

AGENDA ITEM NO:

**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 25 APRIL 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 of the clinical quality to the Board of Directors and detail the actions being taken following the April 2013 Clinical Quality Monitoring Group (CQMG) meeting.
Confidentiality Level & Reason:	
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). • Ward telephone times monitoring and actions • Progress on VTE prophylaxis performance and actions • 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 from the Executive Governance Visit to Outpatients Area 4
Recommendations:	The Board of Directors is asked to: Discuss the contents of this report and approve the actions identified.
Signed:	Date: 16 April 2013

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS THURSDAY 25 APRIL 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 April 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 two investigations underway into Doctors' performance. Both investigations are into Consultant Grade Doctors'.

3. CUSUM (Cumulative Summary Mortality Indicator)

The Trust has breached the mortality threshold for CCS group 233 - Intracranial injury with 9 observed deaths in the period of December 2012 with only 4 Expected deaths.

The Trust officially became a Major Trauma Centre (MTC) in April 2012 and therefore has received a high volume of patients who are very critical, only experience by a Major Trauma Centre. The Trust understands that no consideration is given to the Trust as a Major Trauma Centre in the CUSUM algorithm calculation.

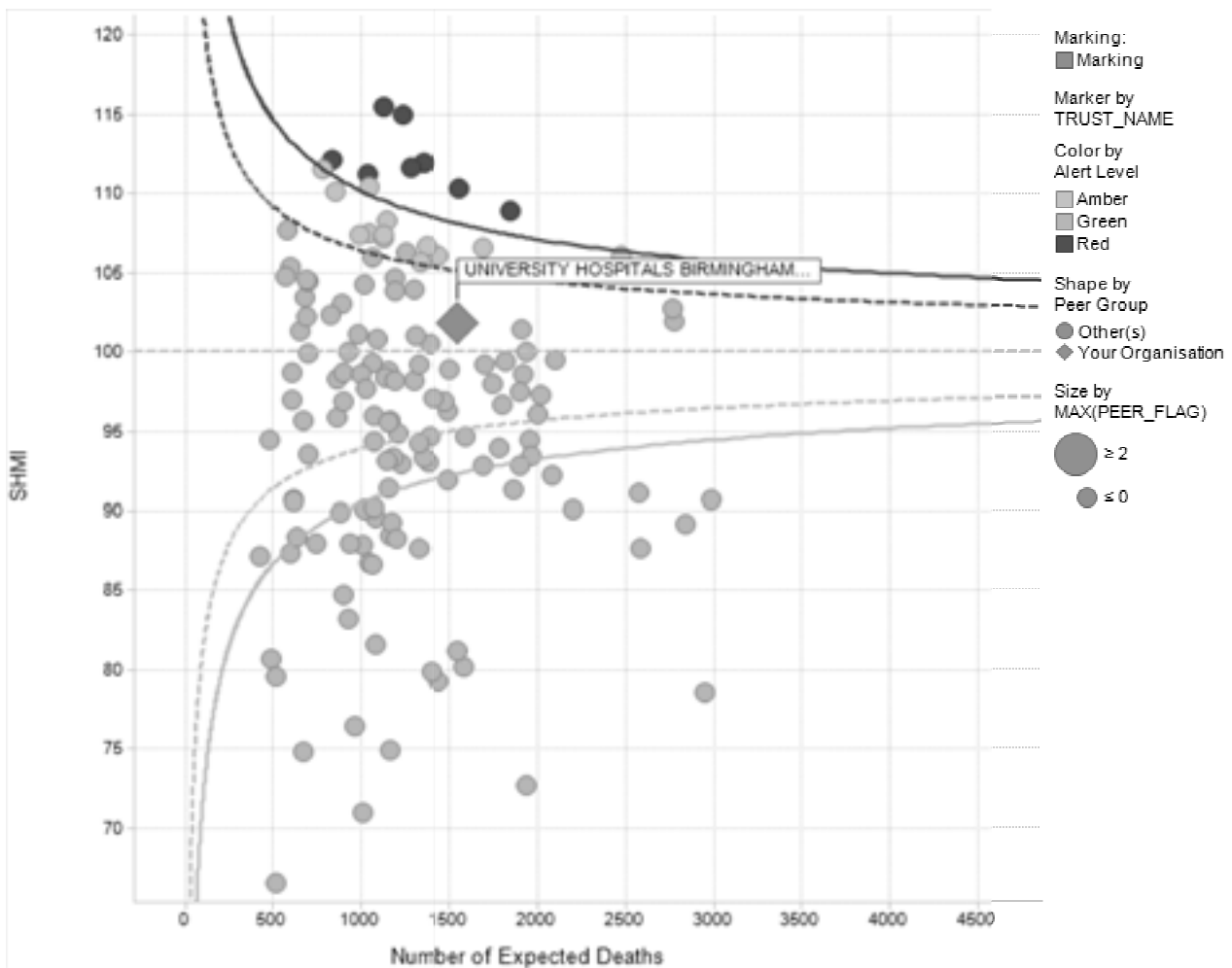
The increase in the number of Trauma patients since becoming a Major Trauma Centre has reflected in the increase in the CUSUM since April 2012 and eventually triggering in December 2012.

Initial review of the 9 patients highlights the critical condition all 9 patients were in on admission. 6 patients from the 9 were Major Trauma Centre patients and 3 of the 6 were transferred in from other hospital providers.

The Clinical service lead for Neurosurgery has been requested to review the deceased patients with a primary diagnosis relating to intracranial injury CCS group.

4. SHMI (Summary Hospital-level Mortality Indicator)

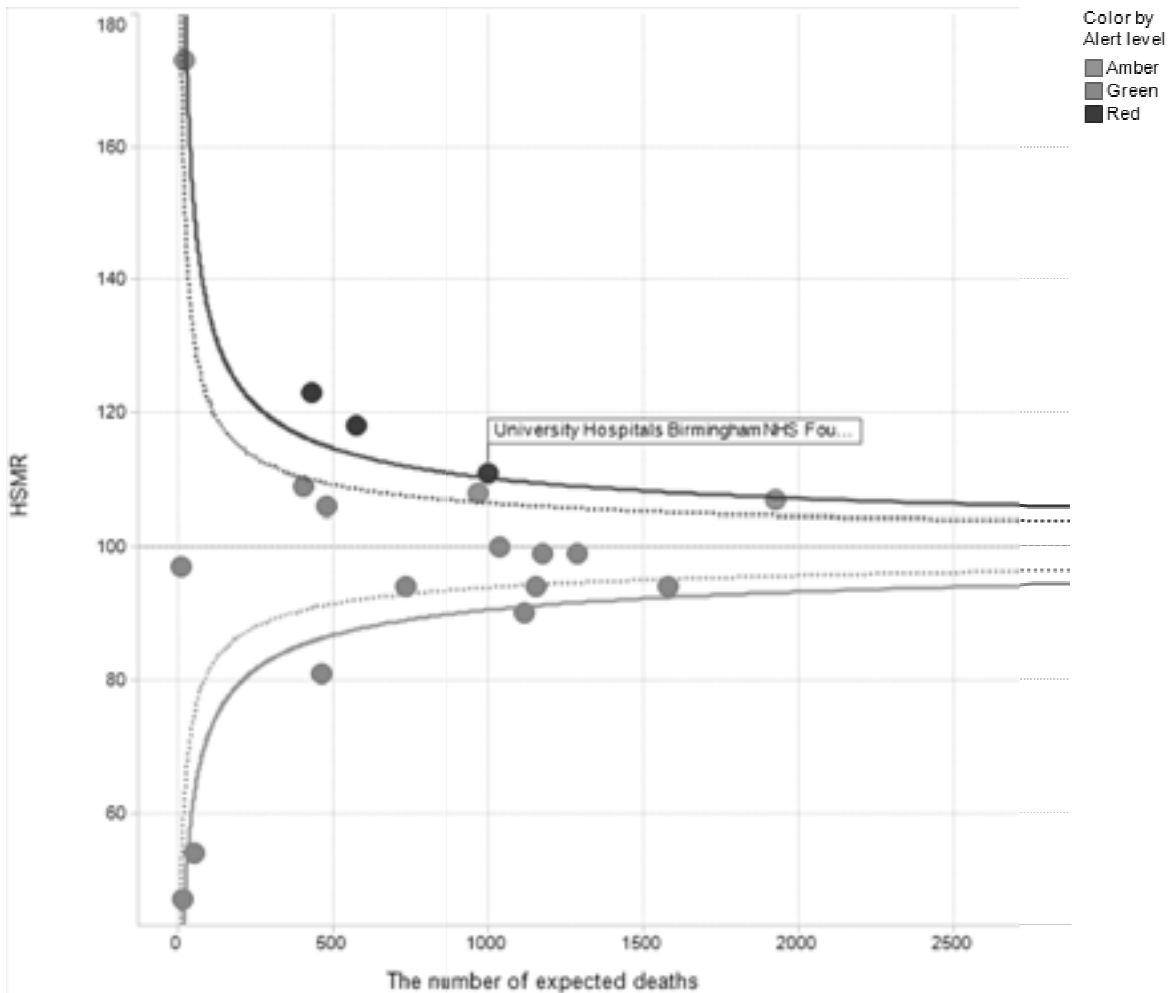
The Trust's SHMI performance from April 2012 to November 2012 is 101.85 slightly above the predicated expected mortality of 100. The Trust has an actual 1546 mortalities with 1517 expected. The Trust is within the acceptable limits as identified in graph 1 below.



Graph 1: SHMI indicator for the period April 2012 to November 2012

5. HSMR (Hospital Standardise Mortality Ratio)

The Trust's HSMR in 2012/13 (April 2012 to December 2012) is 111. With an observed mortality of 1105 against 997 expected. The Trust is at the upper acceptable limit as identified in graph 2 below.

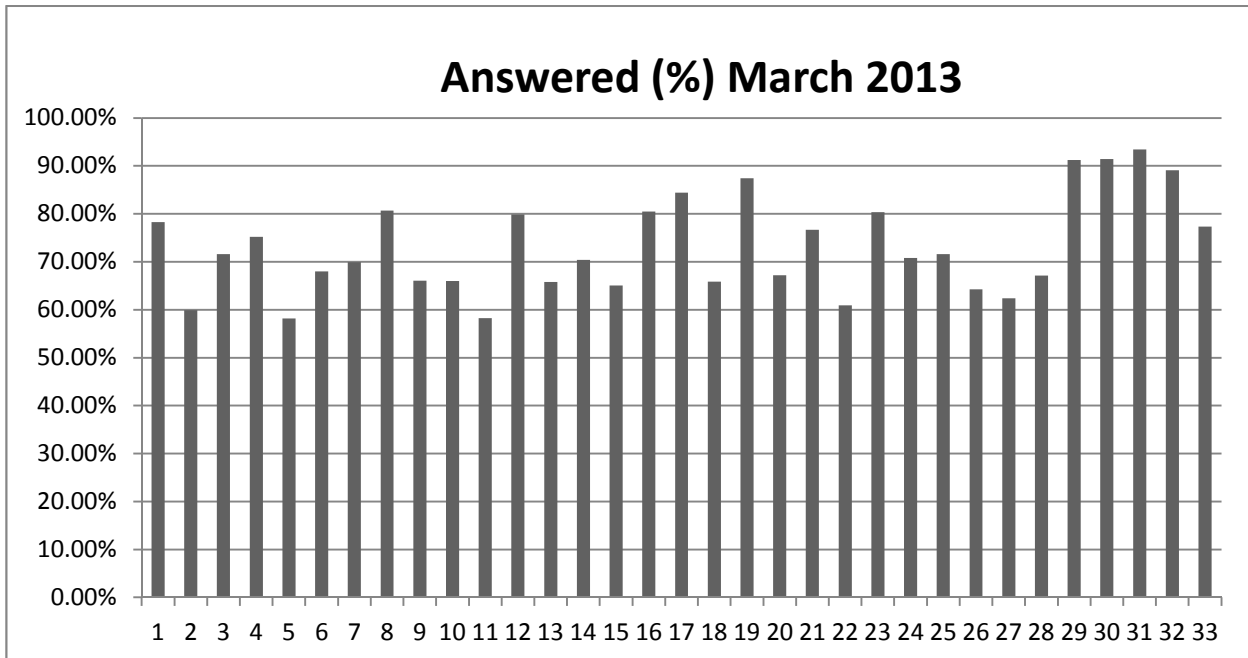


Graph 2: HSMR indicator for the period April 2011 to December 2012.

The Trust has undertaken some additional analysis into the HSMR algorithm which is appended (1).

6. Ward telephone Answer Times

The Trust has begun monitoring Ward Telephone answer times. Currently only 71% of telephone calls are being answered with the remaining 29% of calls going unanswered. The best ward in the Trust answers 93% of telephone calls while the worst ward in the Trust answers 58% of telephone calls.



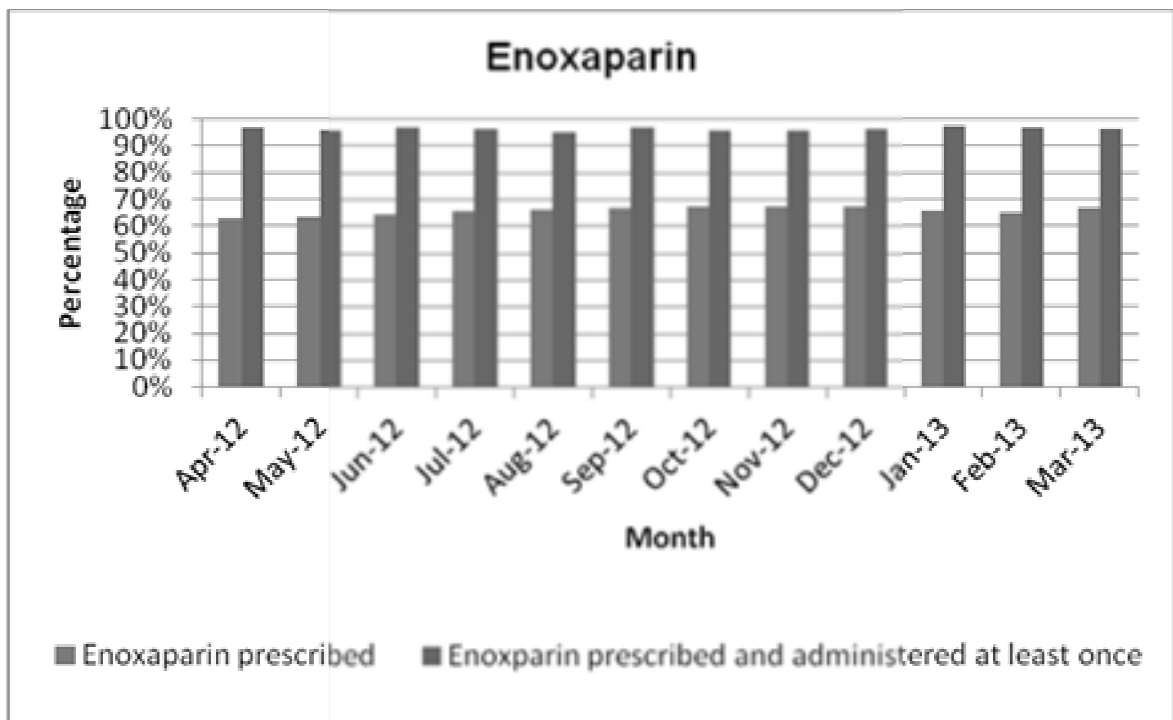
Graph 3: Ward Answered Telephone Call (%) for March 2013

The following actions have been undertaken to address and increase performance in the ward telephones being answered. The actions include:

- Ward telephone numbers have been rationalised and re-launched by the Trust Communications Department.
- Each Ward has an identified extension number to receive internal calls on and a dedicate telephone extension number to receive external calls on.
- Wards have been provided education and training for telephone answering.
- The Chief Operating Officer has presented to the Band 7 Nurse Grand Round to outline expectations in relation to telephone answering times.
- Poorly performing wards will in the future be requested to attend the Chief Executive Root Cause Analysis meetings to be present action plans to improve performance.
- The Clinical Quality Monitoring Group will continue to monitor the ward answered telephone times and develop further indicators to increase performance.

7. Enoxaparin Recommendations and Administration

The graph 4 below shows the percentage of patients who were recommended enoxaparin medication following venous thromboembolism (VTE) risk assessment and were prescribed it and of those, the percentage who were given it at least once. Overall, 65.9% of patients who required enoxaparin following VTE risk assessment were prescribed it in 2012/13. Of the patients who were prescribed enoxaparin, 96.4% were given it at least once. As with other forms of medication, there can be valid reasons why enoxaparin is not administered such as immediately prior to and after surgery to reduce the risk of bleeding.



Graph 4: Enoxaparin prescribed and Enoxaparin prescribed and administered

VTE prophylaxis is a Trust quality improvement priority for 2013/14 as outlined in the Trust's Quality Account. The prescription of enoxaparin as part of the VTE prophylaxis quality improvement priority is also a key metric being measured through the Junior Doctors Monitoring System.

8. Junior Doctors Monitoring System Update

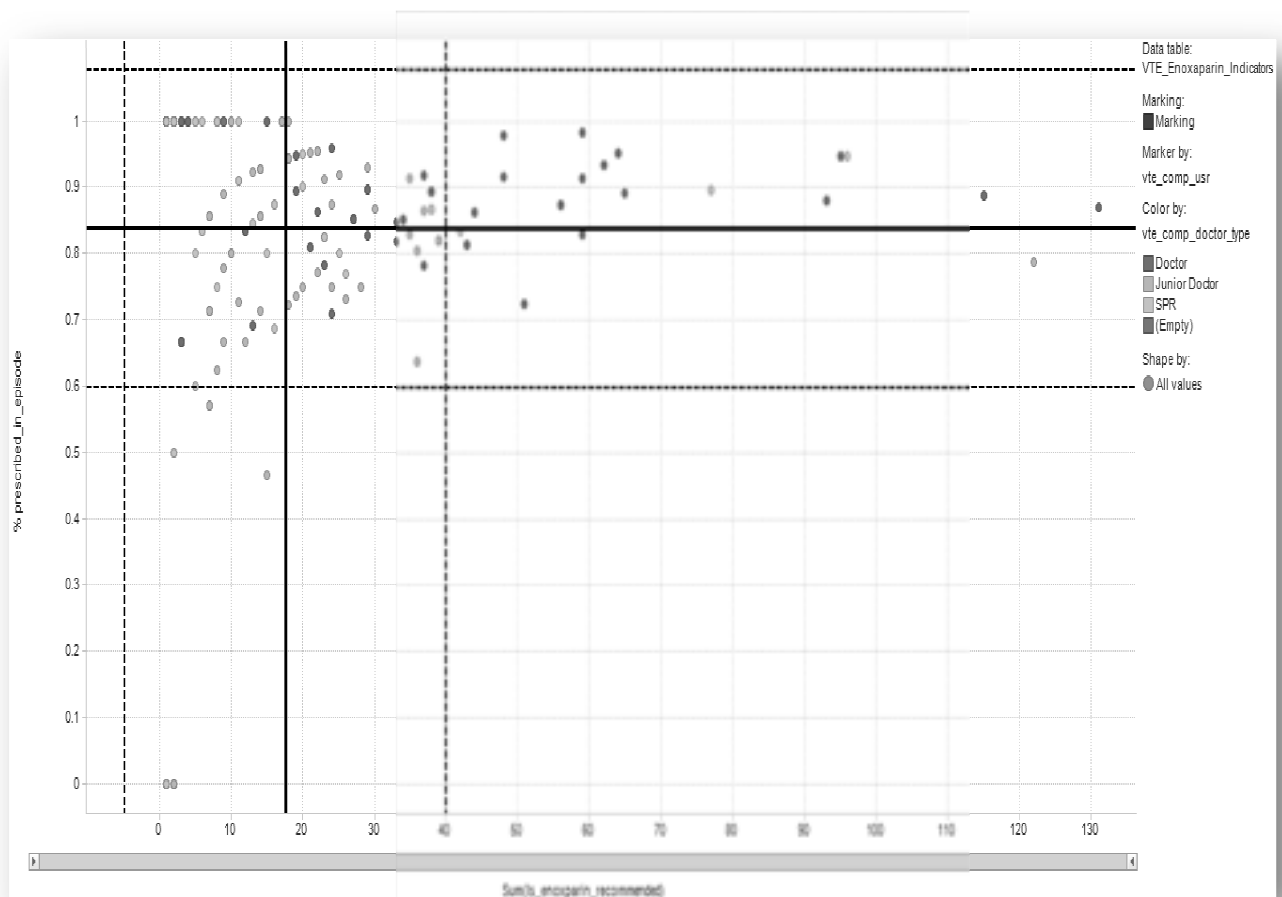
A system has been developed to continually monitor all non consultant activity for specific areas of interest. The key aim of this project is to support non-consultant doctors' educational and training needs whilst refining our monitoring systems to ensure the quality and safety of services for our patients.

The information pulled into the observational analysis is fed by the Prescribing Information and Communication System (PICS) and combined with laboratory

results and patient administration systems. The information is updated on a monthly basis and set through a statistical outlier policy.

The outlier policy aims to identify those clinicians with a higher need for further educational support. The team will also be looking to identify high performing clinicians to ensure shared learning and contribute positive outcome data to their e-portfolio. In addition the team hope to learn what contributes to this high achievement so they can feedback to the Educational Team for future cohorts of junior medical staff.

As this type of monitoring is highly innovative, the team plans to produce a research paper for publication in a Peer-Reviewed Journal.



Graph 5: Sample funnel plot from Junior Doctoring Monitoring System used to examine prescribing compliance for (VTE) assessment

Two Consultant clinicians along with senior management support currently provide weekly Education and Training Clinic sessions to non consultant medical staff. The clinics currently focus on the following indicators:

- Out of hours sedative prescribing, especially to the over 65 year old patient cohort.

- VTE assessments and compliance with prescribing enoxaparin (where no contraindications).
- Ad-hoc requests – predominantly focussing on PICS red lines.

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

There are 2 ‘Serious Incidents Requiring Investigation’ (SIRI) relating to indistinguishable mass excised from breast site and a return to theatre post-thyroidectomy.

There are 7 ‘Serious Incidents Requiring Internal Investigation’ (SIRII) and these relate to delayed assessment; management, treatment, follow up and unmonitored acute coronary syndrome and a near miss – missed diagnosis.

Processes were the root cause for 5 of these incidents and in a further 4 cases the root cause is to be identified. In 1 case patient impact was direct. In a further 5 cases the patient impact was indirect. Patient impact is currently unknown in 3 cases. 2 incidents resulted in no harm, 3 incidents resulted in permanent harm, 1 in temporary harm and in 2 cases patient outcome is not yet known. In 1 case a patient has died but the death had no relation to the incident.

10. **Executive Governance Visits**

The March 2013 visit was to Outpatients Area 4. With the key themes relating to the adherence to infection control policy, patient movements and better communication with patients in relation to waiting times included in the action plan.

The April 2013 visit was to CCU and the action plan will be reported in the May 2013 report.

11. **Recommendations**

The Board of Directors is asked to:

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

David Rosser
Executive Medical Director