UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 24 JANUARY 2019

Title:	**CLINICAL QUALITY MONITORING REPORT**
Responsible Director:	Prof. Simon Ball, Executive Medical Director
Contact:	Mariola Smallman, Head of Medical Directors' Services, 13768

Purpose:	To provide assurance on clinical quality to the Board of Directors following the December 2018 UHB Clinical Quality Monitoring Group (UHBCQMG) 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:	• Latest performance for a range of mortality indicators (CUSUM, SHMI, HSMR). • Learning from Deaths, Quarter 3, 2018/19 update. • Summary of Serious Incidents (SIs) meeting Never Event criteria reported between 12/10/18 and 10/01/19.	
Recommendations:	The Board of Directors is asked to: Discuss the contents of this report.	
Approved by:	Prof. Simon Ball	Date: 16/01/2019

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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, following the December 2018 UHB Clinical Quality Monitoring Group (UHB CQMG) meeting. The Board of Directors is requested to discuss the contents of this report and approve any actions identified.

2. Mortality - CUSUM

QEHB:

Two CCS (Clinical Classification System) diagnosis groups had higher than expected number of mortalities in September 2018:

- Septicaemia (except in labour) – 10 observed deaths, 8.33 expected deaths.
- Intracranial injury – 8 observed deaths, compared to 5.38 expected deaths. This triggered in September 2018.

The case-lists for these have been provided to an Associate Medical Director for review.

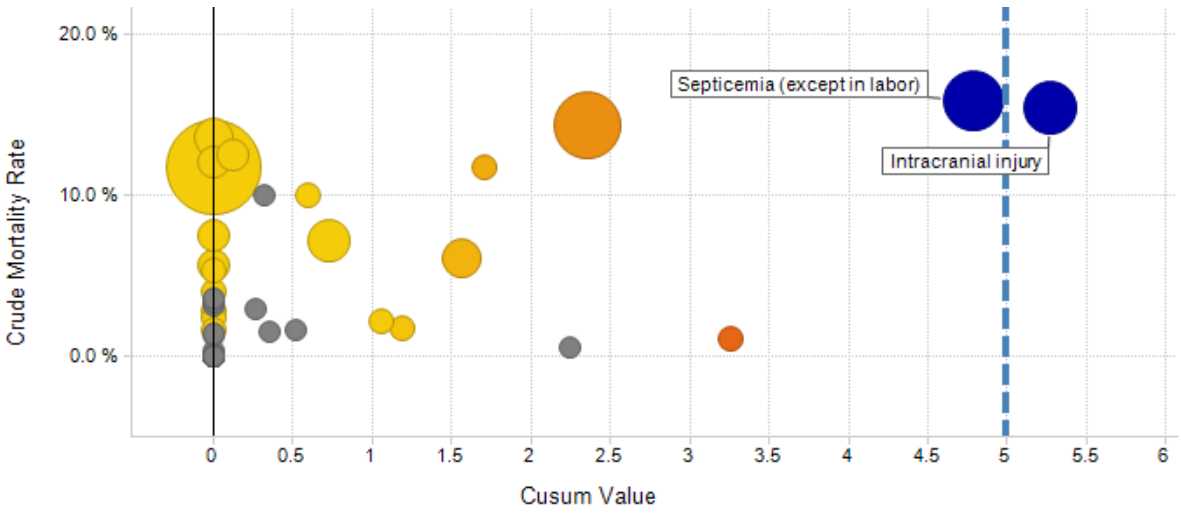


Figure 1: CCS Groups for QEHB, September 2018

HGS:

Two CCS (Clinical Classification System) diagnosis groups had higher than expected number of mortalities in September 2018:

- Pneumonia (except that caused by tuberculosis or sexually transmitted disease) – 44 observed deaths, 30.44 expected deaths. This triggered in September 2018.
- Acute Bronchitis – 6 observed deaths, 4.38 expected deaths.

The case-lists for these will be provided to an Associate Medical Director for review.

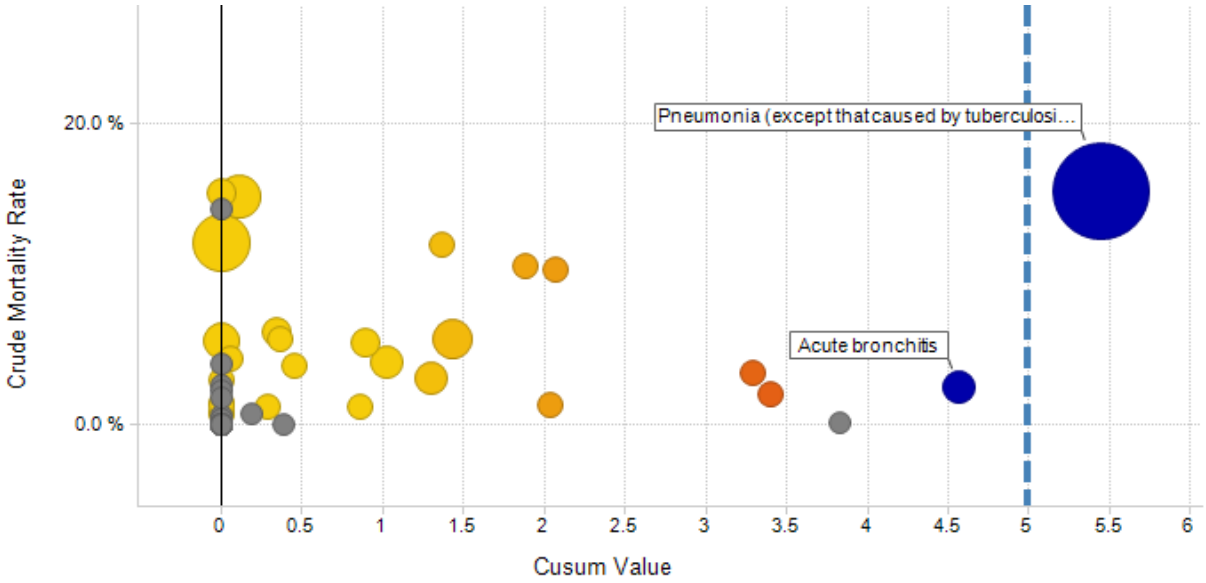


Figure 2: CCS Groups for HGS, September 2018

The overall mortality rates for QEHB and HGS as measured by the CUSUM are within the acceptable limits (see Figure 3 below).

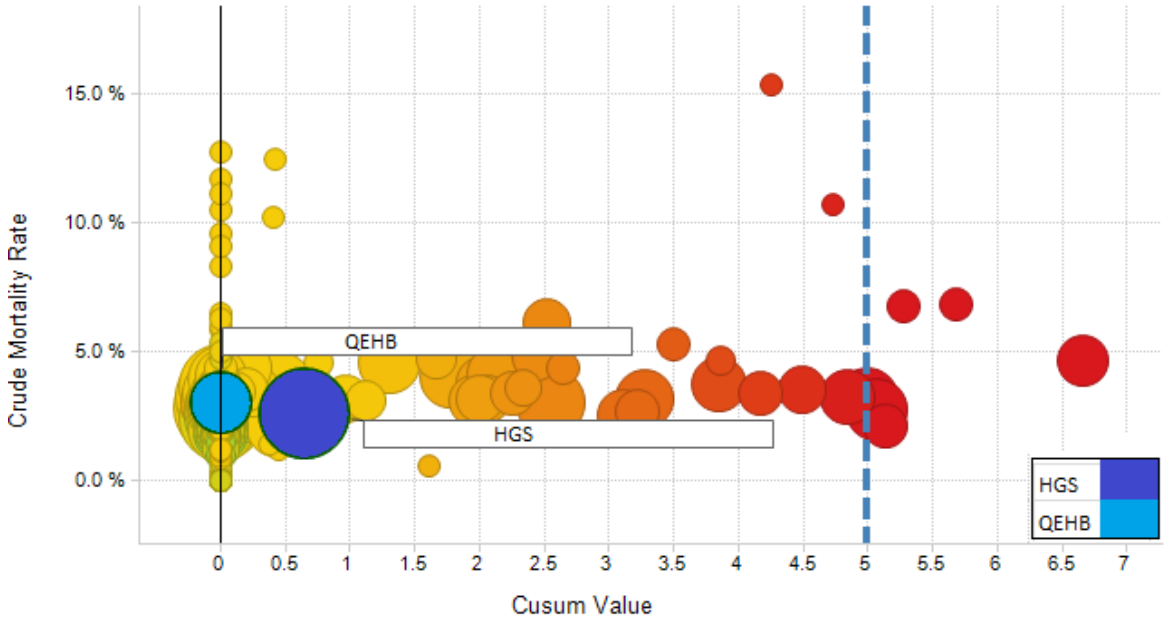


Figure 3: Mortality CUSUM at Trust level, September 2018

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

3.1. QEHB

QEHB's SHMI performance for the period April 2017 to March 2018 was 102. The expected level is 100. There were 2,687 deaths compared with 2,628 expected.

3.2. HGS

HGS's SHMI performance for the period April 2017 to March 2018 was 96. The expected level is 100. There were 4,622 deaths compared with 4,803 expected.

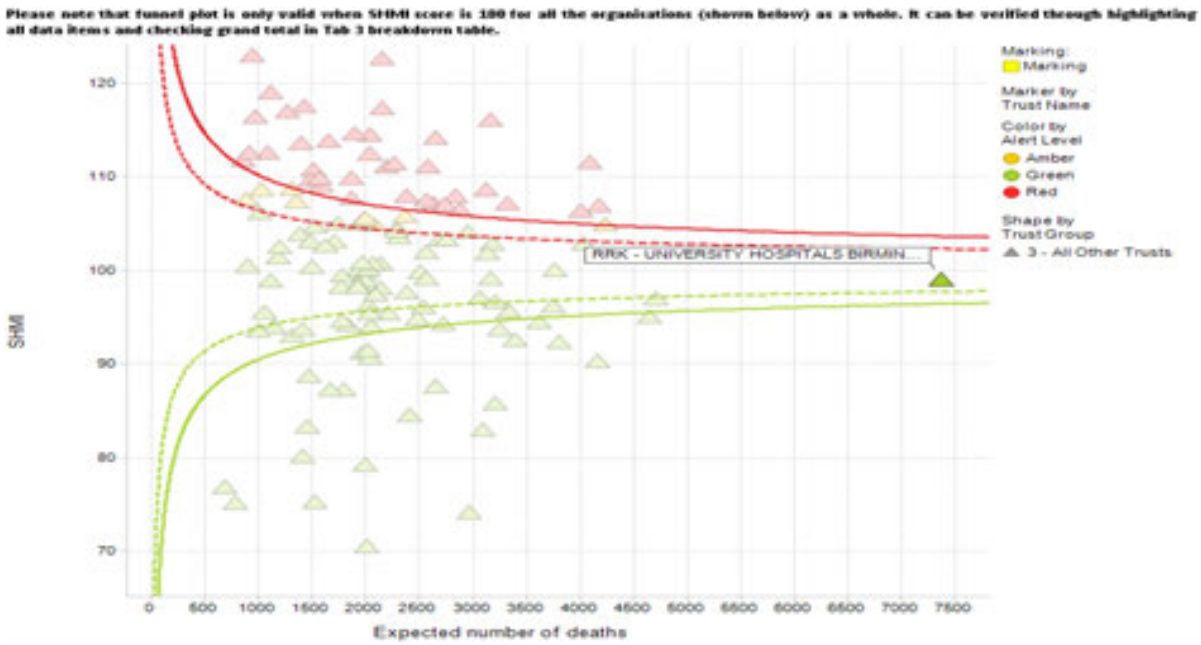


Figure 4: Trust SHMI April 2017 to March 2018

Treatment Site Name	SHMI	Expected number of deaths	Number of patients discharged who died in hospital or within 30 days	Number of total discharges	Average comorbidity score per spell	Crude mortality rate	Obs. - Exp.
GOOD HOPE HOSPITAL	94.88	1852.80	1758	58482	3.88	3.01%	-95
HEARTLANDS HOSPITAL	99.59	2172.86	2164	102069	2.91	2.12%	-9
QUEEN ELIZABETH HOSPITAL	107.34	59.62	64	2770	3.40	2.31%	4
QUEEN ELIZABETH HOSPITAL BIRMINGHAM	102.13	2568.29	2623	65181	5.51	4.02%	55
SOLIHULL HOSPITAL	90.01	777.68	700	20974	4.15	3.34%	-78
Grand total	98.35	7431.44	7309	249553	3.93	2.93%	-122

4. Trust HSMR (Hospital standardised mortality ratio)

UHB HSMR, between April 2018 to September 2018, was 105.88 due to 1993 observed deaths compared to 1882 expected.

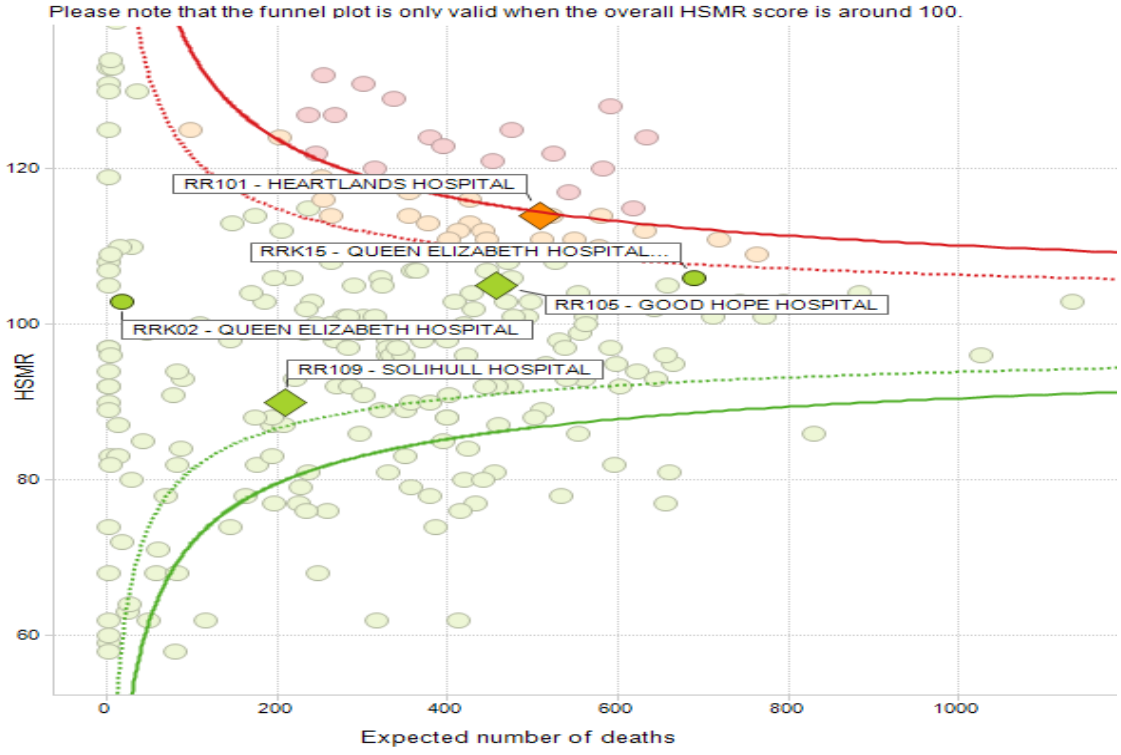


Figure 6: Trust HSMR April 2018 to September 2018

Treatment Site	Number of discharges	Expected number of deaths	Number of deaths	HSMR	Average comorbidities per spell	Crude mortality rate	Obs. - Exp.
RR101 - HEARTLANDS HOSPITAL	19647	508.74	578	113.61	4.85	2.94%	69
RR105 - GOOD HOPE HOSPITAL	16252	457.14	480	105.00	5.69	2.95%	23
RR109 - SOLIHULL HOSPITAL	9554	209.85	189	90.06	5.76	1.98%	-21
RRK02 - QUEEN ELIZABETH	1890	16.58	17	102.52	4.06	0.90%	0
RRK15 - QUEEN ELIZABETH	21954	690.06	729	105.64	5.87	3.32%	39
Grand total	69298	1882.37	1993	105.88	5.47	2.88%	111

5. Learning from Deaths Quarter 3, 2018/19.

In line with national *Learning from Deaths* requirements, a summary of the results of reviews of inpatient deaths during Quarter 3, 2018/19 was completed and is at Appendix A. The report includes information for all hospital sites for benchmarking purposes.

6. Never Events

The Trust has reported two serious incidents that met Never Event criteria between 12th October 2018 and 10th January 2019. These were misplaced nasogastric tube incidents occurred on different sites and within different specialties (Critical care, Good Hope Hospital and Neurosurgery, Queen Elizabeth Hospital). Investigations are in progress.

There are currently three Never Event incident investigations, previously reported to the Board, that are in progress. In addition to these three NE investigations, two incidents (unintentional transfusion of blood group B+; guidewire left in situ) previously reported to the Board were subsequently downgraded as the investigations confirmed they did not meet Never Event criteria.

7. Recommendations

The Board of Directors is asked to:

Discuss the contents of this report.

Prof. Simon Ball,
Executive Medical Director

University Hospitals Birmingham FT
Learning from Deaths Quarter 3 2018-19
01/10/2018 – 31/12/2018

1. Introduction

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

A summary of 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.

2.3. 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.

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

2.4.1. Score 1: Definitely avoidable
2.4.2. Score 2: Strong evidence of avoidability
2.4.3. Score 3: Probably avoidable
2.4.4. Score 4: Possibly avoidable but not very likely
2.4.5. Score 5: Slight evidence of avoidability
2.4.6. Score 6: Definitely not avoidable.

2.5. It is important to note that Medical Examiners are, by design, 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 to provide a definitive final view on each case.

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

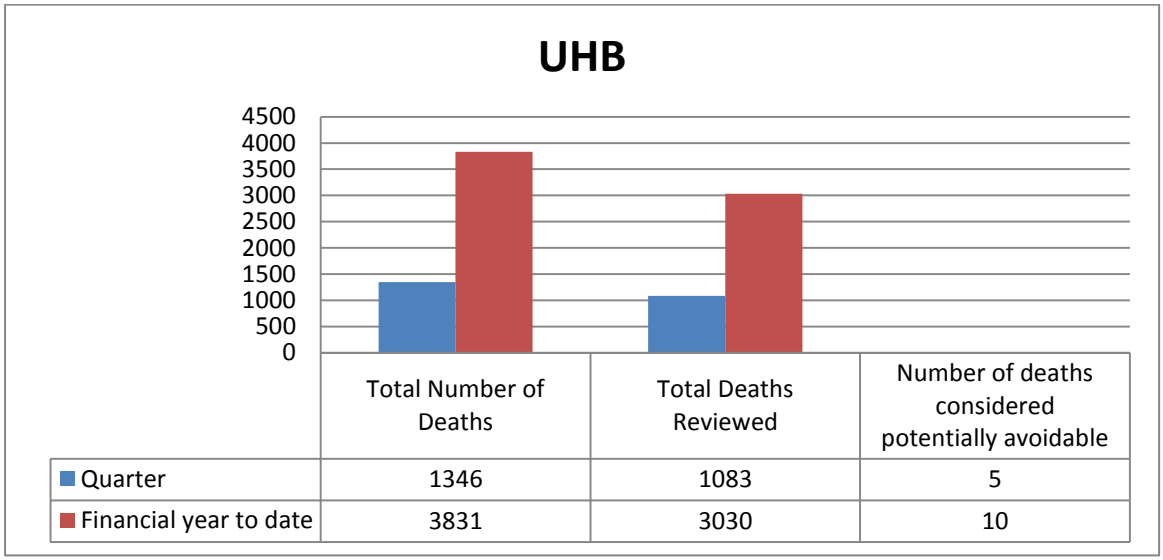
2.7. The graph below shows the total number of deaths in the Trust within the last quarter, the total number of deaths reviewed by the Medical Examiners, and the number considered potentially avoidable broken down by site.

2.8. 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:

2.8.1. 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.

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

2.8.3. Deaths referred to out of areas Coroners, where the notes are also not available to the Trust.



	Total Number of Deaths	Total Deaths Reviewed	Number of deaths considered potentially avoidable
Quarter	1346	1083	5
Financial year to date	3831	3030	10

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.

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

2.9.1. The first of these refers to a potential never event relating to a wrongly sited NG tube. This had already been identified via the Trust's incident reporting process and had been escalated; it is currently under investigation as a Serious Incident (SI).

2.9.2. The second relates to a patient who fell as an inpatient and suffered a large subdural haemorrhage. This had already been identified via the Trust's incident reporting process and been escalated and investigated via the falls investigation process.

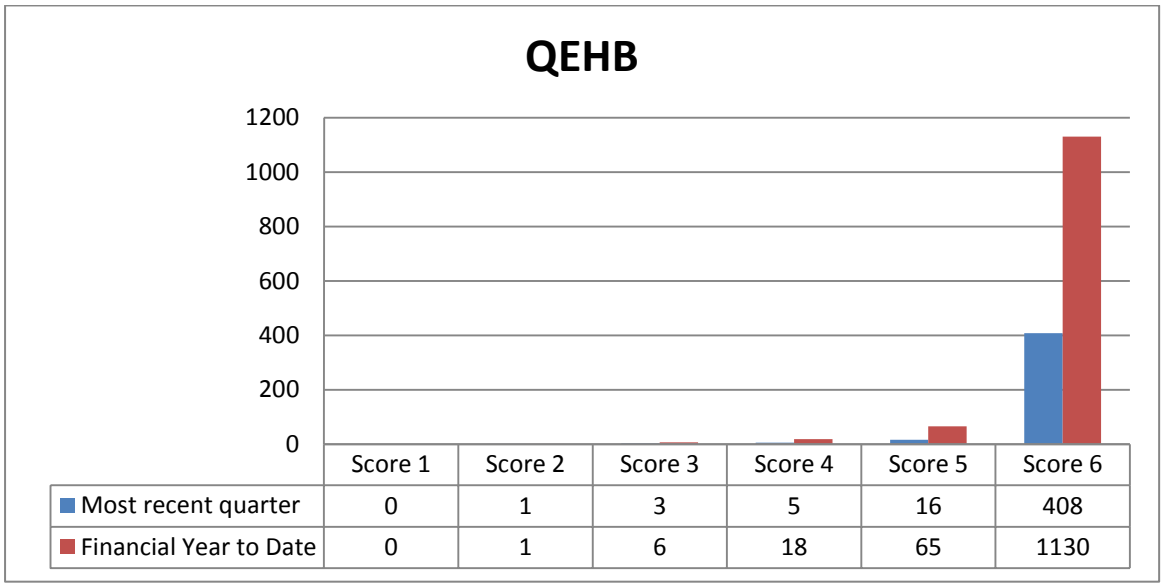
2.9.3. The third relates to a patient who had an outpatient CT scan that identified a possible pulmonary embolism. This was not reported for several weeks before the patient attended having suffered an arrest. The patient in question had metastatic pancreatic cancer and it is not clear whether this or the PE was the cause of their deterioration. This case is currently under review.

2.9.4. The fourth relates to a concern regarding initial medical review and care of a deteriorating patient who died within 12 hours of attendance on CDU. The ME concerns relate to a lack of escalation of raised SEWS and no evidence of review by medical staff more senior than FY1.This is currently being scoped by the Acute Medicine CSL.

2.9.5. The fifth case relates to a patient who was discharged from GHH ED and was subsequently readmitted 24 hours later with severe sepsis. This was raised as an incident at the time and is under investigation as an SI.

2.10. Site Breakdown:

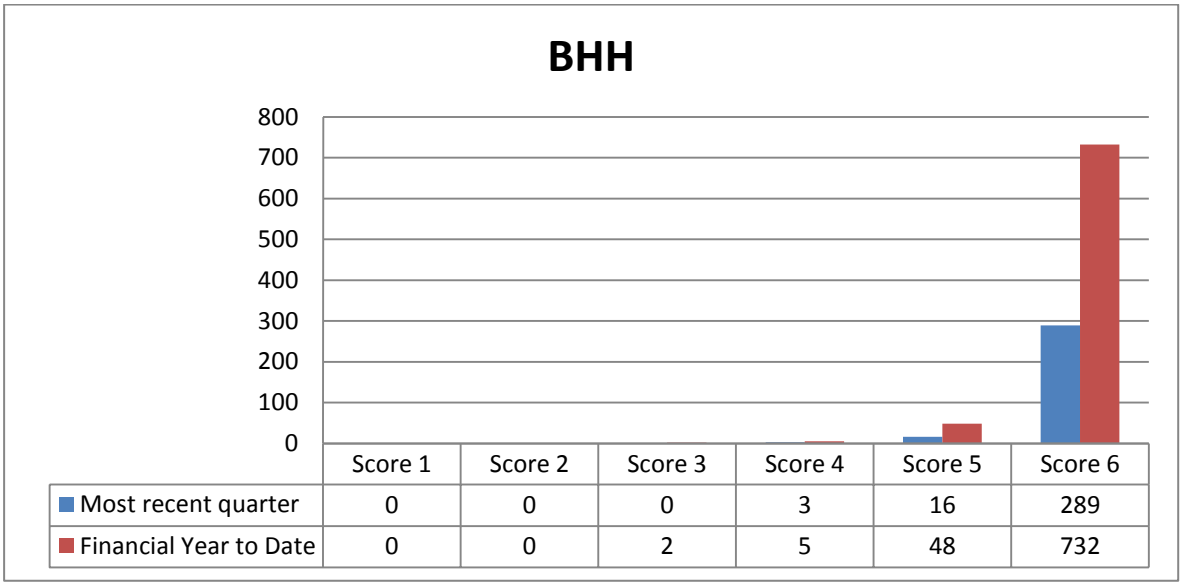
2.10.1. The graph below shows the breakdown of scoring against the RCP Avoidability of Death scoring system for Q3 at the Queen Elizabeth Hospital.



	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	1	3	5	16	408
Financial Year to Date	0	1	6	18	65	1130

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

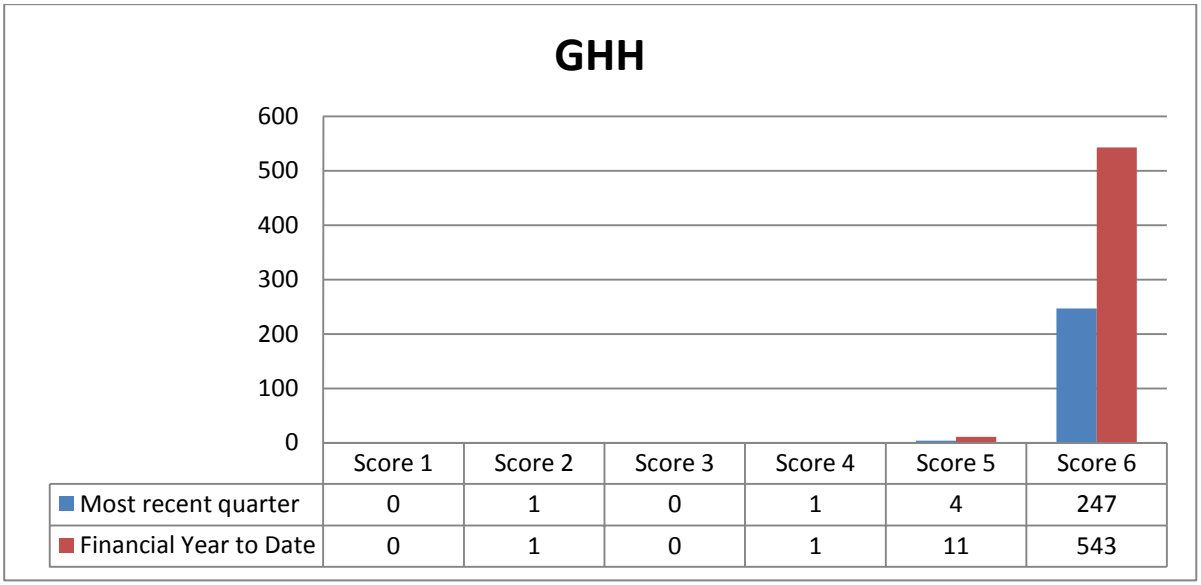
2.10.2. The graph below shows the breakdown of scoring against the RCP Avoidability of Death scoring system for Q3 at Heartlands Hospital.



	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	0	0	3	16	289
Financial Year to Date	0	0	2	5	48	732

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

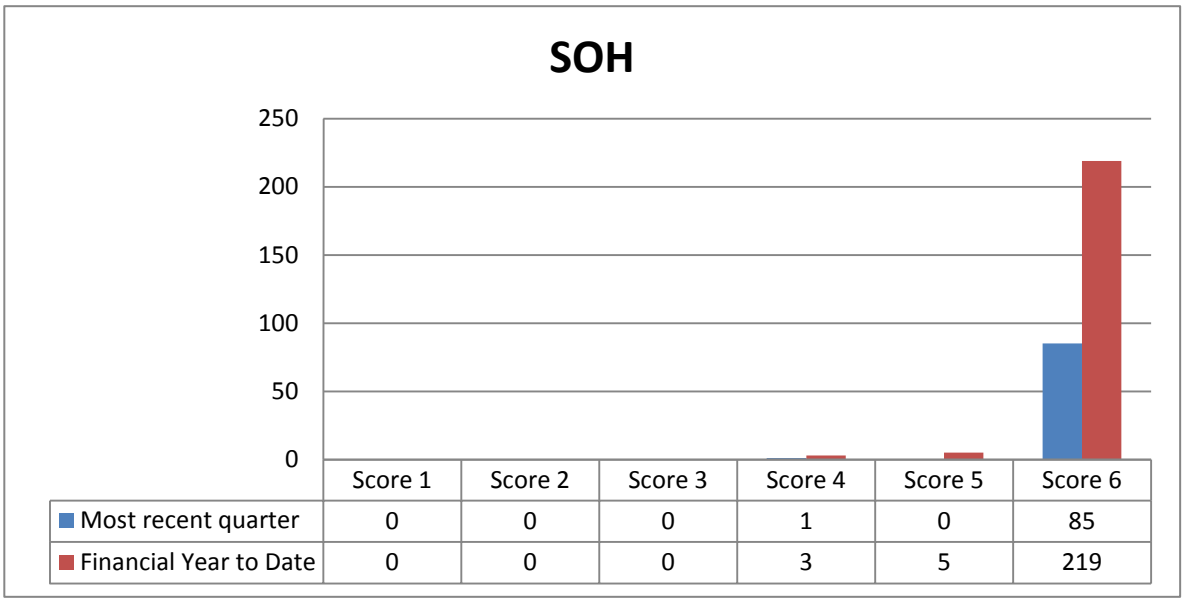
2.10.3. The graph below shows the breakdown of scoring against the RCP Avoidability of Death scoring system for Q3 at Good Hope Hospital.



	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	1	0	1	4	247
Financial Year to Date	0	1	0	1	11	543

Figure 4: Breakdown of number of deaths scoring each point on the RCP Avoidability of Death scoring system at GHH.

2.10.4. The below graph shows the breakdown of scoring against the RCP Avoidability of Death scoring system for Q3 at Solihull Hospital.



	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	0	0	1	0	85
Financial Year to Date	0	0	0	3	5	219

Figure 5: Breakdown of number of deaths scoring each point on the RCP Avoidability of Death scoring system at SOH.