

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 26 SEPTEMBER 2013

Title:	CLINICAL QUALITY MONITORING REPORT
Responsible Director:	David Rosser, Executive Medical Director
Contact:	Mark Garrick, Head of Medical Director's Services, X13699

Purpose:	To provide assurance on clinical quality to the Board of Directors and detail the actions being taken following the September 2013 Clinical Quality Monitoring Group (CQMG) meeting.
Confidentiality Level & Reason:	None
Annual Plan Ref:	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.
Key Issues Summary:	<ul style="list-style-type: none"> • Update provided on the investigations into Doctors' performance currently underway. • Update on mortality indicators (CUSUM, SHMI, HSMR). • Mortality for emergency admissions: analysis of UHB data from April 2007 to August 2013. • Deaths of patients with intracranial injury: analysis of data from April 2009 to June 2013. • In hospital mortality for patients with stroke diagnosis analysis of data from April 2007 to August 2013. • Automatic Incident reporting progress update. • Impact of the clinical portal on Missing Medical record incidents. • Junior Doctors Monitoring System update. • Latest progress reported for the Serious Incidents Requiring Investigation/Serious Incidents Requiring Internal Investigation. • Themes from the action plan following the Executive Governance Visits to ward 726 and Harborne Ward.
Recommendations:	The Board of Directors is asked to: Discuss the contents of this report and approve the actions identified.
Approved by:	Dr David Rosser
	Date: 17/09/2013

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

**BOARD OF DIRECTORS
THURSDAY 26 SEPTEMBER 2013**

CLINICAL QUALITY MONITORING REPORT

PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

1. Introduction

The aim of this paper is to provide assurance of the clinical quality to the Board of Directors, detailing the actions being taken following the September 2013 Clinical Quality Monitoring Group (CQMG) meeting. The Board of Directors is requested to discuss the contents of this report and approve the actions identified.

2. Investigations into Doctors' Performance

There are currently three investigations underway into Doctors' performance. The investigations include two Consultant Grade Doctors and one into a Senior Clinical Medical Officer.

3. CUSUM (Cumulative Summary Mortality Indicator)

The Trust has breached the mortality threshold for 4 CCS (Clinical Classification System) groups. The patient groups which have breached in May 2013 include:

- 30-Cancer of testis (0.2 Expected, 1 Observed)
- 89-Blindness and vision defects (0.4 Expected, 1 Observed)
- 243- Poisoning by non medicinal substances (0.1 Expected, 2 Observed)
- 248 – Gangrene (0.1 Expected, 2 Observed)

A case-list review has been undertaken and does not identify any concerns or future actions.

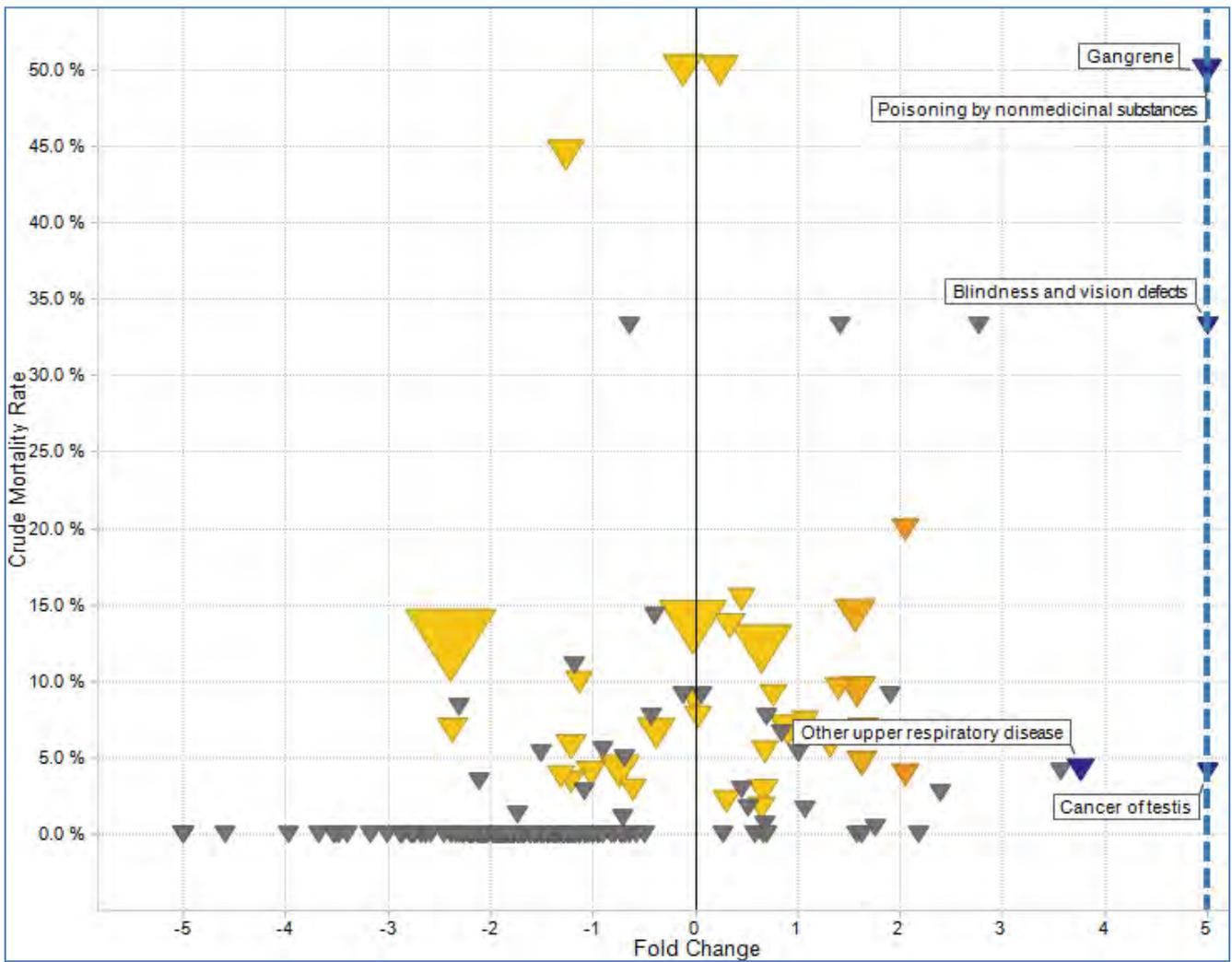


Figure 1: UHB CUSUM by CCS Group

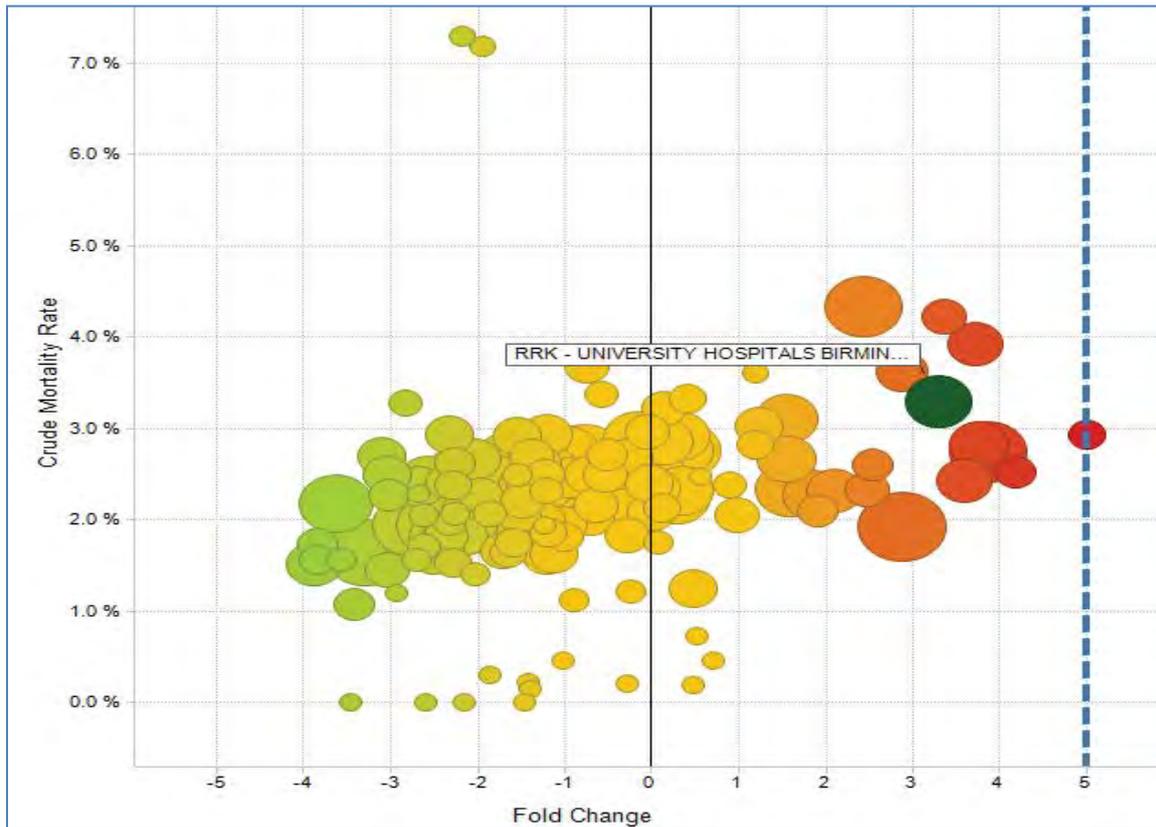


Figure 2: UHB Trust total CUSUM

The Trusts overall mortality rate as measure by the CUSUM is within the acceptable limit see figure 2 above.

4. **SHMI (Summary Hospital-Level Mortality Indicator)**

The Trust's SHMI performance from April 2012 to February 2013 is 105.88 slightly above the predicated expected mortality of 100. The Trust has had 2270 deaths compared with 2143 expected. The Trust is within the acceptable limits as identified in figure 3 on the following page.

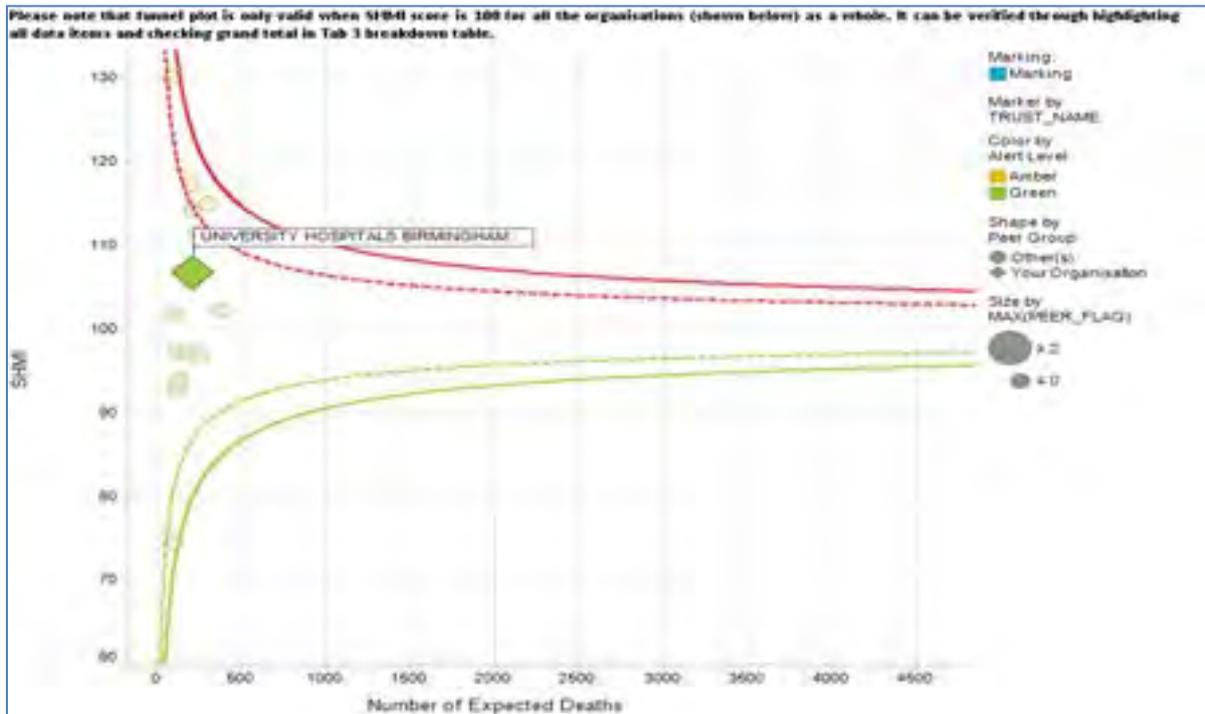


Figure 3: UHB SHMI

5. **HSMR (Hospital Standardise Mortality Ratio)**

The Trust's HSMR in 2012/13 (April 2012 to March 2013) is 109, with an observed mortality of 1539 against 1408 expected. The Trust is at the upper acceptable limit as identified in Figure 4 below.

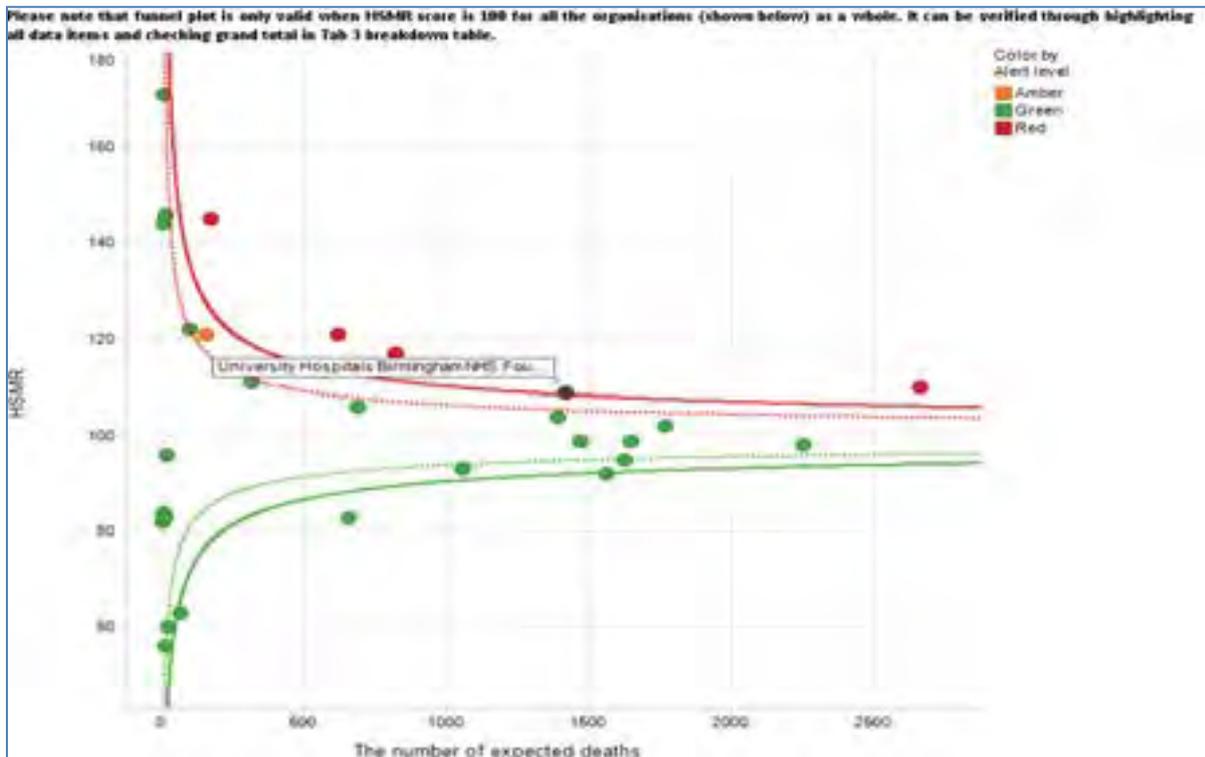


Figure 4: UHB HSMR for the year 2012/2013 (April 2012 to March 2013)

However, the Trust's HSMR for the months April 2013 to May 2013 is 99, with an observed mortality of 260 against 262 expected. The Trust is in the middle of the acceptable limits as identified in Figure 5 below.

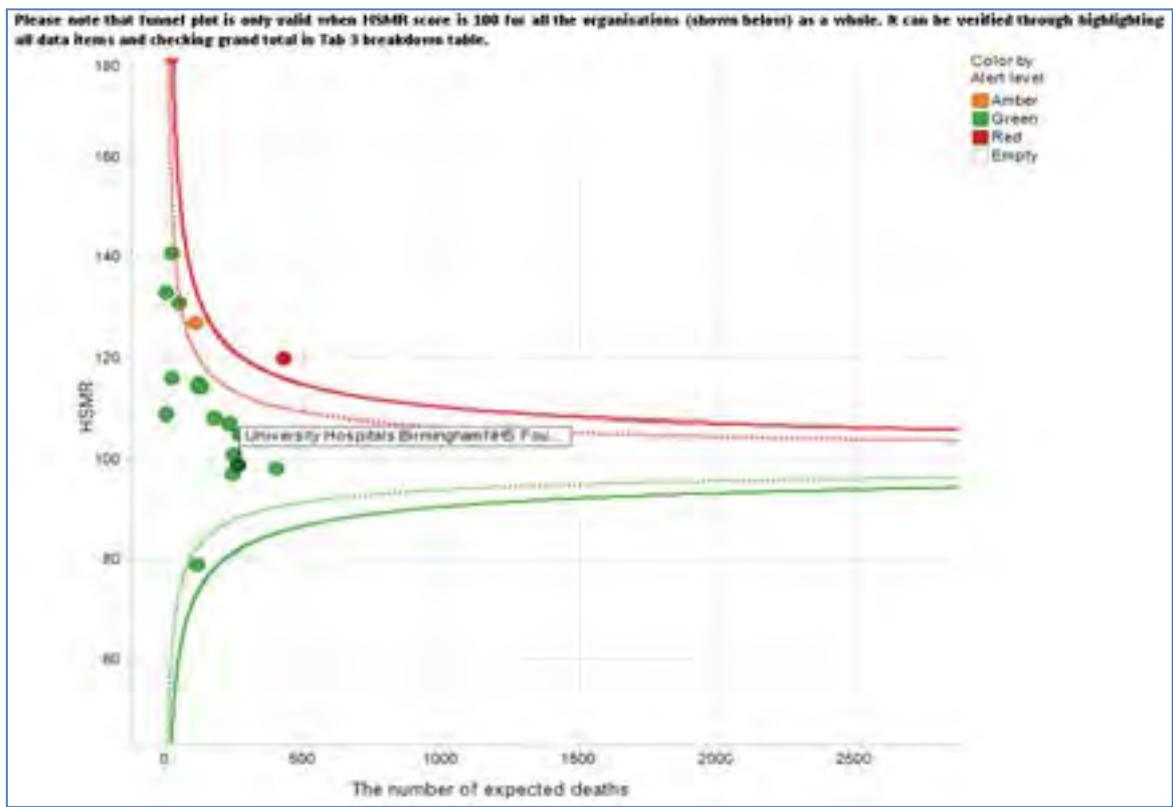


Figure 5: UHB HSMR for the Months April to May 2013

6. **Mortality for Emergency Admissions: Analysis of UHB Data from April 2007 to August 2013**

Analysis has been undertaken on the twelve-monthly mortality for emergency admissions at UHB. The analysis identified a decrease from 5.0% at the start of the period analysed to a minimum of 4.0% for the twelve month period ending June 2011. It then rose to 4.7% for the twelve month period ending May 2012 and remained at this level for seven months, since then it has decreased to 4.5%. This is shown in figure 6 on the following page.

During the period analysed expected mortality based on CCS groups has increased from 4.4% to 5.0%, with the steepest increase occurring between January 2012 and September 2012.

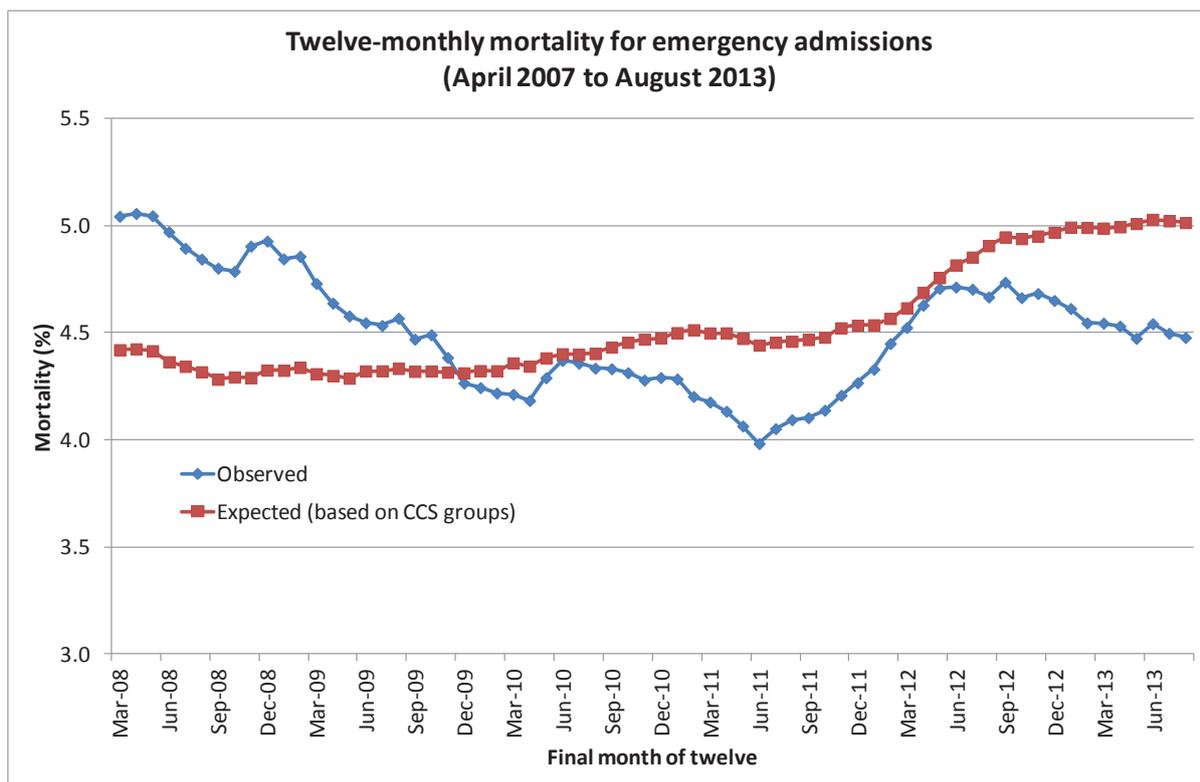


Figure 6: Twelve-monthly mortality for emergency admissions April 2007 to August 2013

7. **Deaths of Patients with Intracranial Injury: Analysis of Data from April 2009 to June 2013**

Analysis has been undertaken into the number of deaths of patients with intracranial injury for the West Midlands. The number of deaths was relatively stable at around 200 per year during the first part of the period analysed, but has now increased by 25% to 250 per year.

The corresponding number of deaths in England has also increased by 25% (from 1650 per year to 2065), although the pattern of the increase was different to that observed for the West Midlands data. This is shown in figure 7 on the following page.

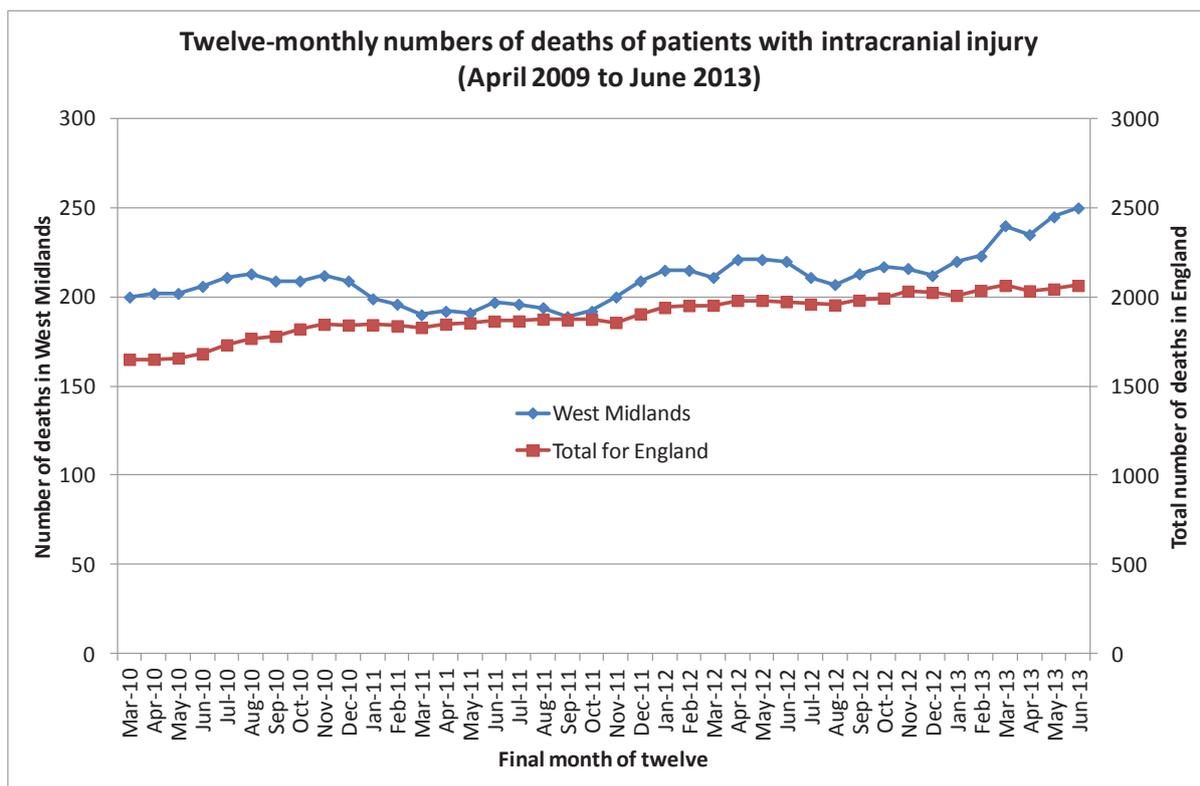


Figure 7: Twelve-monthly numbers of deaths of patients with intracranial injury

8. **In-hospital Mortality for Patients with Stroke Diagnosis Analysis of Data from April 2007 to August 2013**

Analysis has been undertaken into the in hospital mortality for patients with stroke diagnosis codes I61*, I63* or I64*. The mortality rate rose from 21% at the start of the period analysed to a peak of 24% for the twelve month period ending November 2008.

For the period from October 2009 to September 2011 the average mortality was 16%. Since this period there have been two months (October 2011 and February 2013) see figure 8 on the following page when mortality has exceeded the 95% prediction limit based on a mortality rate of 16% and twelve-monthly mortality has also exceeded the 95% prediction limit on two occasions (the twelve month periods ending in August 2012 and November 2012).

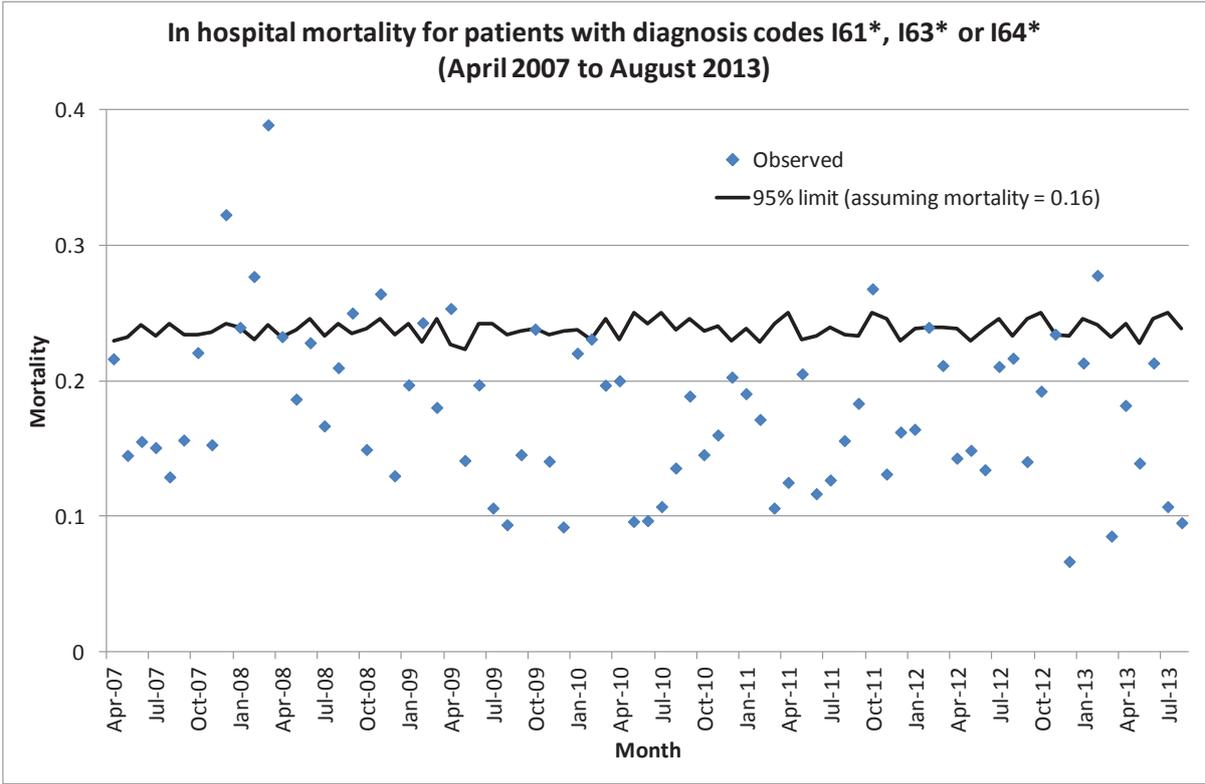


Figure 8: In hospital mortality for patient with diagnosis codes I61*, I63* or I64* (April 2007 to August 2013).

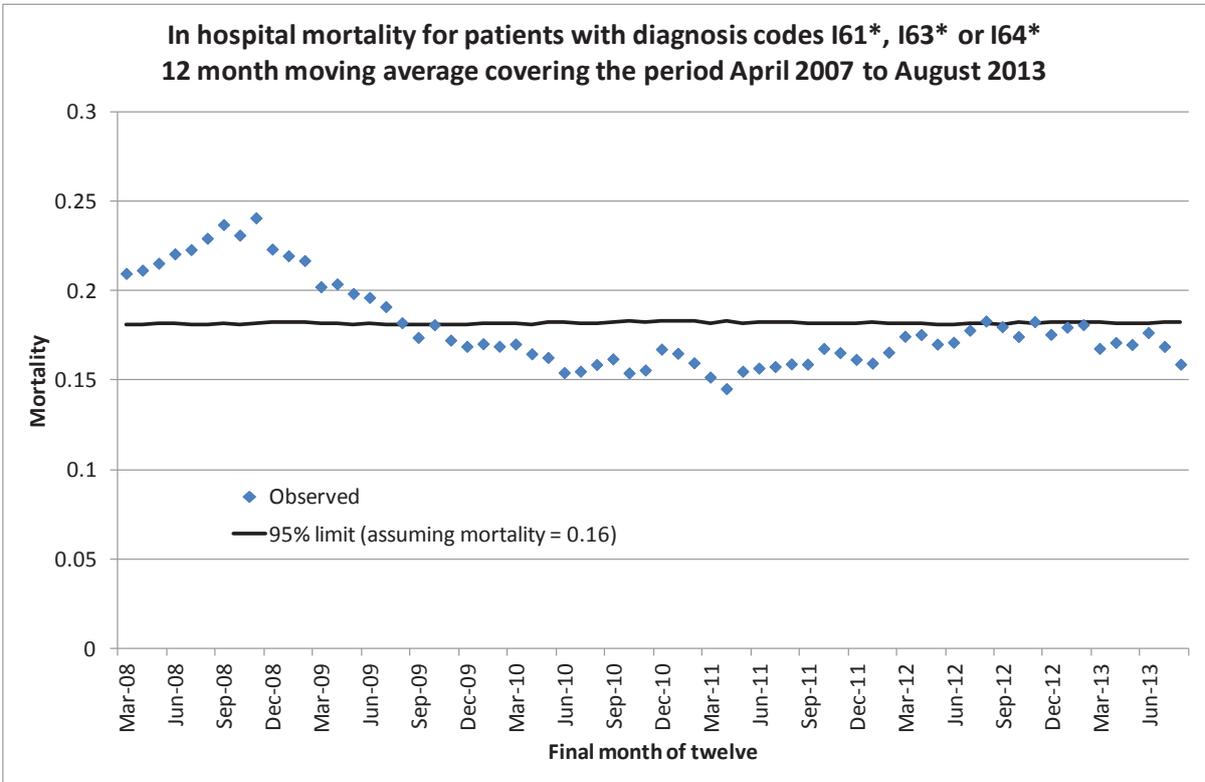


Figure 9: In hospital mortality for patients with diagnosis codes I61*, I63* or I64* 12 month moving average covering the period April 2007 to August 2013.

9. Automatic Incident Reporting Progress Update

As reported to the May 2013 Clinical Quality Committee the Trust has gone live with the first automatic incident reporting indicator “PICS archive daily check not completed”.

Preliminary work has been completed and identified that for the next indicator to go live “any one 24 hour period for any patient not receiving a full completed set of observations” will see an increase in an estimated 10 incident reports daily.

The automatic reporting of incidents will change the Trust’s current incident reporting profile. With additional no-harm incidents being reported.

The plan is to continue to roll out on a monthly basis the below indicators as automatic incidents reported into the Trust’s risk management system.

- 2 or more missed doses of antibiotics
- 3 or more missed does of non-antibiotics
- Patients who fall
- Any 2 out of 3 missing nursing assessments for a given patient

10. Impact of the Clinical Portal on Missing Medical Record Incidents.

Analysis has been undertaken to identify the impact of the roll out of the clinical portal within the Trust versus the number of missing records incident forms being completed. Figure 10 below identifies the reduction in missing records incidents with the various interventions.

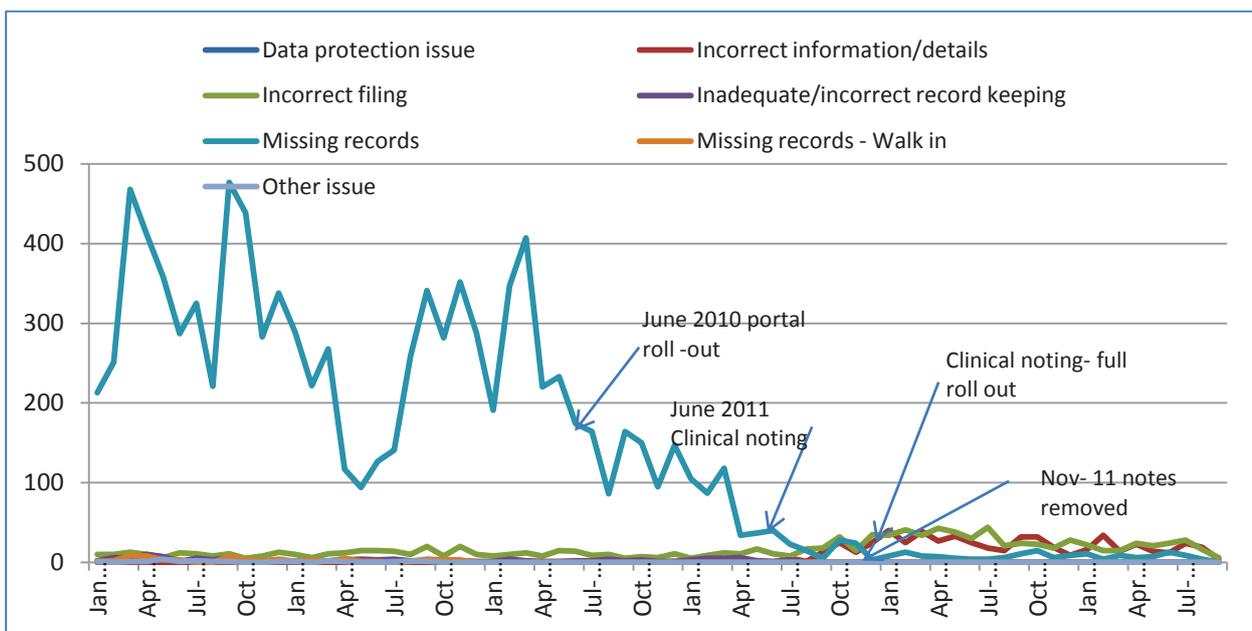


Figure 10: Impact of the clinical portal on missing records incidents.

11. Junior Doctors Monitoring System Update

Following the update on the Junior Doctors Monitoring System reported to the Board of Directors in July 2013, the team continue to monitor all non consultant activity for specific areas of interest.

Figure 11 below and 12 following page identifies the performance of Junior Doctors in relation to VTE prevention. In line with Trust expectations Junior Doctors are required to complete as part of the patient clerking process the VTE risk assessment tool embedded in PICS.

Figure 11 identifies the average number of assessments completed by Junior Doctors as 15 assessments per doctor (horizontal axis). The vertical axis identifies the percentage of preventative prescriptions of enoxaparin completed by the same Junior Doctors if recommended by the VTE risk assessment.

The red shaded area shows the poorer performing doctors who have not completed 90% of the required prescriptions (the prescription being completed later by another doctor). The green area identifies the better performing doctors who have not completed less than 20% of the prescriptions recommended by the VTE assessment tool.



Figure 11: Before Junior Doctor Monitoring Clinics



Figure 12: After implementation of Junior Doctor Monitoring Clinics

Figure 12 above identifies the change in the average number of assessments completed by Junior Doctors from 15 to 19 assessments per doctor (horizontal axis). The vertical axis identifies the percentage of preventative prescriptions completed by the same Junior Doctors if recommended by the VTE risk assessment.

The change in trend identified in figure 12 has occurred after the implementation of the Consultant led Junior Doctors monitoring clinics.

Figure 13 on the following page further identifies the impact of the Consultant led Junior Doctors monitoring clinics. Figure 13 measures the percentage of compliance with prescribing enoxaparin before the clinics began and the current status once the clinics have been implemented.

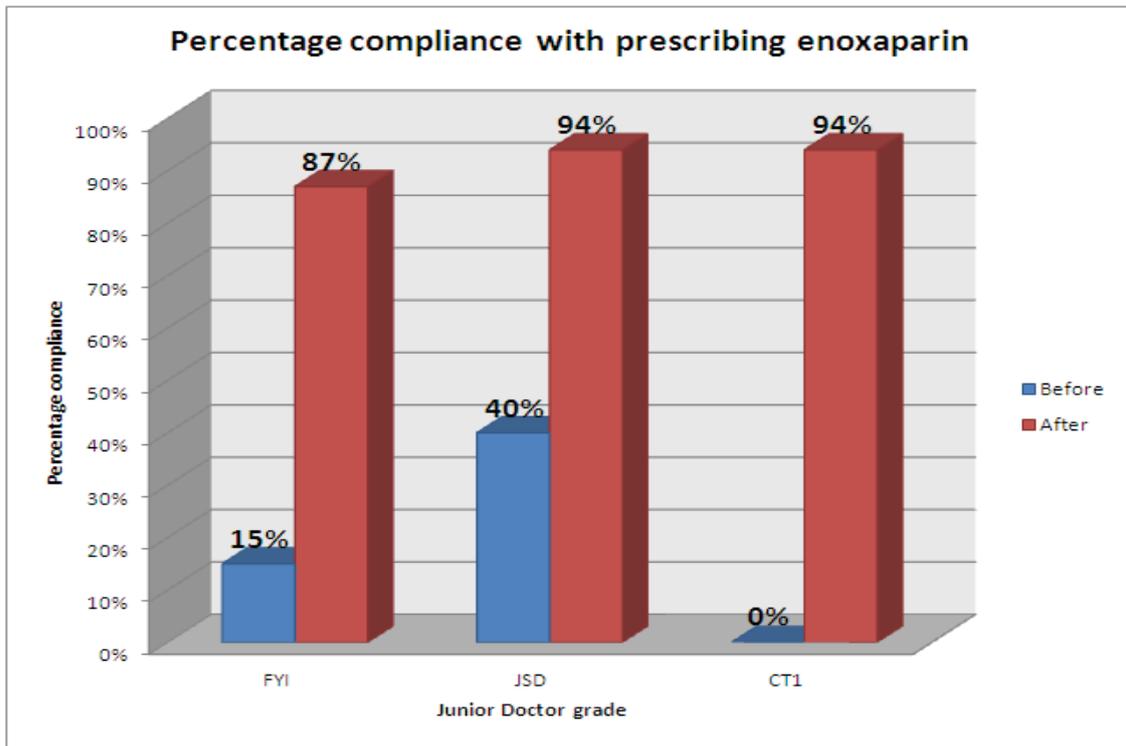


Figure 13: Percentage Compliance with Prescribing Enoxaparin

12. **Serious Incidents Requiring Investigation (SIRIs) and Serious Incidents Requiring Internal Investigation (SIRIIs).**

There is 1 new 'Serious Incidents Requiring Investigation' (SIRIs) relating to a delay in CT scan follow up.

There are 10 new 'Serious Incidents Requiring Internal Investigation' (SIRIIs) and these relate to: patient death in emergency department, patient bleed and deterioration, additional swab found during procedure, delay in acting on blood results, blood transfusion issue, patient suitability for TAVI procedure, unsafe patient transfer from New Cross Hospital, skin graft removal, omitted patient observations and an issue with a patient's diabetic insulin management. .

13. **Executive Governance Visits**

The July 2013 visit was to ward 726 which was a positive visit with all patients receiving very good care. The ward is a 36 bedded liver surgery ward and patients on the ward are sometimes required to travel long distances for the specialist care provided. The ward was very busy but calm. Both patients and staff discussed the requirement of providing patients with the food ordered. Staff are all aware of the process to follow if the food provided to patients does not meet the patient's expectations. The ward had a small amount of clutter which required tidying.

The August 2013 visit was to the Harborne Ward. The Harborne Ward is a 23 bedded ward located in the retained estate. The ward caters for patients who are awaiting care packages in the home or for agreement into appropriate nursing

home beds. The patients on the ward are happy with the care provided. Some patients raised the issue of being bored on the ward and requiring more activities to keep busy. Other issues identified include a dignity issue in relation to one patient who had no carers or relatives available to provide the patient with clean clothes. The patient therefore spent time in hospital gowns. The Trust is approaching various charities to identify if the issue can be resolved. Other issues on the ward related to environmental issues which included a broken air conditioner that required replacement and a lack of blinds in the kitchen which made the kitchen temperature variable depending on outside conditions.

The September visit was to Ward 305 and will be reported to the next meeting.

14. **Recommendations**

The Board of Directors is asked to:

Discuss the contents of this report and approve the actions identified.

David Rosser
Executive Medical Director