this was a very positive visit to a calm and well-organised ward which had received positive feedback from a number of its patients. There were ongoing issues with staff vacancies which were being addressed by ward management as part of a longer-term plan to create a 24/7 thrombolectomy service. Other areas to improve were noted to be in communicating treatment plans to patients
<b>Ward 306</b>	Cardiothoracic Surgery	David Burbridge, Director of Corporate Affairs Ian Sharp, Deputy Medical Director Imogen Acton, Head of Quality Development	Excellent feedback from patients. Concerns raised around staffing which are being addressed by the Matron and Divisional Management Team. Actions relate to staffing, the environment and data protection.
<b>Emergency Department (ED) / Emergency Observations Unit (EOU)</b>	Emergency Medicine	Jacqui Smith, Chair Mike Hallissey, Interim Medical Director Fiona Alexander, Director of Communications Jonathan Brotherton, Chief Operating Officer, HGS Samantha Baker, Quality Support Manager Kieran Bolger, Quality Support Manager	Staff were calm, open, professional and communicative and said that they enjoyed working in the department. Patients were happy with care and aware of how busy the department is and how hard the staff work. Overall, the EOU area was clean with new equipment. ED was busy but there was calm atmosphere, but with some clutter. (The Matron informed the visitors that some of the corridor storage is a temporary measure due to refurbishments, and were due to be taken away that week).

# Integration of clinical information systems

- **Network and Infrastructure**
- **Consolidation of Domain**
- **Consolidation of Master Patient Index**
  
- **Oceano PAS**
- **IP PICS in 1 x ward** (followed by phased roll out)
  
- **OP PICS**
- **Portal**
- **OPTIMS**
- **Digital Dictation**
  
- **Somerset Cancer Registry, NORSE, MyHealth**
- **ED, 24x7, Sexual Health, Hospital@Night**
- **ERHA, Badgernet, Community Systems**

Underlying dependencies for implementation of clinical systems

Core projects required by January / September 2019 - Jonathan Brotherton ID implementation plan for HGS

Core projects required for ACAD by June 2020

Other clinical systems identified for delivery;