UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 25 JANUARY 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 of Directors and detail the actions being taken following the December 2017 Joint Clinical Quality Monitoring Group (JCQMG) 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). • Themes from the action plan following the most recent Board of Directors' Unannounced Governance Visit. • Learning from Deaths Quarter 3 2017 update.	
Recommendations:	The Board of Directors is asked to: Discuss the contents of this report and approve the actions identified.	
Approved by:	David Rosser	Date: 10/01/2018

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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 2017 Joint Clinical Quality Monitoring Group (JCQMG) 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 four investigations underway into Doctors' performance. The investigations relate to four Consultant Grade Doctors.

3. Mortality - CUSUM

One CCS (Clinical Classification System) group had a higher than expected but had not triggered a mortality alert in September 2017. There were 5 observed mortalities for the group 'Intracranial Injury' (233) with 3.45 expected.

As previously reported to the Clinical Quality Committee (CQC) and the Board of Directors the CCS group 'Intracranial Injury' (233) 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 complexity of UHB's Major Trauma Centre (MTC) status is not fully reflected in the expected number of deaths.

An Associate Medical Director has reviewed the five mortalities and no concerns were identified in relation to four of the patients. Further review for one of the patients is in progress and will be reported at a future JCQMG meeting. Statistical analysis of the intracranial injury CCS Group was presented to the December 2017 JCQMG meeting following the trigger in June 2017 (reported to the September 2017 JCQMG meeting). There is a 40% chance that the CCS Group will trigger in January 2018. Please see Figure 1 on the following page.

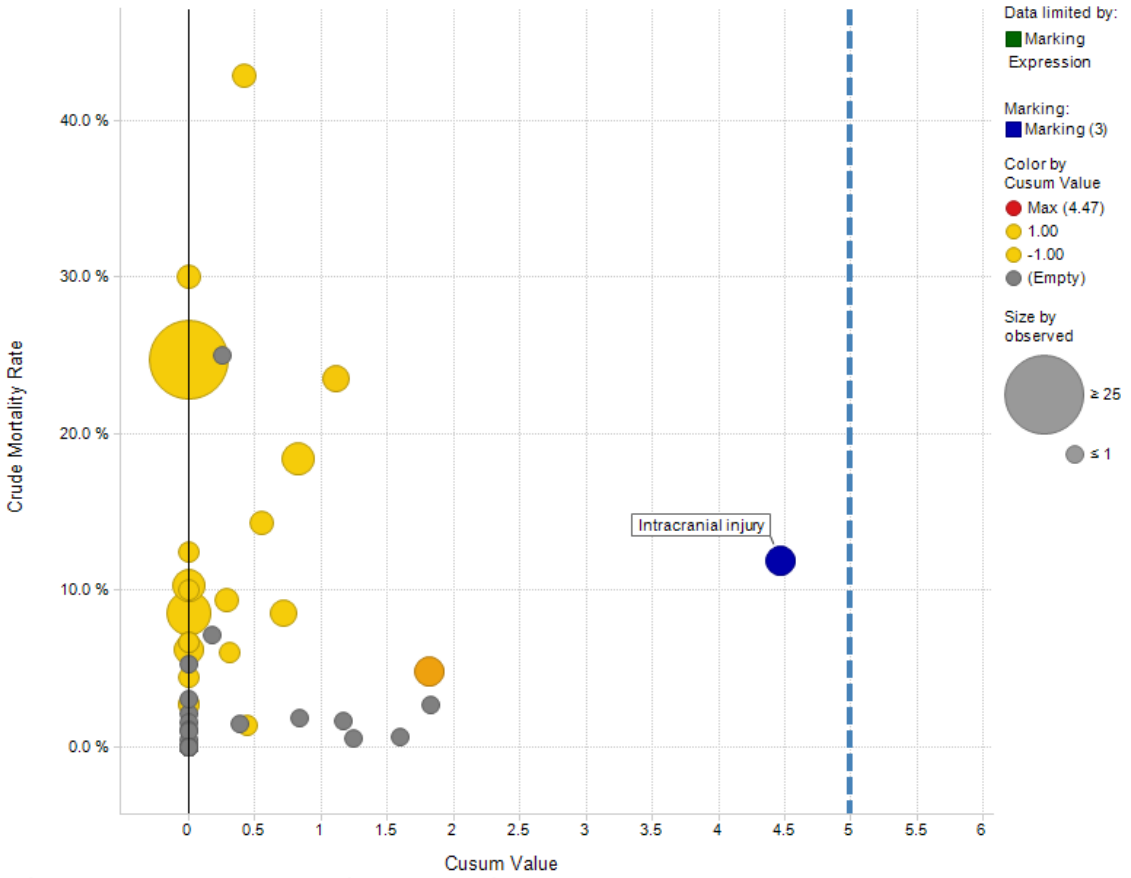


Figure 1: UHB CUSUM in September 2017 for CCS Groups.

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

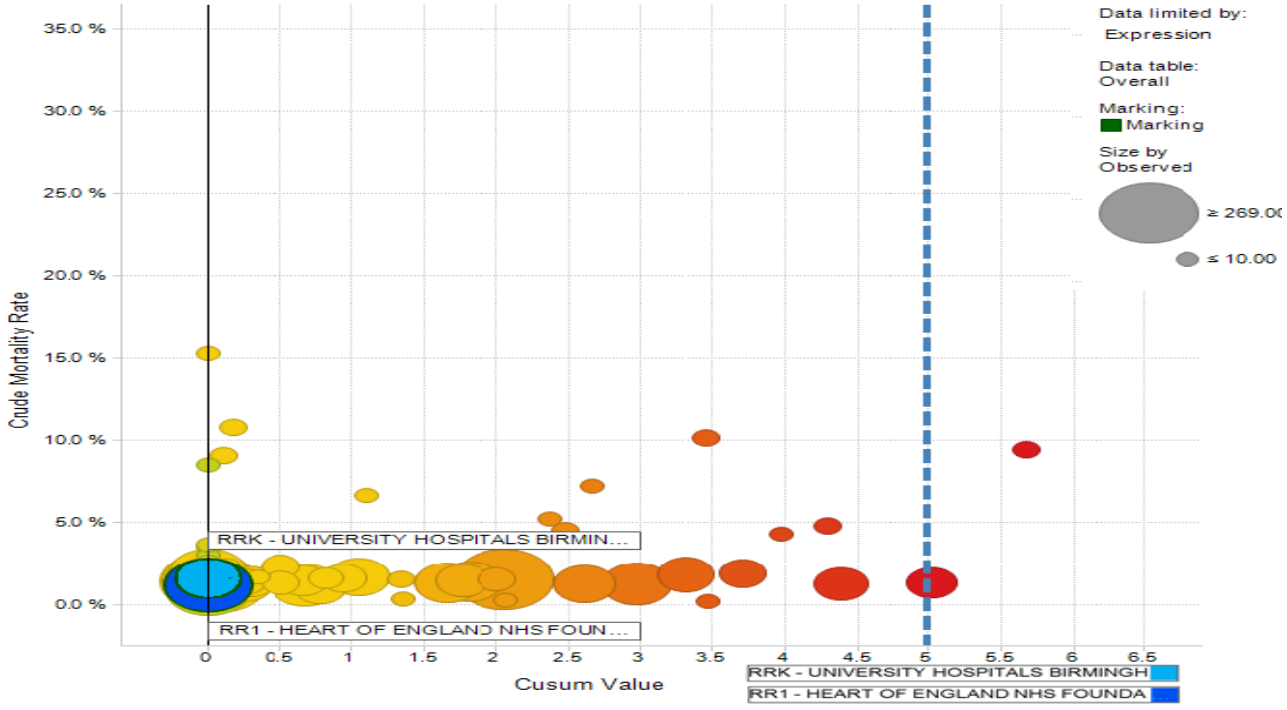


Figure 2: UHB CUSUM in September 2017 at Trust level. HEFT CUSUM included for benchmarking purposes.

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

The Trust's SHMI performance from April 2017 to August 2017 was 96. The Trust has had 1068 deaths compared with 1116 expected, which is within the acceptable limits as shown in Figure 3 below.

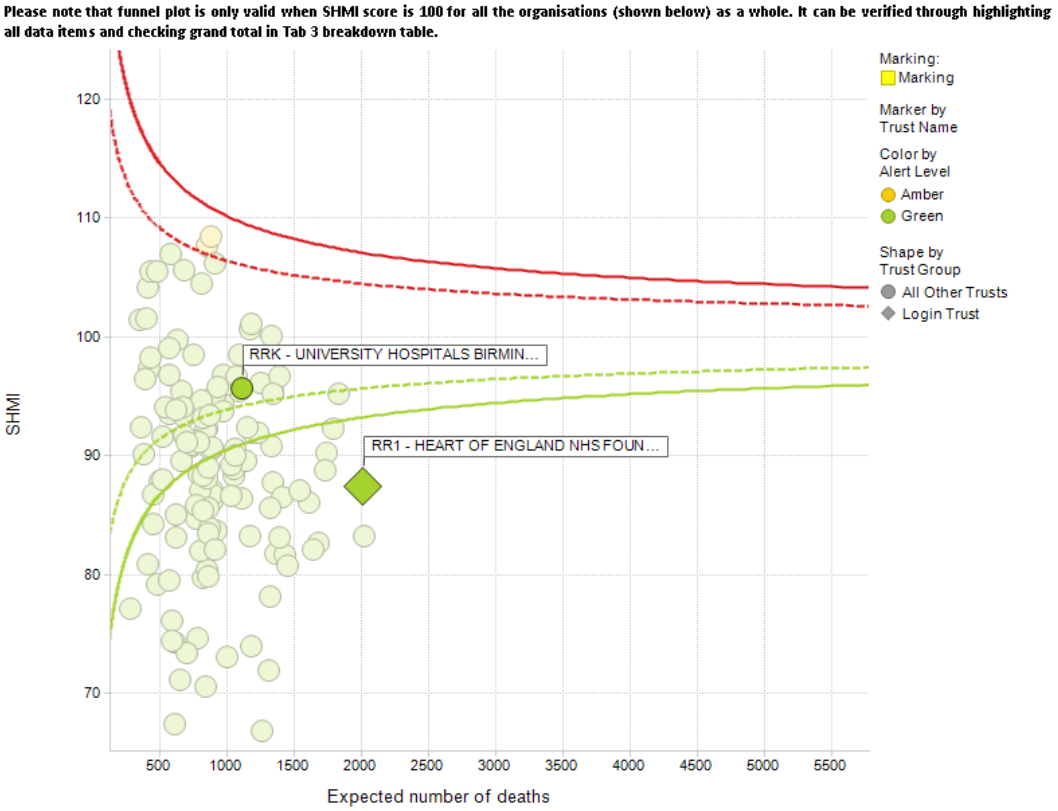


Figure 3: UHB SHMI. HEFT SHMI included for benchmarking purposes.

5. Mortality - HSMR (Hospital Standardised Mortality Ratio)

The Trust's HSMR April 2017 – September 2017 was 104 which is slightly higher than expected. The Trust had 755 deaths compared with 722 expected.

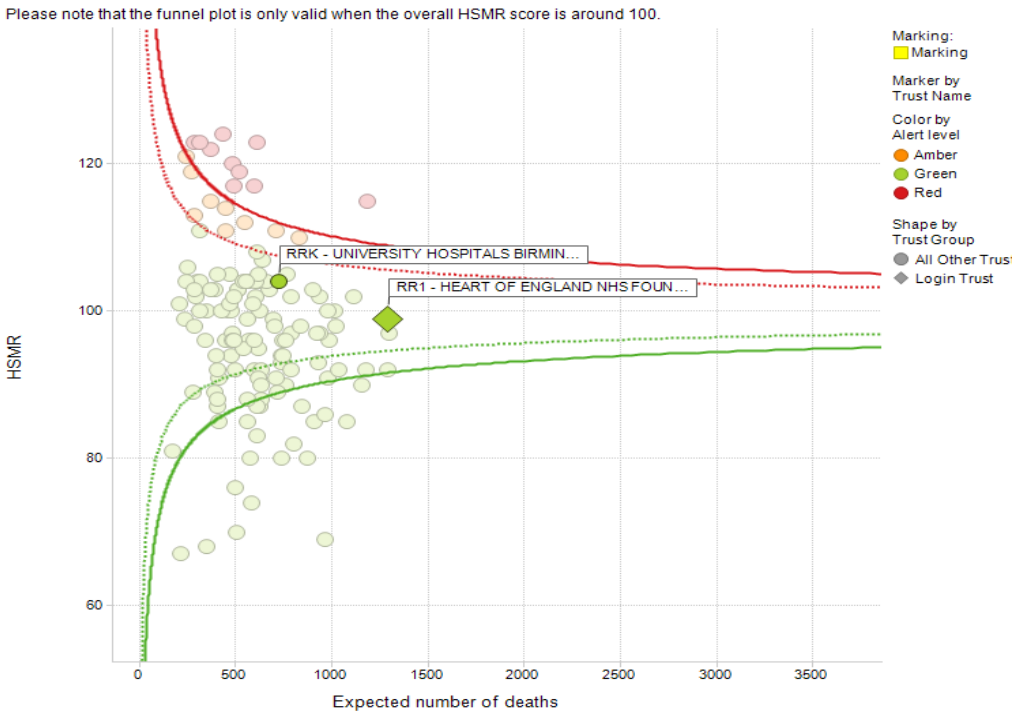


Figure 4: UHB HSMR. HEFT HSMR included for benchmarking purposes.

6. Learning from Deaths Quarter 3 2017.

In line with national *Learning from Deaths* requirements. A summary of the all results of reviews of inpatient deaths during Quarter 3 2017/18 has been undertaken and appended (A). The report includes information for both UHB and HEFT for benchmarking purposes.

7. Board of Directors' Unannounced Governance Visits

The visit in December 2017 was to Ophthalmology Outpatients (Area 1). Overall the environment was clean. Although a high volume department, it was not as busy as usual on the day of the visit.

A couple of Information Governance issues were observed and some queries were raised about the booking process. A patient stated that they had received multiple letters about their appointments. The patient had received individual appointments (optometrist and ophthalmologist) which were both on the same day (this is due to individual appointments being booked as individual clinics). A patient stated that he was an inpatient for leukaemia treatment and had not been told why he was taken to the eye clinic, although other patients that spoke to the visit team were happy with their experience.

The specialty benefits from a highly skilled / expert group of clinicians, including a consultant who is the president of the Royal College of Ophthalmologists who welcomed the opportunity to discuss staffing and capacity challenges and potential solutions. It was noted that due to the specialised nature of the service there was high usage of bank staff to manage a high vacancy rate.

A few minor environmental issues were observed (e.g. hand written door signs). A number of IG risks were identified in relation to unlocked PCs and staff belongings in view in unlocked rooms. The use of a fax machine and printing Trust branded patient leaflets in black and white was raised as part of the feedback report and action plan.

8. Recommendations

The Board of Directors is asked to:
Discuss the contents of this report.

Dr David Rosser,
Executive Medical Director

University Hospitals Birmingham FT and Heart of England FT
Learning from Deaths Quarter 3 2017
01/10/2017 – 10/12/2017

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 3 2017/18, in line with national *Learning from Deaths* requirements.

2. Quarter 3 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 possibly 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. Heart of England Foundation Trust (HEFT) uses a different scoring system for identifying avoidable deaths; the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) scoring system.

2.4.1. Any case that scores a 2 or more is considered to be possibly due to problems in care and so a possibly avoidable death.

2.5. The CESDI scoring system is defined as follows:

2.5.1. Grade 0: No suboptimal/substandard care

2.5.2. Grade 1: Suboptimal care, but different management would have made no difference to the outcome.

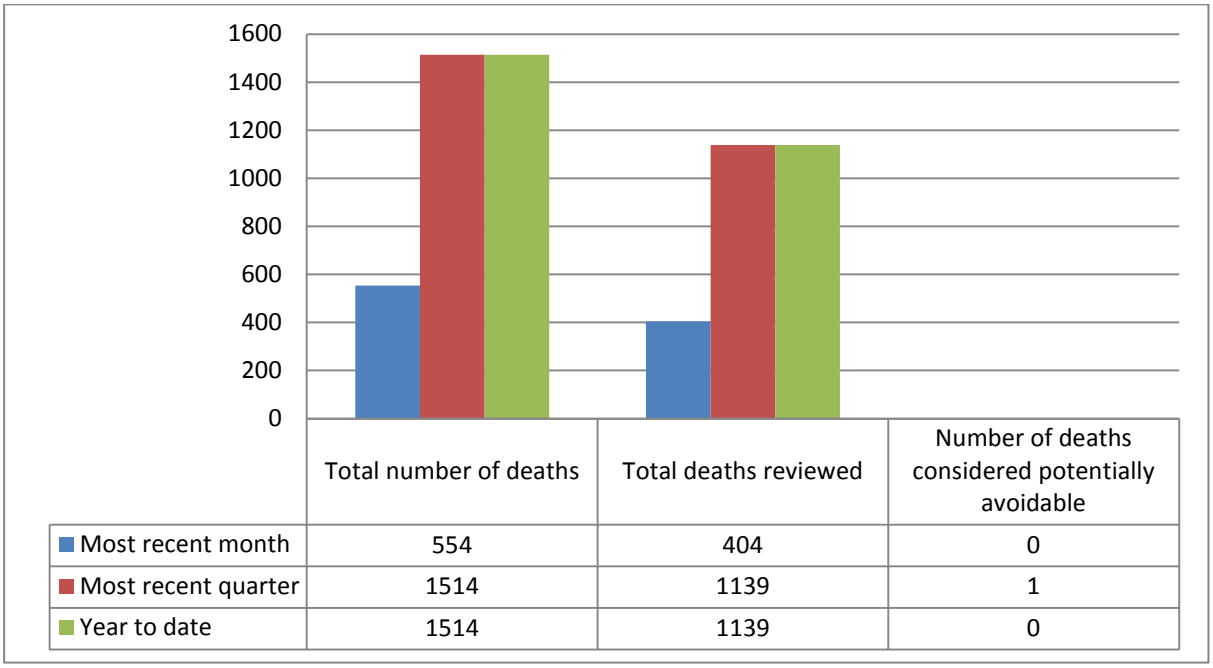
2.5.3. Grade 2: Suboptimal care; different care might have made a difference (possibly avoidable death).

2.5.4. Grade 3: Suboptimal care; different care would reasonably be expected to have made a difference (probably avoidable death).

2.6. 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.

2.6.1. 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.

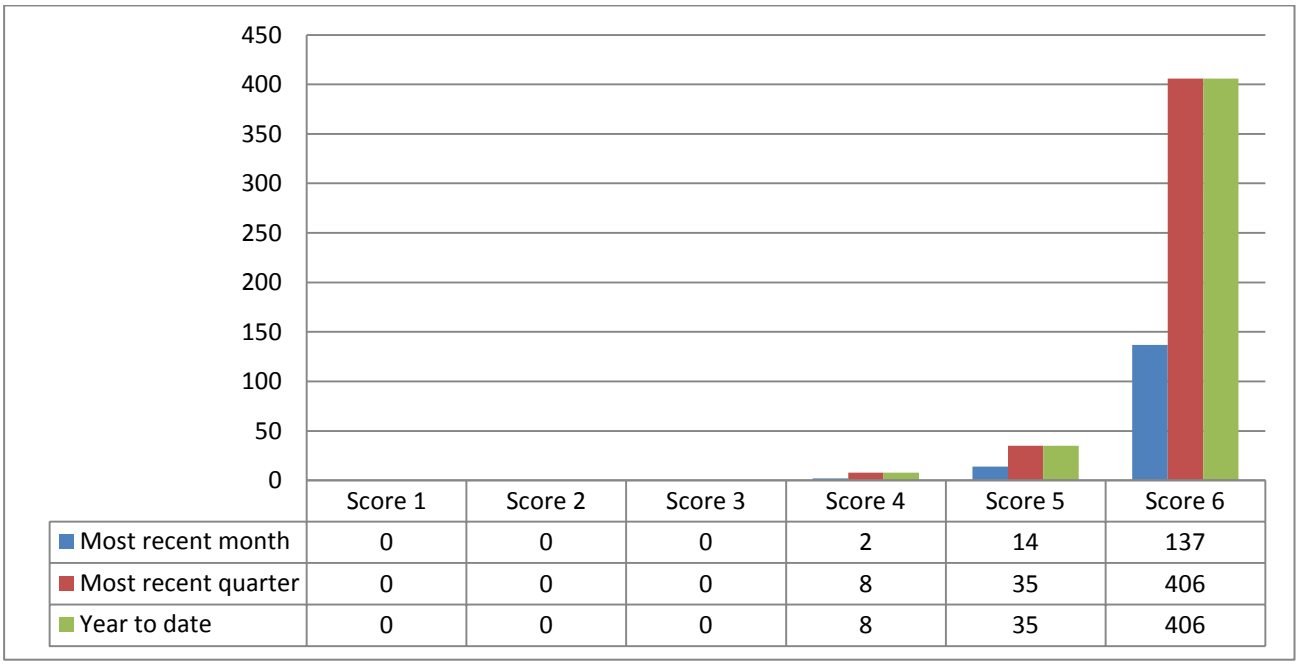
2.7. The below graph shows the total number of deaths in both Trusts combinedwithin the last quarter, the total number of deaths reviewed by the Medical Examiners, and the number considered potentially avoidable.



	Total number of deaths	Total deaths reviewed	Number of deaths considered potentially avoidable
Most recent month	554	404	0
Most recent quarter	1514	1139	1
Year to date	1514	1139	0

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 or score of 2 or higher on CESDI scoring system) based on front line Medical Examiner reviews.

2.8. The below graph shows the breakdown of scoring against the RCP Avoidability of Death scoring system for quarter 3 at UHB.

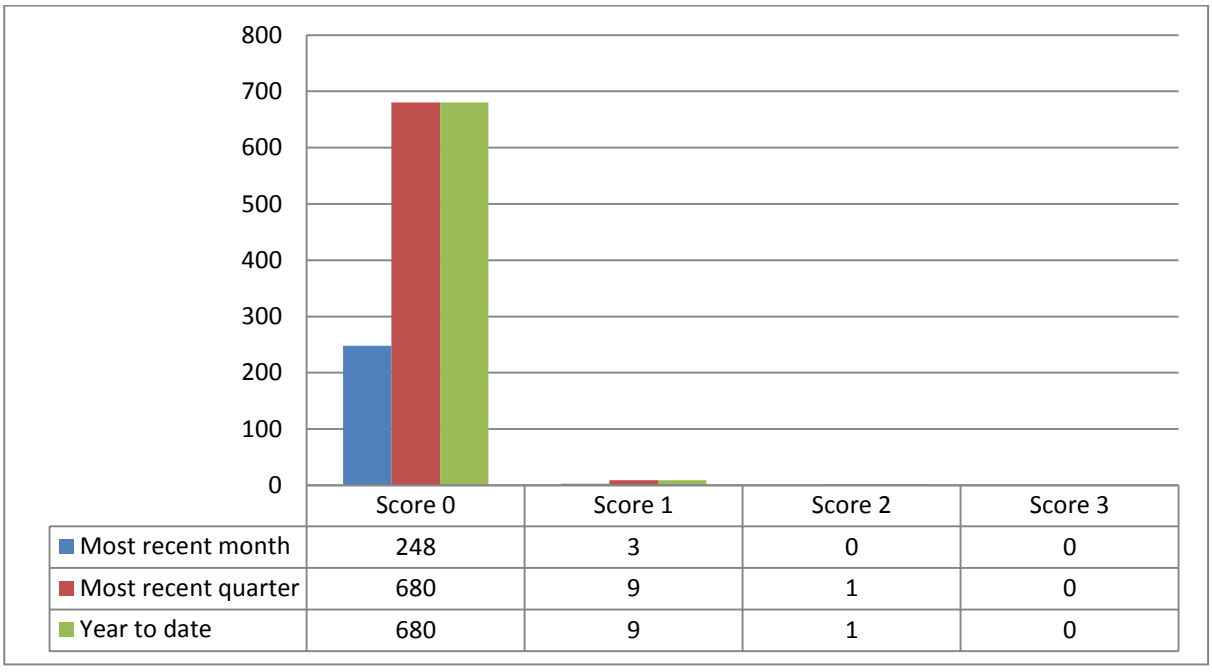


	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent month	0	0	0	2	14	137
Most recent quarter	0	0	0	8	35	406
Year to date	0	0	0	8	35	406

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

2.8.1. No deaths received a score of 3 or less which is the criteria for being classified as potentially avoidable.

2.9. The graph below shows the breakdown of scoring against the CESDI scoring system for quarter 3 at HEFT.



	Score 0	Score 1	Score 2	Score 3
Most recent month	248	3	0	0
Most recent quarter	680	9	1	0
Year to date	680	9	1	0

2.9.1. One case scored a 2 which is the criteria for being classified as potentially avoidable.

2.9.1.1. As per Trust process, this was escalated to the Clinical and Professional Review of Incidents (CaPRI) group where no significant concerns in care were identified and the the decision was made for

local Root Cause Analysis (RCA) prior to coroner’s inquest on 28/02/2018.

2.9.1.2. Learning outcomes will be shared and any actions implemented following the conclusion of these processes.