UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 26th APRIL 2018

Title:	**CLINICAL QUALITY MONITORING REPORT**
Responsible Director:	David Rosser, Executive Medical Director
Contact:	Mark Garrick, Director of Medical Directors' Services, 13699

Purpose:	To provide assurance on clinical quality to the Board and Directors and detail the actions being taken following the March 2018 Joint Clinical Quality Monitoring Group (JCQMG) meeting, and the Clinical and Professional Review of Incidents Group (CaPRI).	
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:	• Update provided on the investigations into Doctors' performance which are currently underway. • Summary of CTG Interpretation and Response • Latest performance for a range of mortality indicators (CUSUM, SHMI, HSMR). • Themes from the action plan following the most recent Board of Directors' Unannounced Governance Visit. • Learning from Deaths Report – Q4 • Update on Serious Incidents (SIs) and Internal Serious Incidents (ISIs)	
Recommendations:	The Board of Directors is asked to: Discuss the contents of this report and approve the actions identified.	
Approved by:	David Rosser	Date: 18/04/2018

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 26th APRIL 2018

CLINICAL QAULITY 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 March 2018 Joint Clinical Quality Monitoring Group (JCQMG) meeting and the Clinical and Professional Review of Incidents Group (CaPRI). 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 nine investigations underway into Doctors' performance. The investigations relate to eight Consultant Grade Doctors and one Specialty Doctor.

3. **Summary of CTG Interpretation and Response**

A significant piece of work is being undertaken in obstetrics partly in response to a number of incidents which raise concern about Cardiotocography (CTG), the monitoring of foetal heart rate, interpretation in labour locally. There are also national and regional initiatives to reduce harm caused by birth asphyxia and stillbirths.

A report will be brought to the Committee for Clinical Quality giving more details of these initiatives shortly.

4. **Mortality**

Due to the delays in Hospital Episode Statistic (HES) data being available to the Trust it will be some months before it is possible to report these indicators for the new Trust.

5. **Mortality - CUSUM**

QEHB:
One CCS (Clinical Classification System) group had a higher than expected mortalities in December 2017. There were 27 observed mortalities for the group 'Septicaemia (except in labor)' (2) with 19.94 expected. A review has been undertaken by an Associate Medical Director and no issues have been identified as a concern.

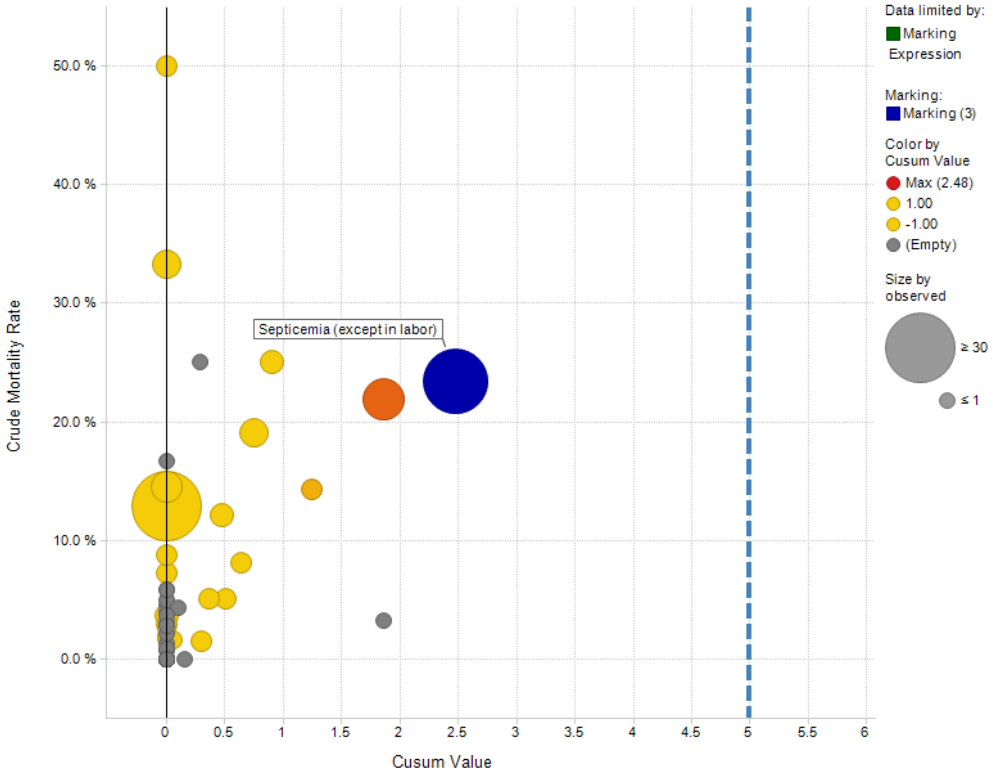


Figure 1: QEHB CUSUM in December 2017 for CCS Groups.

HGS:

Three CCS groups had higher than expected mortality in December 2017. The groups were:

- 'Pneumonia (except that caused by tuberculosis or sexually transmitted disease)' (122), for which 44.87 deaths were expected and 54 deaths were observed;
- 'Chronic Obstructive Pulmonary disease and bronchiectasis' (127) for which 9.49 deaths were expected and 18 deaths were observed;
- 'Gastrointestinal haemorrhage' (153) for which 4.50 deaths were expected and 10 deaths were observed.

A review of CCS group Pneumonia (except that caused by tuberculosis or sexually transmitted disease)' (122), was requested with the update to be brought to HGS CQMG. An initial review was undertaken a further increase in numbers it has been agreed that further in depth review will be complete. The CCS groups ('Chronic Obstructive Pulmonary disease and bronchiectasis' and 'gastrointestinal haemorrhage') will be subject to ongoing monitoring.

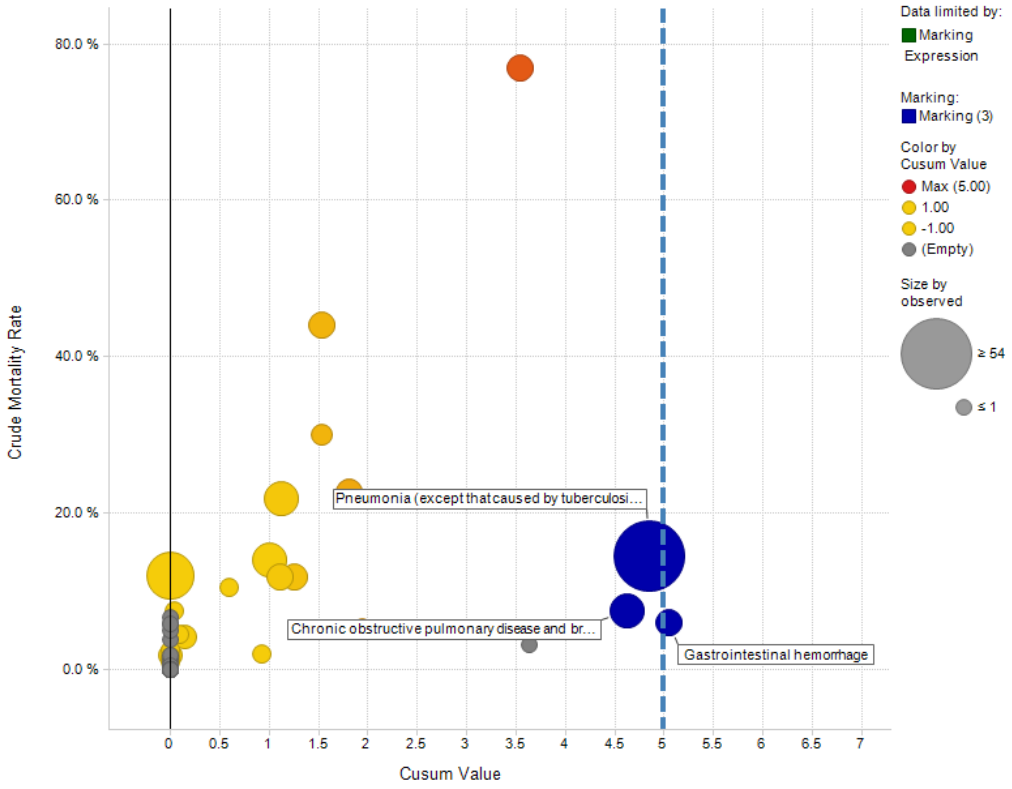


Figure 2: HGS CUSUM in December 2017 for HSMR CCS Groups

QEHB and HGS's overall mortality rate as measured by the CUSUM is within the acceptable limits (see Figure 3 below).

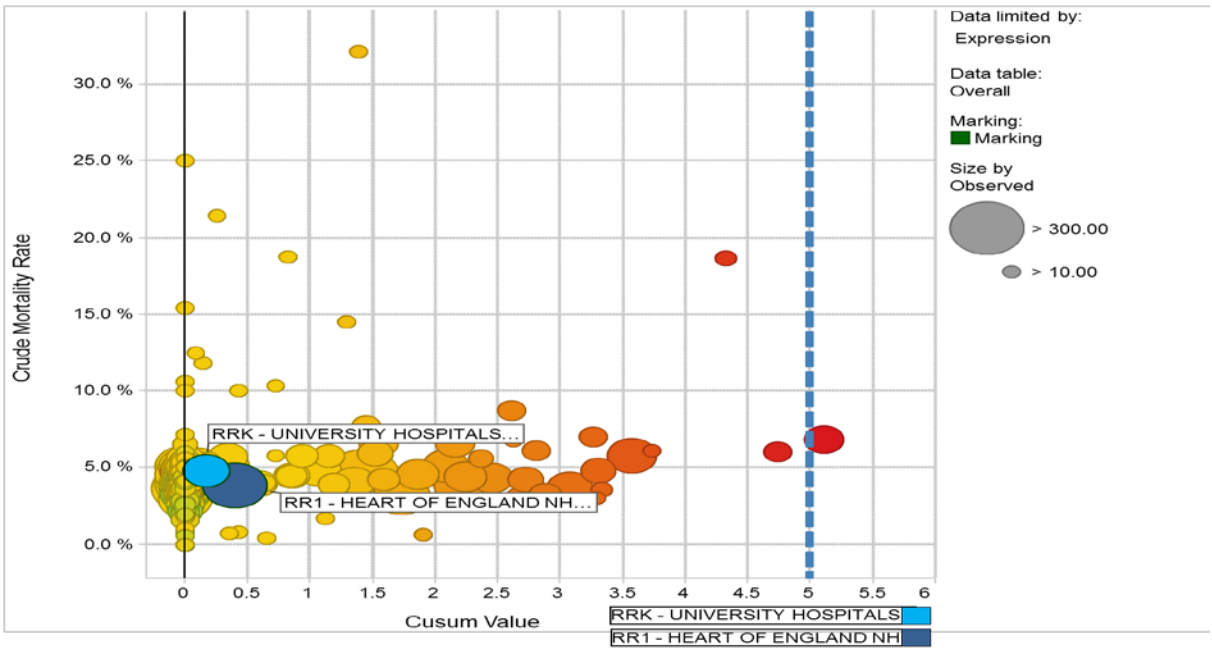


Figure 3: CUSUM for QEHB and HGS (Formerly HEFT) in December 2017 at Trust level.

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

QEHB

QEHB's SHMI performance from April 2017 to November 2017 was 96. There were 1688 deaths compared with 1764 expected,

HGS

HGS's SHMI performance for April 2017 to November 2017 was 88. There were 2817 deaths compared with 3194 expected.

The Trust is within the acceptable limits as shown in Figure 4 below.

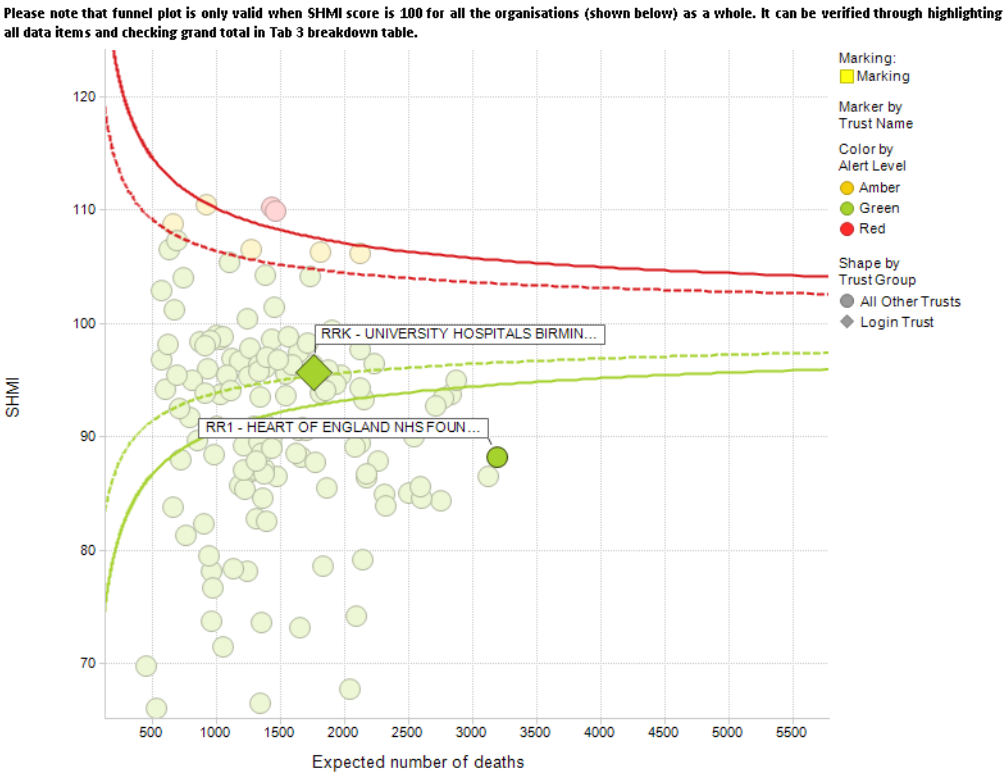


Figure 4: SHMI for QEHB and HGS

7. **Mortality - HSMR (Hospital Standardised Mortality Ratio)**

QEHB

QEHB's HSMR April 2017 – December 2017 was 106 which is slightly higher than expected. There were 1160 deaths compared with 1098 expected.

HGS

HGS's HSMR for the period April 2017 to December 2017 was 100 which is within acceptable limits. There were 1939 deaths compared with 1937 expected.

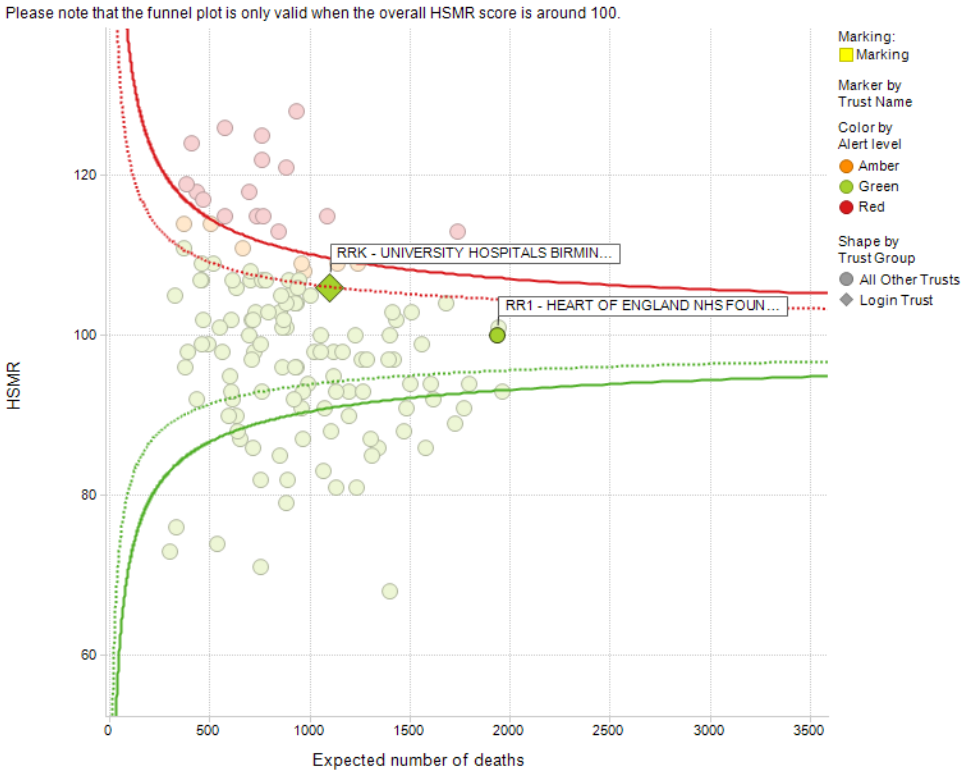


Figure 5: HSMR for QEHB and HGS

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

QEHB

The visit in February 2018 was to the Emergency Observation Unit (EOU). The area opened in November 2017 and there are a number of process, clinical systems and governance compliance issues that need to be prioritised to ensure that the area is functioning optimally. Patients were understanding regarding the pressures the area was experiencing and positive about their interactions with nursing staff. Following the visit the Medical Directorate was asked to review use of clinical systems within the EOU.

There was no visit in March 2018. The visit in April 2018 will be included in a future report.

HGS

The visit in February 2018 was to Ward 15, Solihull Hospital. This was a positive visit to a clean and well organised ward with good feedback from patients and staff.

The visit in March 2018 was to Ward 16, Good Hope Hospital. Again, this was a positive visit to a clean and well organised ward with good feedback from patients and staff. The visit highlighted a specific request to review the procurement of a bladder scanner for the area and this has been passed on to the Division. Timely reviews of outliers was flagged as a continued cause of delay in discharge. The checking of the resus trolley and the documentation of this in terms of the Care Quality Metrics for Ward 16 was also raised as a concern with an action recorded asking for the Medical Directorate to clarify the methodology around recording data for the Metrics.

9. **Learning from Deaths**

The report includes a summary of all results of reviews of inpatient deaths during Quarter 4 2017/18 in line with national Learning from Deaths requirements (please see Appendix A). Work is complete on aligning processes such that reporting by Trust, and or hospital site is possible. As the data reported in this quarter relates to the pre-merger period it is reported by the Trusts existing at that time. The next report will be reported by Trust and site.

10. Update on Serious Incidents (SIs) and Internal Serious Incidents (ISIs)

While there has been no discernible increase in concerning incidents across the new UHB footprint, the volume of incidents reported is significant. There has been an increase in the number of incidents subject to investigation, either as an ISI or SI, as a result of a significant reduction in thresholds to trigger investigations, previously discussed at both the UHB and HEFT boards, as part of the reform of clinical quality processes and culture during the intervention.

As a consequence it is felt that a report based on those previously taken to UHB and HEFT CCQs would be unwieldy and unhelpful.

It is planned therefore to report the number and severity of incidents at each stage of the process, identifying any clinical trends or process delays by specialty, site, division or corporate team.

In addition an exception process whereby incidents identified as particularly concerning by the Chair of the Clinical and Professional Review of Incidents (CAPRI) meeting, the Executive Medical Director or the Chief Nurse will be reported individually.

11. Recommendations

The Board of Directors is asked to:
Discuss the contents of this report and approve the actions identified.

Dr David Rosser,
Executive Medical Director

Appendix A

University Hospitals Birmingham NHS Foundation Trust
Learning from Deaths Quarter 4 2017
01/01/2018 – 31/03/2018

1. Introduction

1.1. The purpose of this report is to provide the Board of Directors with:

1.1.1. A summary of the all results of reviews of inpatient deaths during Quarter 4 2017/18, in line with national Learning from Deaths requirements.

2. Quarter 4 Outcomes

2.1. In accordance with the National Quality Board's Learning from Deaths guidance The Trust is required to include the following information in a public Board paper on a quarterly basis:

2.1.1. The total number of inpatient deaths in the Trust,
2.1.2. The total number of deaths receiving a front line review,
2.1.3. The number identified to be more likely than not due to problems in care.

2.2. University Hospitals Birmingham's (UHB) definition of more likely than not due to problems in care is based on the Royal College of Physician's (RCP) Avoidability of Death scoring system.

2.2.1. Any case that scores as a 3 or less is considered to be possibly due to problems in care and so a potentially avoidable death.

2.3. The RCP Avoidability scoring system is defined as follows:

2.3.1. Score 1: Definitely avoidable
2.3.2. Score 2: Strong evidence of avoidability
2.3.3. Score 3: Probably avoidable
2.3.4. Score 4: Possibly avoidable but not very likely
2.3.5. Score 5: Slight evidence of avoidability
2.3.6. Score 6: Definitely not avoidable.

2.4. Medical Examiners are not specialists in the clinical specialty of the deceased patient in order to provide an external opinion into the case. As such, their front line reviews are supposed to be overly critical and cautious to prompt further review into cases where there is the suggestion of shortfalls in care rather than a definitive final view on each case.

2.4.1. Any cases which are identified by the Medical Examiners as having potential shortfalls in care are escalated as per Trust processes to provide further review.

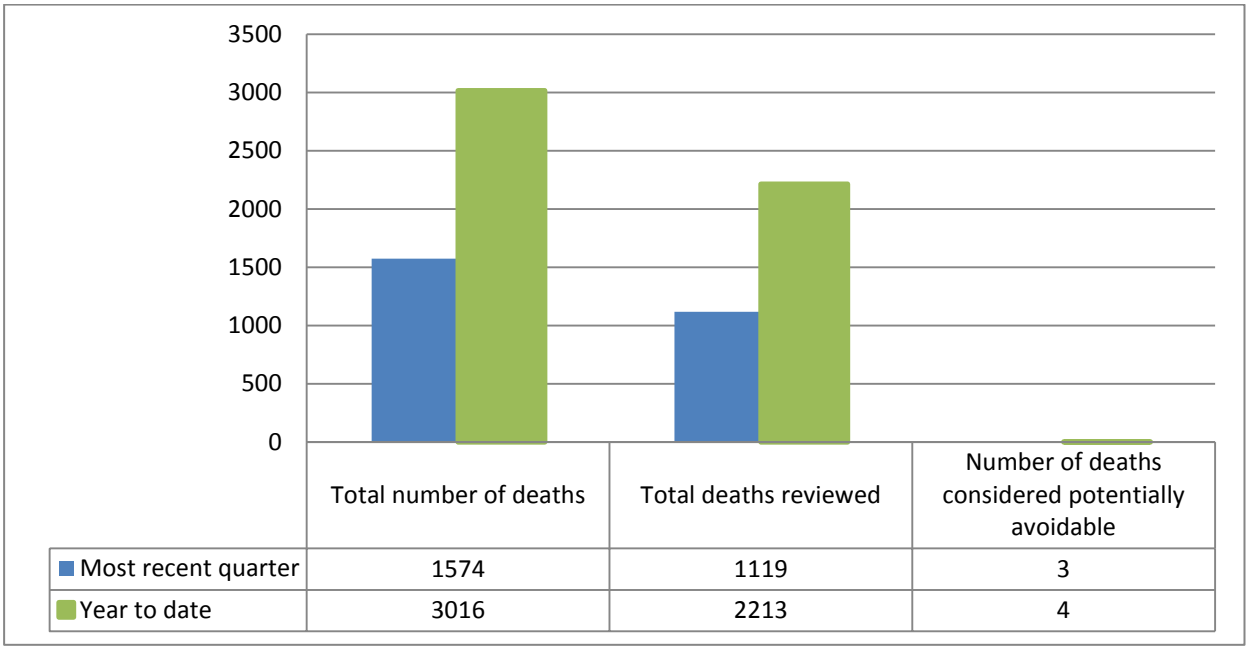
2.5. The below graph shows the total number of deaths in the Trust within the last quarter, the total number of deaths reviewed by the Medical Examiners, and the number considered potentially avoidable.

2.6. The number of deaths exceeds the number of reviews as a number of deaths may be appropriately not reviewed by the Medical Examiners for the following reasons:

2.6.1. Deaths referred directly to the coroner where the medical notes review are retained by the coroner, for the purposes of a coroner's post-mortem or inquest.

2.6.2. Forensic deaths subject to police inquiry as the notes will be similarly unavailable.

2.6.3. Deaths referred to out of areas coroners, where the notes are also not returned to the Trust.



	Total number of deaths	Total deaths reviewed	Number of deaths considered potentially avoidable
Most recent quarter	1574	1119	3
Year to date	3016	2213	4

Figure 1: Number of front line reviews of deaths and those considered avoidable (a score of 3 or less on the RCP Avoidability of Death scoring system) based on front line Medical Examiner reviews.

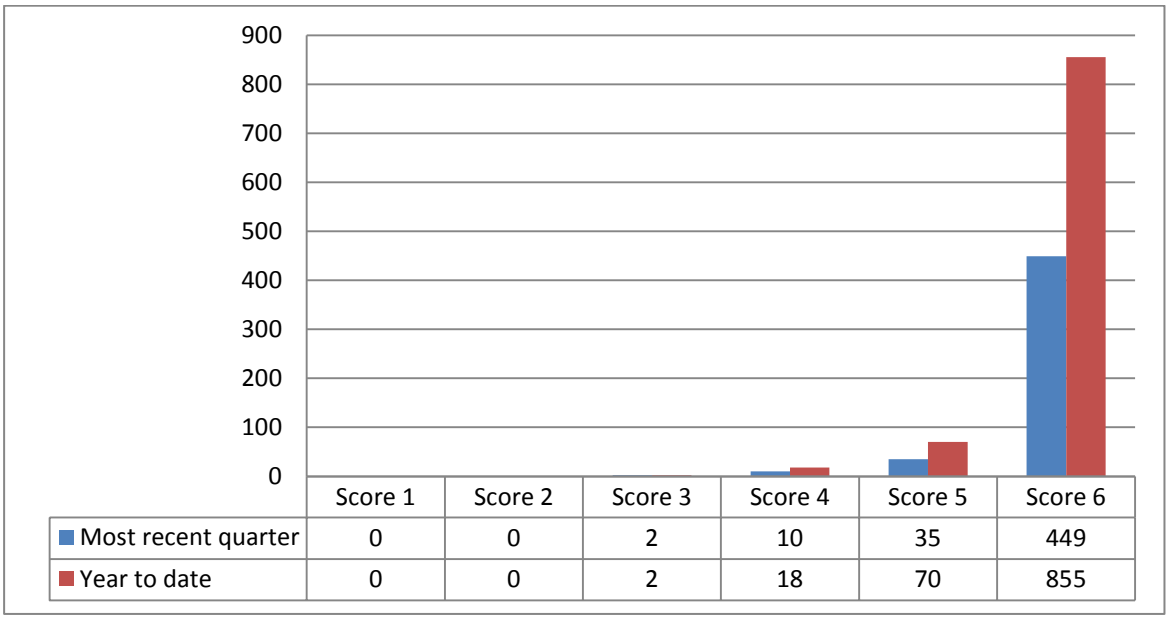
2.6.4. 4 deaths have been identified as potentially avoidable and requiring further investigation during the year to date, representing 0.13% of deaths and 0.18% of deaths subject to front line review.

2.7. The below graph shows the breakdown of scoring against the RCP Avoidability of Death scoring system for quarter 4 at QEHB.

2.7.1. 2 deaths received a score of 3 or less which is the criteria for being classified as potentially avoidable.

2.7.1.1. All of these cases were escalated as per Trust processes for further senior review.

2.7.1.2. One of these cases is currently under investigation as serious incidents (SI).



	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	0	2	10	35	449
Year to date	0	0	2	18	70	855

Figure 2: Breakdown of number of deaths scoring each point on the RCP Avoidability of Death scoring system at QEHB.

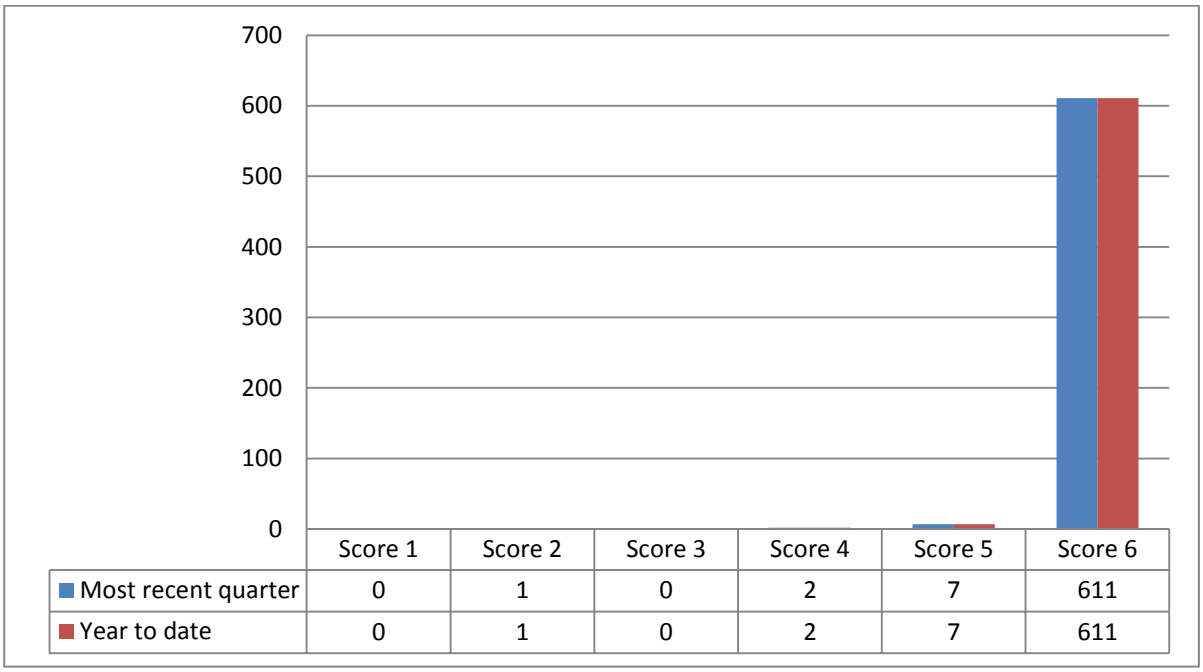
2.7.1.3. The 2nd is awaiting review at the Trust's Clinical and Professional Review of Incidents (CaPRI) group, but initial review has suggested there are no significant concerns with the outcome and that all appropriate and possible actions were undertaken at the time.

2.8. The below graph shows the breakdown of scoring against the RCP Avoidability of Death scoring system for quarter 4 at HGS.

2.8.1. Please note that the year to date numbers are the same as the quarter's numbers, as a different scoring system was previously used.

2.8.2. One case was identified as potentially avoidable which was escalated as appropriate.

2.8.3. This is currently under investigation as an SI.



	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	1	0	2	7	611
Year to date	0	1	0	2	7	611

Figure 3: Breakdown of number of deaths scoring each point on the RCP Avoidability of Death scoring system at HGS.