UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 25 JULY 2013

Title:	**CLINICAL QUALITY MONITORING REPORT**
Responsible Director:	David Rosser, Executive Medical Director
Contact:	Mark Garrick, Head 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 June 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:	• Update provided on the investigations into Doctors' performance currently underway. • Update on mortality indicators (CUSUM, SHMI, HSMR). • Progress on the Junior Doctors Monitoring System and future actions. • Latest progress reported for the Serious Incidents Requiring Investigation/Serious Incidents Requiring Internal Investigation. • Themes from the action plan following the Executive Governance Visit to ward 620.	
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: 15/07/2013

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS
THURSDAY 25 JULY 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 June 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 CCS (Clinical Classification System) group 233 (Intracranial injury) with 9 observed deaths in December 2012 compared to 4 expected deaths. A patient case note review is being undertaken as part of the Trust's assurance process.

The patient groups in which an elevated mortality was recognised in February 2013 include:

- 71-Other psychoses (0 Expected, 2 Observed)/ March 2012 to February 2013 (3 expected 11 observed)
- 30-Cancer of testis (0 Expected, 1 Observed) / March 2012 to February 2013 (1 expected 1 observed)
- 240-Burns (0 Expected, 3 Observed) / March 2012 to February 2013 (7 expected 15 observed)
- 109 Acute cerebrovascular disease (6 Expected,14 Observed) / March 2012 to February 2013 (95 expected 139 observed)

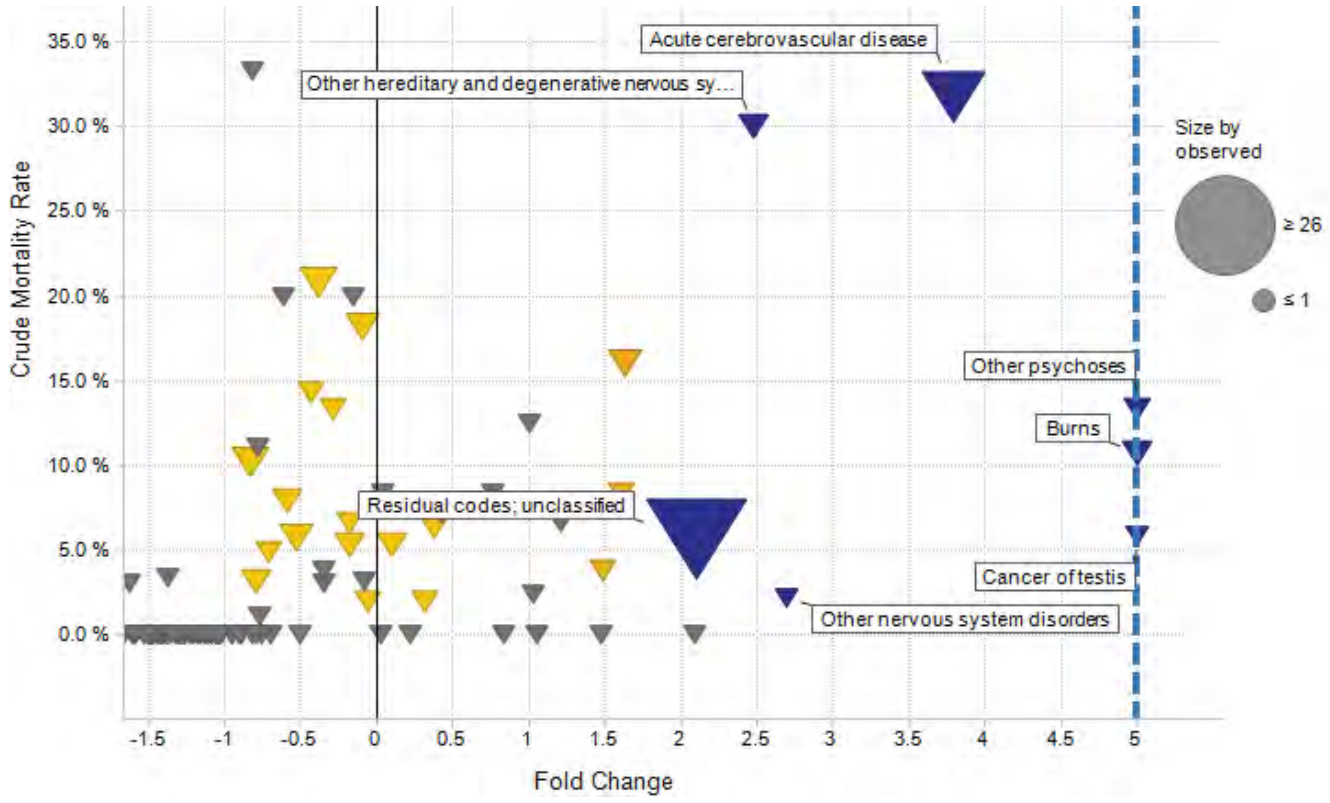

Figure 1: UHB CUSUM by CCS Group

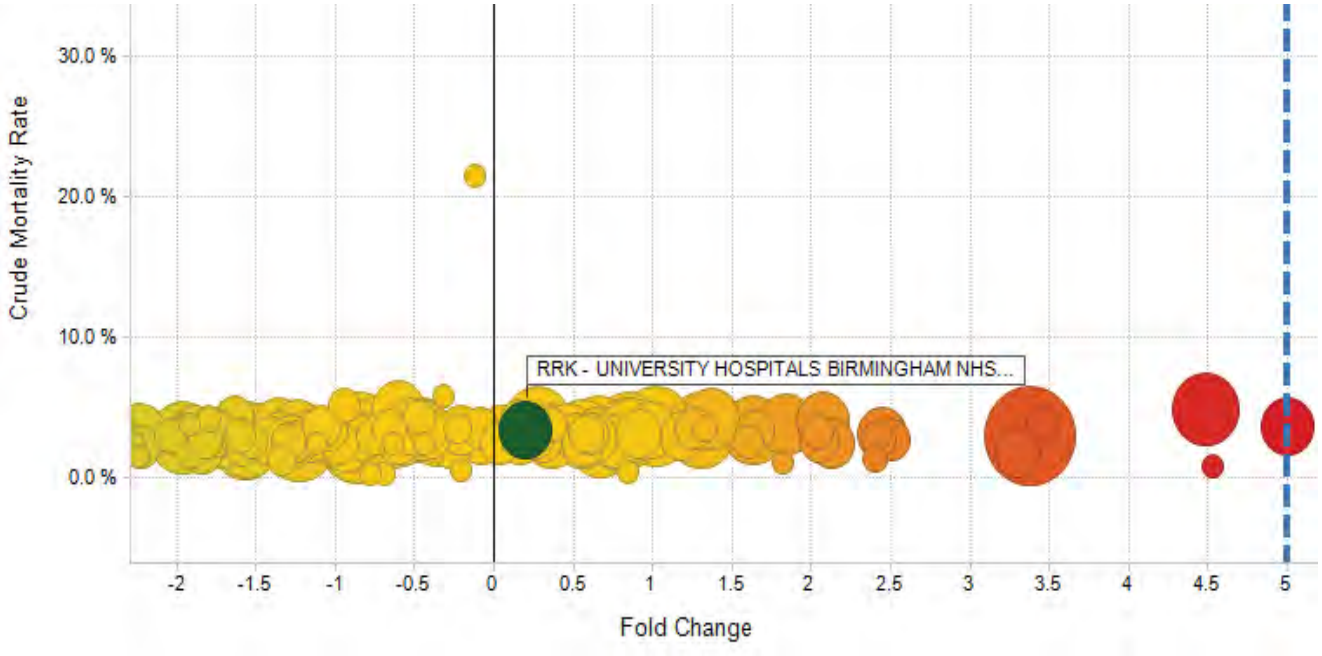

Figure 2: UHB Trust total CUSUM

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

The Trusts' SHMI performance from April 2012 to January 2013 is 104.37 slightly above the predicated expected mortality of 100. The Trust has had 2044 deaths compared with 1958 expected. The Trust is within the acceptable limits as identified in figure 3 below.

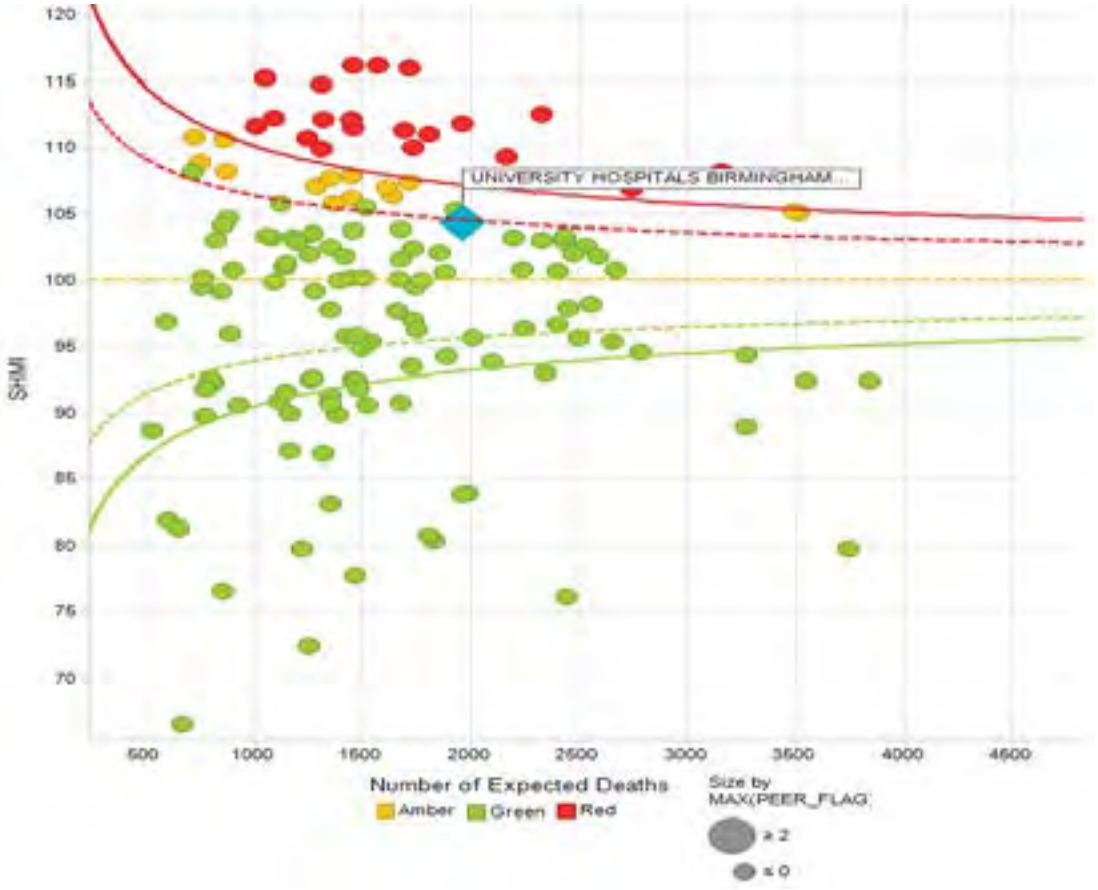

Figure 3: UHB SHMI

5. HSMR (Hospital Standardise Mortality Ratio)

The Trust's HSMR in 2012/13 (April 2012 to February 2013) is 111, with an observed mortality of 1379 against 1239 expected. The Trust is at the upper acceptable limit as identified in Figure 4 below.

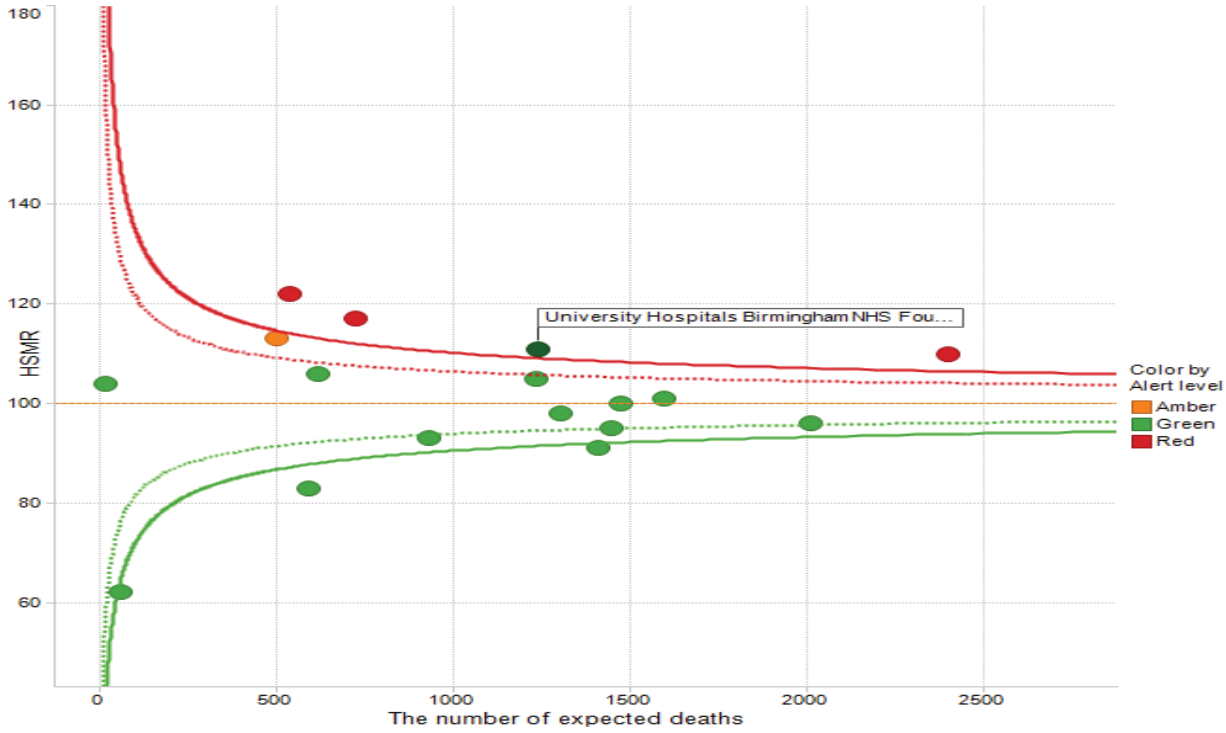

Figure 4: UHB HSMR

6. Mortality for selected major trauma centres: analysis of data from April 2010 to January 2013

The 12-monthly mortality for Neurosurgery at UHB has increased steadily during the period analysed from 4.0% to 6.2%. This is quite different to the trends observed in the other major trauma centres analysed. See figure 5 on the following page.

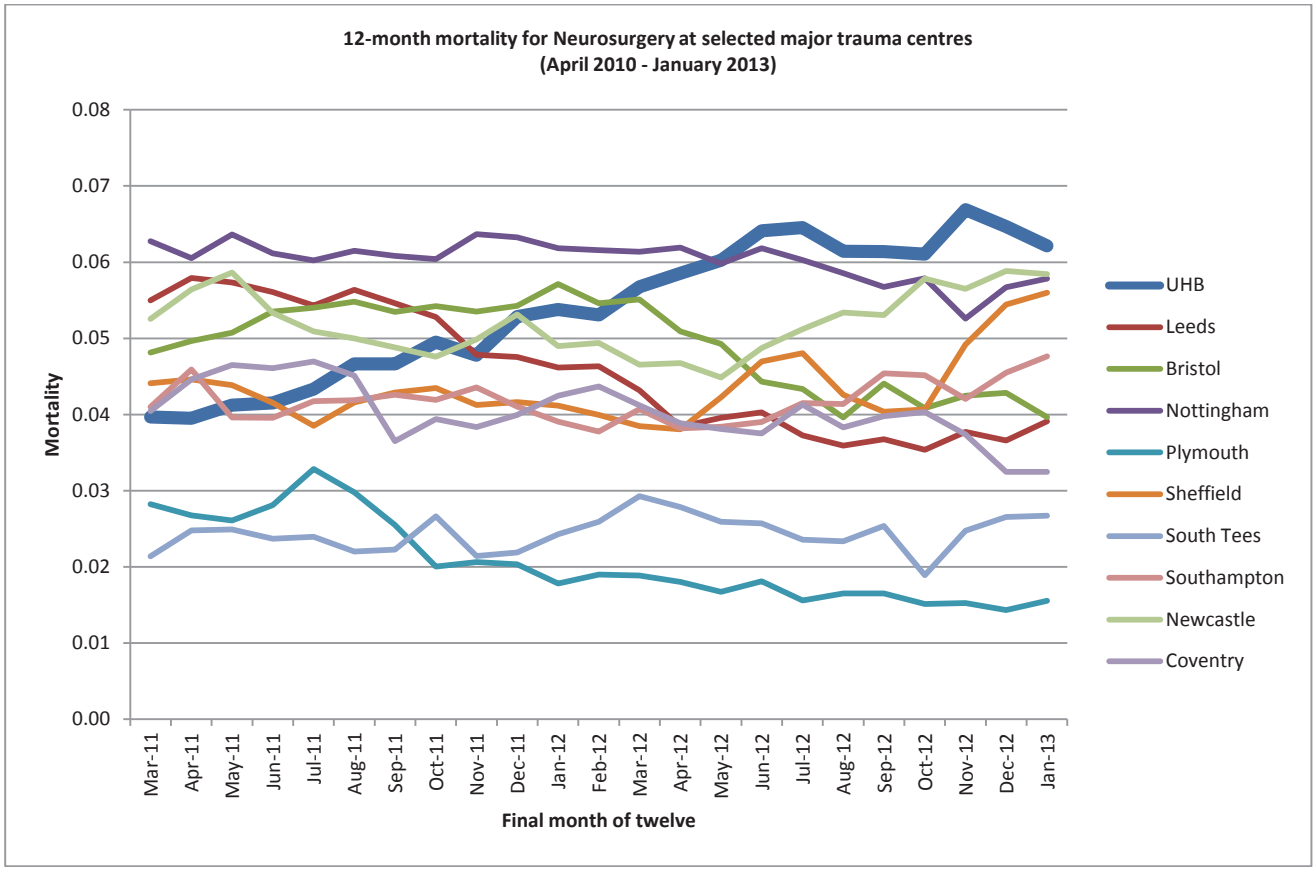

Figure 5: 12 Month Mortality for Neurosurgery at selected Major Trauma Centres

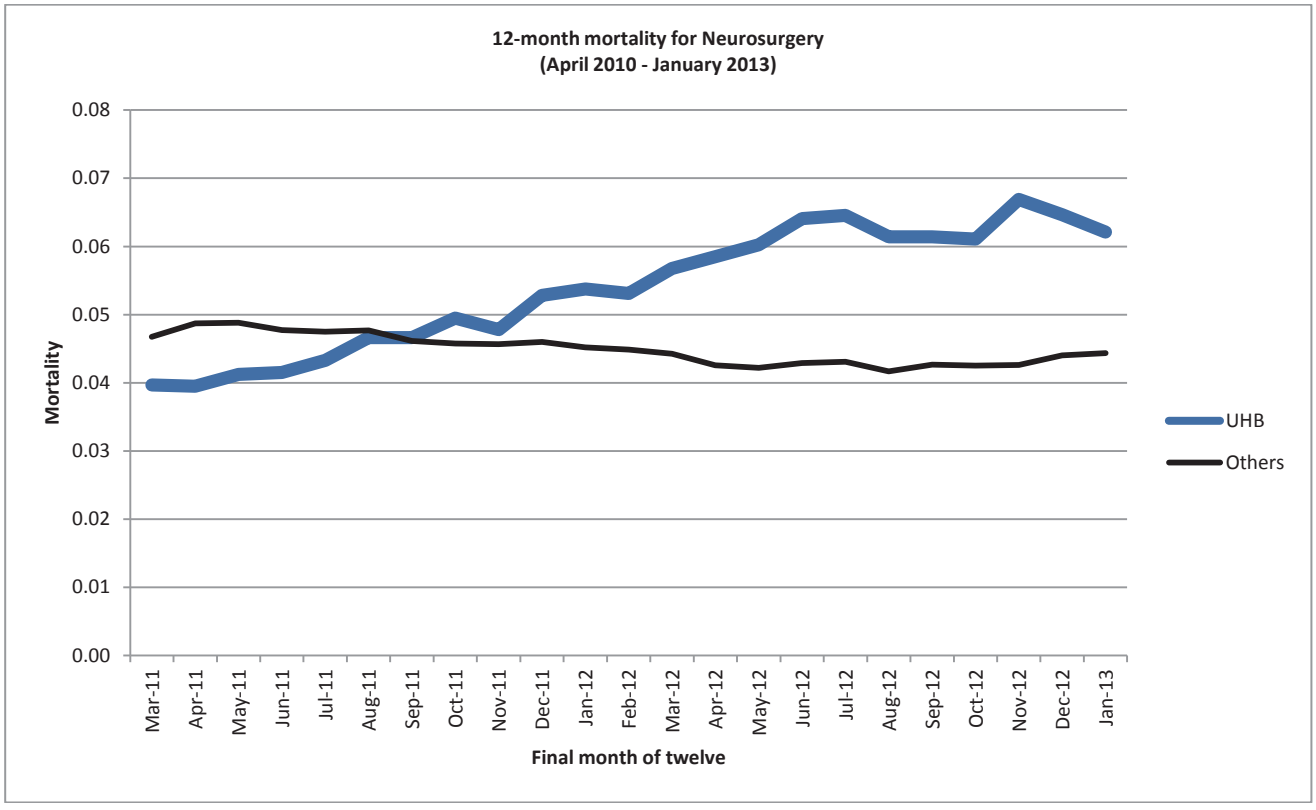

Figure 6: 12 Month Mortality for Neurosurgery

The 12-monthly mortality for Trauma and Orthopaedics at UHB decreased from 2.7% to 2.1% and then increased steadily to 2.9%. Several of the other major trauma centres analysed showed similar increases over the same period.

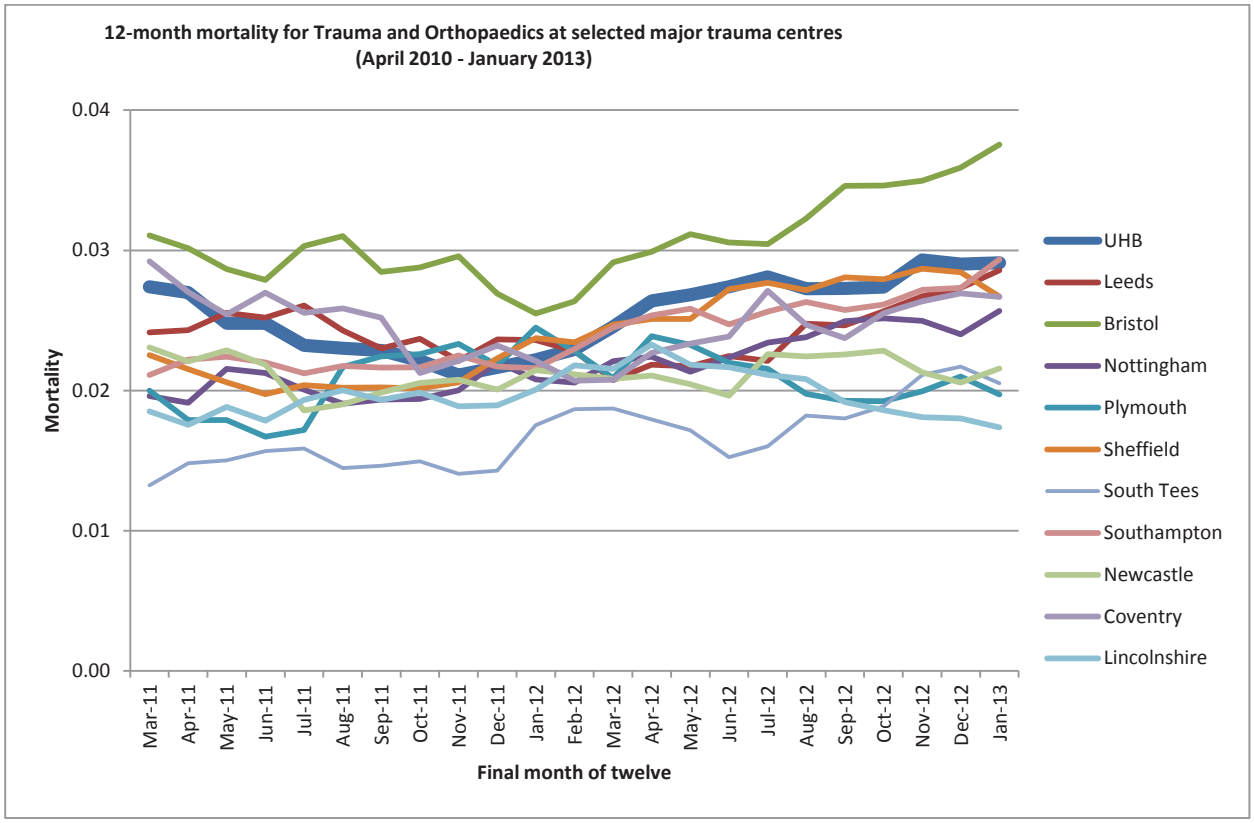

Figure 7: 12 Month mortality for Trauma and Orthopaedics at selected major trauma centres

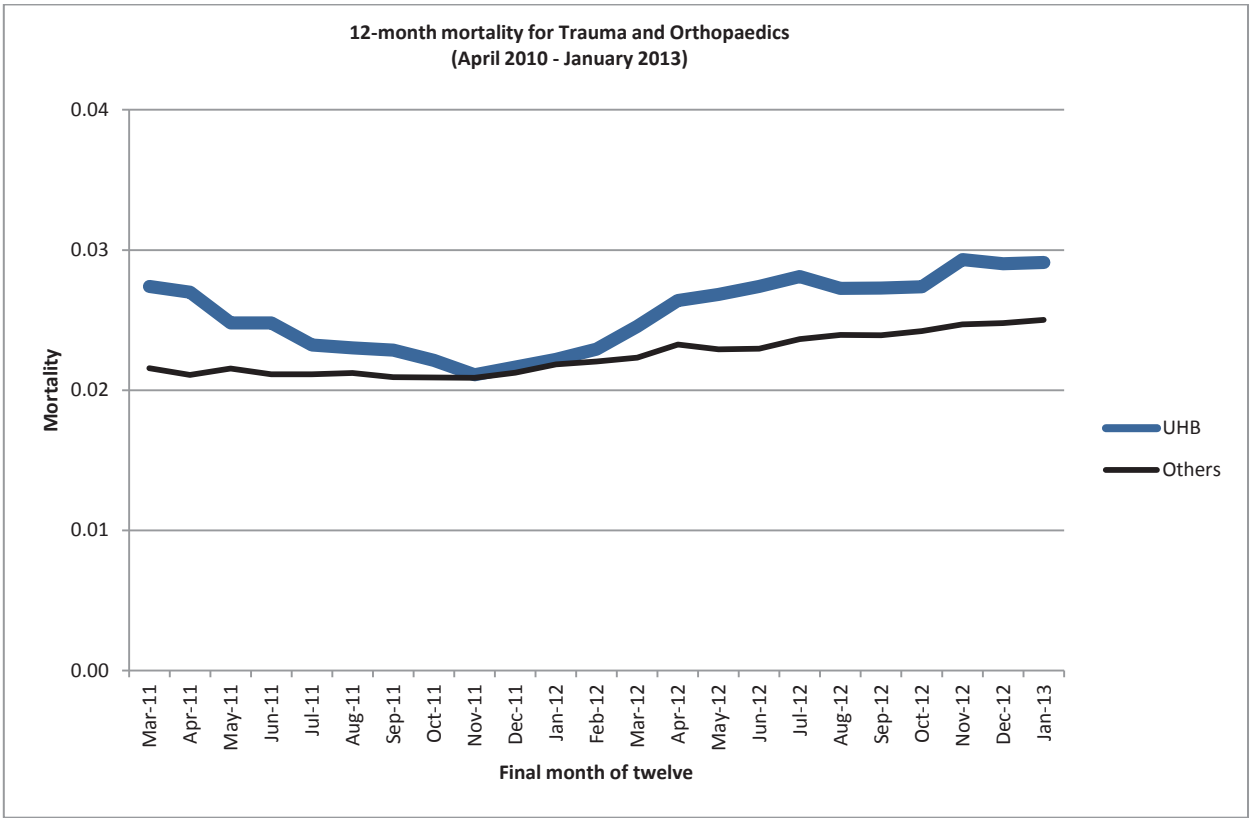

Figure 8: 12 Month mortality for Trauma and Orthopaedics

7. Junior Doctors Monitoring System update

Following the update on the Junior Doctors Monitoring System reported to the Board of Directors in April 2013, the team continue to monitor all non consultant activity for specific areas of interest. In line with the Trust's Quality Account, the main focus of the analysis at present is on VTE risk assessment completion and compliance. One of the key findings from the clinic sessions is that the level of experience of a Junior Doctor contributes to their confidence in prescribing enoxaparin before bloods are returned and assessments completed. The use of two fields in the VTE risk assessment - 'Patient unable to give history' and 'Active bleeding' – are being monitored to ensure they are not used inappropriately as a way of avoiding having to fully complete the assessment.

A CT1 level Doctor who has been the through the process has shown a dramatic increase in performance. Prior to the clinic meeting, the Doctor had completed 12 assessments with enoxaparin recommended (over 3 months). The Doctor had not prescribed enoxaparin for any of the patients assessed which meant zero compliance with Trust Policy. The latest audit data for this Doctor revealed that in one month 15 assessments had been completed with enoxaparin recommended and the doctor had prescribed enoxaparin in 14 out of the 15 cases, giving 94% compliance. The remaining patient had enoxaparin prescribed by another Doctor so compliance is 100%.

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

There are 5 ‘Serious Incidents Requiring Investigation’ (SIRIs) relating to a return to theatre post-thyroidectomy, two incorrect surgical sites (both never events) and two delayed CT scan follow-ups.

There are 11 ‘Serious Incidents Requiring Internal Investigation’ (SIRIIs) and these relate to delayed assessment, near miss – missed diagnosis, transfer issues, missed ST elevation, patient aspiration, deterioration post liver biopsy, patient bleed and deterioration, additional swab during surgical procedure and a delay in acting on blood results.

9. **Executive Governance Visits**

The June 2013 visit was to ward 620 which was positive with all patients receiving very good care. As the ward was initially opened due to winter pressures, no bedside televisions have been installed which has made it more difficult for the ward to capture patient feedback. The ward is looking at asking volunteers to assist with collecting patient feedback. The ward is also focusing on improving the clinical dashboard indicators with a focus on the completion of patient assessments in a timelier manner when the patient arrives on the ward.

The July visit was to Ward 726 and will be reported to the next meeting.

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

Addendum to the Clinical Quality Monitoring Report 25 July 2013.

Due to the MDs annual leave and some technical difficulties some text to explain the graphs in sections 3 and 6 was omitted from the original paper and is provided here with apologies.

RE; section 3.

- As can be seen by figure 1 only 3 of the CCS groups has actually triggered the mortality threshold, namely other psychoses, cancer of testis and burns. The other groups will continue to be monitored but no concers have been identified on case list review.

- Other psychoses is a generic code used to cover many presenting symptoms including confusion of unknown origin. The use of this code for the presenting symptom has increased since the dementia CQUIN for dementia screening was introduced and once applied as the presenting code persists in the coding even if subsequently replaced clinically by a more robust diagnosis. The case records of these patients have been examined and both patients were complex elderly patients with multiple comorbidities and no concerns were identified.

- The cancer of the testis trigger is a good example of the difficulties of applying this sort of statistic to such low numbers. The condition carries a 5% mortality however the "death expected" algorithm does not allocate a death to every time period as the number of deaths annually is low. It is therefore a somewhat random phenomenon whether deaths when they occur do so in a time period with an expected death allocated. The case notes for this patient revealed widespread disseminated malignancy and no concerns were identified.

- There was known to be a cluster of deaths on the Intensive Care Unit from patients with major burns. These have been thoroughly investigated leading to further work on preventing cross contamination of patients by acinitobacter. Although none of the deaths were attributable to acinitobacter contamination the unit was closed to the admission of major burns for a few days while assurance that the outbreak was under control was established. No referrals were received, and therefore refused, during this period.

- Figure 2 demonstrated that the overall CUSUM for the Trust is well within the acceptable range.

RE section 6.

- Analysis of these data so far suggests that there are a number of phenomena behind the mortality changes at UHB. There appears to be a shift of the more complex work relating to the Major Trauma Centre (MTC) towards UHB and away from the other 2 MTCs in the region. There also appears to be an increasing number of head injury and other neurosurgical emergencies coming to the MTCs rather than staying in district general hospitals. There does not appear to be an increase in the number of deaths in these groups across the whole region but a shift from smaller hospitals to the MTCs. This is probably appropriate care.

- Further work is ongoing to validate, or otherwise, these conclusions and this will be reported to subsequent BOD meeting and or the appropriate commissioners if appropriate.