UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 26 JANUARY 2017

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

Purpose:	To provide assurance on clinical quality to the Board of Directors and detail the actions being taken following the December 2016 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:	• Update provided on the investigations into Doctors' performance which are currently underway. • Latest performance for a range of mortality indicators (CUSUM, SHMI, HSMR). • Update on the CQC Cardiac Surgery Inspection and external review. • Tracheostomy weaning group. • Themes from the action plan following the most recent Board of Directors' Unannounced Governance Visit.	
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: 19/10/2016

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS
THURSDAY 26 JANUARY 2016

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 December 2016 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 nine investigations underway into Doctors' performance. The investigations relate to eight Consultant Grade Doctors and one Specialty Doctor. .

3. Mortality - CUSUM

No CCS (Clinical Classification System) groups had a higher than expected mortalities in September 2016. The group 'Intracranial injury (233)'. Please see Figure 1 on the following page.

As previously reported to the Clinical Quality Committee (CCQ) and the Board of Directors the CCS group – 233: Intracranial injuries has been identified as having higher than expected deaths and has previously flagged as a mortality outlier, this CCS group includes all head injuries and the complexities of the Major Trauma Centre (MTC) are not fully reflected in the expected number of deaths. In October 2016 a statistical analysis was undertaken into the "Mortality for intracranial injury and leukemias CCS categories: analysis of the cusum from April 2014 to July 2016" this is appended A.

Figure 1: UHB CUSUM in September 2016 for CCS Groups

Two minor CCS (Clinical Classification System) groups (these groups are not included in the HSMR) triggered in September 2016 with higher than expected deaths. The groups are 'Mycoses (4)' 2 deaths with 0.09 expected and 'other hematologic conditions (64)' 1 death with 0.28 expected. The patient case lists for these groups were reviewed at the CQMG meeting in December 2016 and no concerns or further actions were identified.

The Trust's overall mortality rate as measured by the CUSUM is within the acceptable limits (see Figure 2 below).

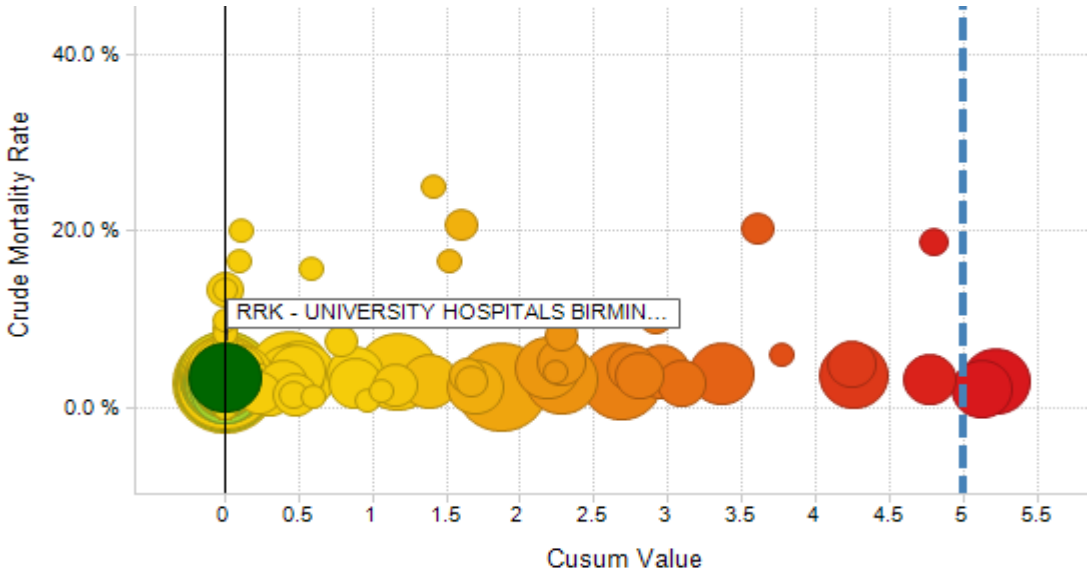


Figure 2: UHB CUSUM in September 2016 at Trust level

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

The Trust's SHMI performance from April 2016 to August 2016 is 98.00. The Trust has had 1050 deaths compared with 1072 expected. The Trust is within the acceptable limits as shown in Figure 3 below.

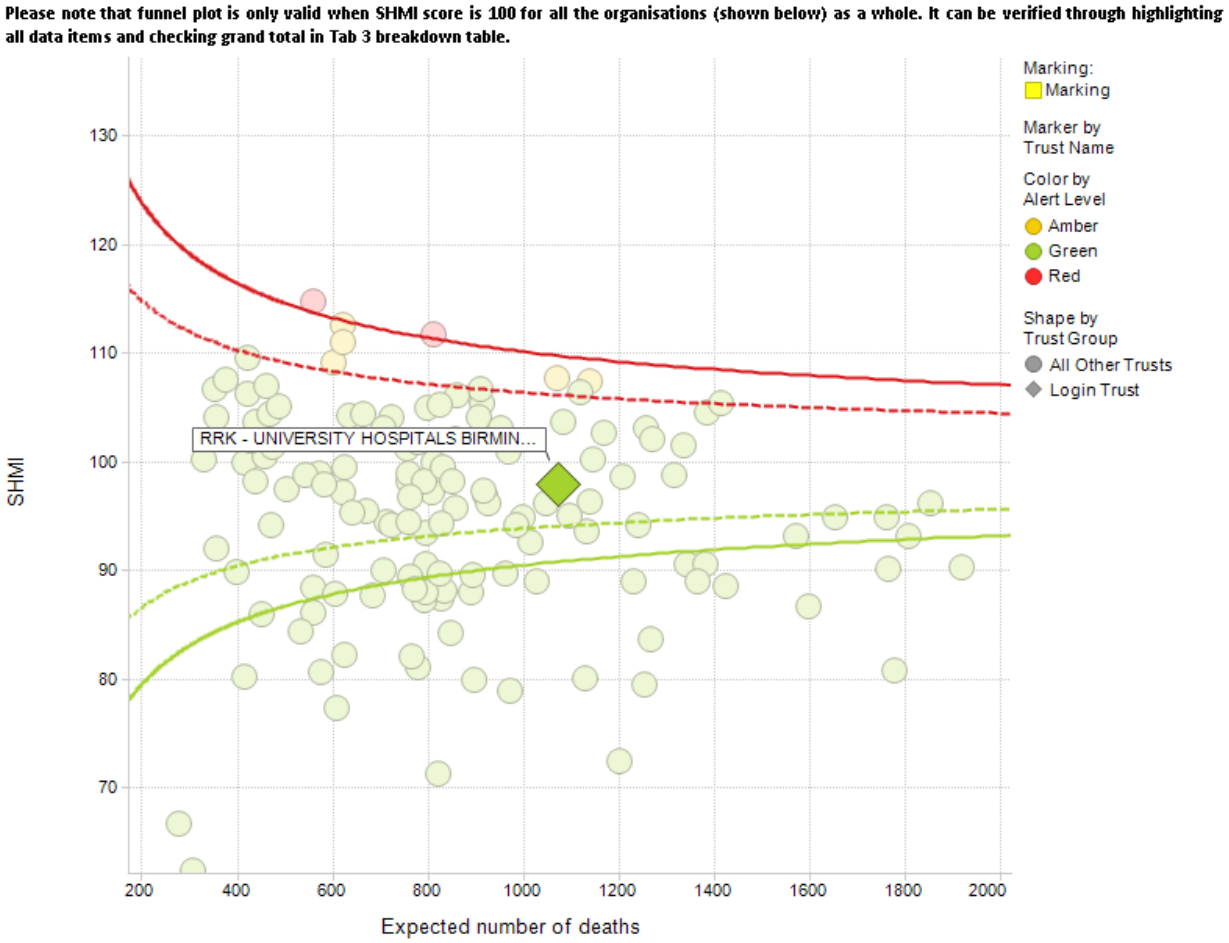


Figure 3: UHB SHMI

5. Mortality - HSMR (Hospital Standardised Mortality Ratio)

The Trust's HSMR in 2016/17 (April 2016 – September 2016) is 103.19 which is slightly above the expected. The Trust had 755 deaths compared with 731 expected (see Figure 4 on the following page).

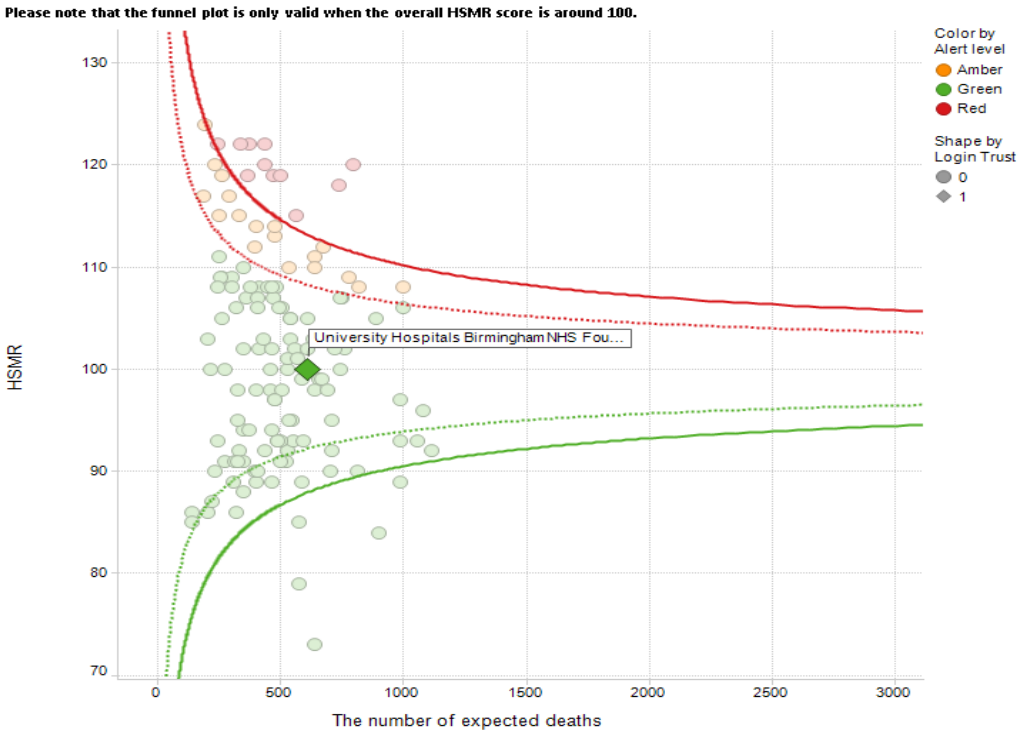


Figure 4: UHB HSMR

6. Cardiac Surgery Inspection and Cardiac Surgical Quality Improvement Programme (CSQIP).

6.1 The Care Quality Commission (CQC) carried out a focused inspection relating to cardiac surgery on the 21st and 22nd December 2015. The visit was triggered by the release of data in September 2015 by the National Institute for Cardiovascular Outcomes Research suggesting that the Trust is an outlier in terms of mortality. During September 2015 the Trust had established, before any notification from the CQC, a Cardiac Surgical Quality Improvement Program (CSQIP).

6.2 Following the inspection the CQC placed the following 2 conditions on the Trusts CQC registration:

(i) Trust is required to commission an external review of the service which was due to be completed by 31 March 2016; and

(ii) The Trust is required to submit weekly outcome data to the CQC every Wednesday.

6.3 On the 25 May 2016 the Trust received notification from the CQC that the above two conditions were removed from the Trust's registration and noted that the data and information submitted, demonstrated that improvements had been made in the service, which has reduced the risk of harm to patients. The CQC advised that the data still demonstrated some variation and requested that the Trust continues to submit the

monitoring data on a quarterly basis. The Trust have provided the CQC and NHS England a quarterly update on the CSQIP, clinical outcome data and progress against the CQC and external reviewers recommendation.

6.4 In September 2016 the Cardiac Steering Group and Oversight Group recognised that the remit of the cardiac project is starting to come to an end, as the majority of the actions have been completed. There is a need to start to hand this back to the division/service to manage without the addition of the project infrastructure, to ensure the actions that have been implemented remain sustainable. As a consequence the existing project structure was reviewed and changed:

(i) The Cardiac Steering Group should remain and continue to meet on a monthly basis to ensure we have the Executive Director level oversight until there is assurance that the actions that have been implemented are sustainable.

(ii) The weekly Cardiac Project meeting should change to be fortnightly with amended attendance – to enable suitable discussions around the priority areas

(iii) The Cardiac Speciality meeting which is the divisional meeting where they manage the service will continue but will include attendance from relevant leads from division A (theatres and ITU) and cardiology

6.5 At the request of the Trust the Royal College of Surgeons carried out a review of the service between 1 and 3 November 2016. The report from the Royal College of Surgeons is due to the Trust anytime within quarter 4.

6.6 As part of the CSQIP project a policy was implemented with the clinical teams to identify the capacity of nursing staff within the ITU who are caring for complex cardiac patients. The implementation of the capacity policy is to ensure patient safety, ensure appropriate capacity is available to treat patients within the Critical Care Unit and maintain patient flow for conventional patients. Non – adherence to the cardiac capacity policy occurred in December 2016. Additionally, a conventional cardiac patient died while the policy was breached. The post mortem identified the death as unavoidable. There were some initial concerns about deficits in care which at the time of this report appear to be unfounded. However, given the short time period between the relaxation of Executive scrutiny and the breach in the capacity policy has led to serious concerns to the engagement of the clinical teams in managing the cardiac services in a sustainable fashion.

6.7 A proposal has been drafted to have an Executive Chaired weekly Integrated Cardiac Services (Cardiac Surgery, Cardiology, Critical Care and Theatres) Root Cause Analysis (RCA) meeting. This meeting will

review specific patient issues from the previous week. The review will include such patient safety and quality indicators as extended pre-operative length of stay, post-operative length of stay, cancellations, bleeding, returns to theatres for example. It is expected that leads from the following services will attend the meeting: Consultants in Cardiac Surgery, Cardiac Anaesthesia, Cardiac Critical Care and Cardiology along with nursing representatives from Cardiac Theatres, the Cardiac wards and the Cardiac Critical Care. In additional representatives from the Divisional Management Team in Division A and Division B will also attend the meeting. The Trust has also appointed and defined the role of Associate Medical Director – Integrated Cardiac Services who will attend the RCA meetings. The RCA meetings expect clinical staff to identify the root cause of any patient care /safety issues and put in place processes to ensure that no such issue occurs in the future. This localised RCA model will become part of the integrated quality management process that has previously been discussed and approved by the Board of Directors. Therefore, the localised RCA model could be utilised across other specialities in the future if required.

9. Board of Directors Unannounced Governance Visits

9.1 The visit on the 13 October 2016 was to the Edgbaston Ward 305. This ward is identified as primarily the private patient's ward but also treats general medical patients. A largely negative visit to a very cluttered, disorganised ward which had a number of issues related to environment and Governance. Ward and Division to be asked to attend a Chief Executive lead Root Cause Analysis (RCA) meeting to discuss these findings. The following improvement actions were identified and shared with the Divisional Management Team for resolution:

- One patient and their fiancée, who were spoken to by members of the visiting team raised a number of issues about their recent care:
    - There was a lack of clinical care and communication about ongoing treatment
    - The patient had been readmitted four times and there was still no diagnosis.
    - Patient had not received the results of multiple HIV tests.
    - Some members of the nursing staff had been rude and abrupt with the patient and his fiancée.
    - Equipment that had been used in their treatment (thermometer) was defective, and although the patient had raised this concern initially, it had been ignored.
- The visiting team observed that that the ward felt quite 'isolated' and that the case mix was quite heavy for a ward of this size.
- The team spoke to one member of staff who advised that she loved working on the ward but felt that the types of patients that they were used to accepting on the ward had changed and that it had been difficult for the unit to adapt to this. She explained that she sympathises with the cohort of private patients that the ward treats due to the difficult nature of some of the other patients who are on

the ward and that recent pressures had also led to difficulties in finding beds for private patients.

- A number of the staff seemed demoralised by the changed nature of the patients who were accepted on the ward and the environment they were working in.
- Ward seemed cluttered on arrival. There were bags of rubbish left on corridor floor and equipment throughout the ward.
- Staff room was open with staff belongings on display.
- There was a whiteboard which had been left by the Safeguarding team which had posters and information related to possible signs of abuse and how to recognise them in patients e.g. F.G.M etc. It was discussed whether this information was relevant to the ward and whether it's positioning at the entrance needed to be reviewed.
- There was a sharps bin attached to the resus trolley without a lid.
- Signage throughout the ward was poor, often without Trust-branding and attached to walls / doors using tape. One inappropriate sign observed by the visiting team stated that "Bathroom was not for use of visitors".
- Utility rooms were both untidy and cluttered. In both rooms, there was equipment left out on side, specimen bottles on surface areas, open boxes and packages in various places.
- The dayroom was cluttered and untidy and generally very unwelcoming to any patients or visitors. A laptop had been left charging in the corner and there was also an inappropriate notice regarding the TV remote control having gone missing which needed to be removed.
- At the entrance to one of the side rooms, there was a pack of wet wipes in place of the alcohol gel. A bottle of liquid cleaner had also been left resting on the corridor barrier.
- Staff toilets were found to be very dirty, no hand gel present.
- There was an unlocked cupboard on the corridor which, when opened, was found to contain loose packets of coffee, as well as analgesics.
- One sister advised that the ward was not secure for dementia patients, highlighting an unlocked door at one end of the ward, which led to a stairwell. She explained concerns she had that a patient would eventually find their way through and injure themselves.
- The visiting team agreed that the temperature on the ward was far in excess of what was comfortable and members of staff working there confirmed that this had been raised previously and not resolved.
- The paperwork in the Junior Sisters office was piled high and there were boxes of care plans and leaflets stacked on top of shelves, creating a hazard. It was questioned by the visiting team whether a 16 bed ward had a requirement for two Senior Sisters offices.
- Drug Trolley was locked and chained to the wall.
- PICS Archive checks had all been done.

- There were significant gaps in the daily resus and hypo checks. At the time of the visit there had only been 2 checks of the resus trolley in the month of October.
- Water tap flushing-checks had not been conducted since April 2016

9.2 The visit on the 17 November 2016 was to ward 727 and the visit on the 15 December 2016 was to ward 407. Both visits will be reported in future reports.

10. Recommendations

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

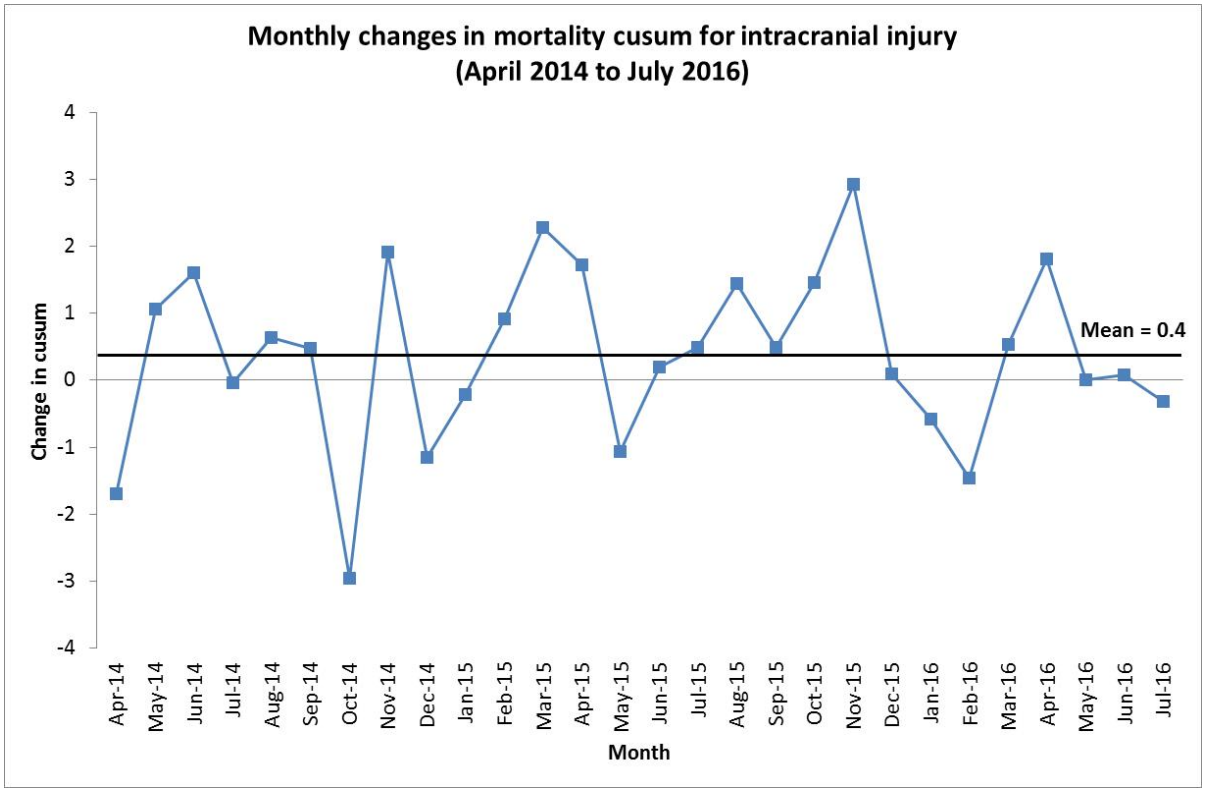
David Rosser, Executive Medical Director

Appendix A

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
CLINICAL QUALITY MONITORING GROUP
WEDNESDAY 26 OCTOBER 2016

Report Title:	**Mortality for intracranial injury and leukemias CCS categories: analysis of the cusum from April 2014 to July 2016**
Contact:	Pete Nightingale

Key Issues/Exceptions:	In July 2016 the value of the mortality cusum for the intracranial injury CCS group was 2.1 and the value for the leukemias CCS group was 3.8. For the intracranial injury group the monthly change in cusum was stable during the period analysed. For the leukemias group it was not, but it was relatively stable from April 2015 onwards. Based on data from April 2014 onwards, it is estimated that there is a 52% probability that the mortality cusum for intracranial injury will trigger within the next six months. Based on data from April 2015 onwards, it is estimated that there is a 52% probability that the mortality cusum for leukemias will trigger within the next three months.


Monthly changes in mortality cusum for intracranial injury
(April 2014 to July 2016)
Change in cusum
4
3
2
1
0
-1
-2
-3
-4
Mean = 0.4
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
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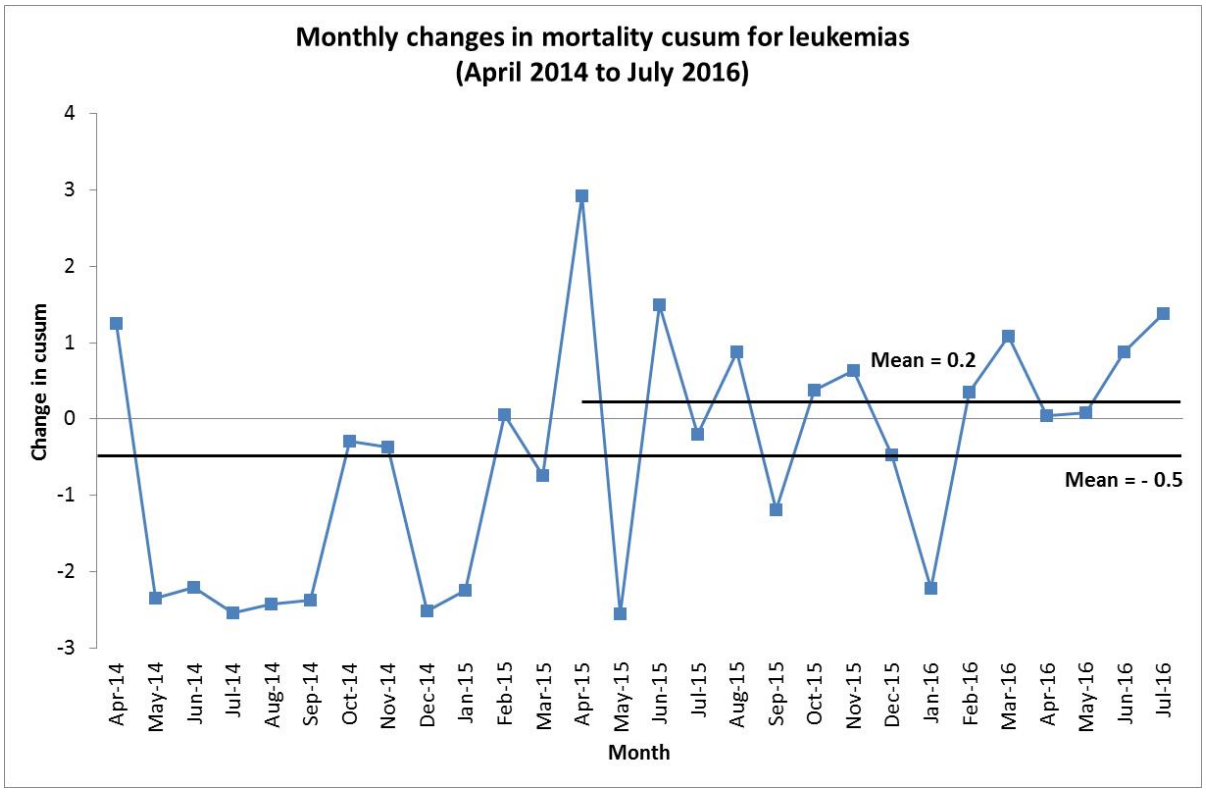
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Month


Monthly changes in mortality cusum for leukemias
(April 2014 to July 2016)
Change in cusum
4
3
2
1
0
-1
-2
-3
Mean = 0.2
Mean = - 0.5
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Month

Estimated probabilities that intracranial injury mortality cusum will trigger

(based on data from April 2014 to July 2016)

Month	Probability of triggering in this month	Probability of triggering in this month or sooner
August 2016	3%	3%
September 2016	11%	14%
October 2016	12%	26%
November 2016	10%	36%
December 2016	9%	45%
January 2017	7%	52%

If the cusum triggers, it resets to zero. There is a 50% chance that it will trigger again within 9 months.

Estimated probabilities that leukemias mortality cusum will trigger

(based on data from April 2015 to July 2016)

Month	Probability of triggering in this month	Probability of triggering in this month or sooner
August 2016	24%	24%
September 2016	17%	41%
October 2016	11%	52%
November 2016	7%	59%
December 2016	5%	65%
January 2017	4%	69%

If the cusum triggers, it resets to zero. There is a 50% chance that it will trigger again within 12 months.