UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 25 JULY 2019

Title:	**CLINICAL QUALITY MONITORING REPORT**
Responsible Director:	Prof. Simon Ball, Medical Director
Contact:	Mariola Smallman, Head of Medical Director's Services, 13768 James Bentley, Medical Director's Services Manager 13693

Purpose:	To present an update to the Board	
Confidentiality Level & Reason:	None	
Strategy Implementation Plan Ref:	#2 Eliminate unwarranted variation in services for patients through aligning and standardising pathways and service delivery #3 Provide the highest quality of care to patients through a comprehensive quality improvement programme #4 Meet regulatory requirements and operational performance standards, in line with agreed trajectories	
Key Issues Summary:	• Latest performance for a range of mortality indicators (CUSUM, SHMI, HSMR). • Learning from Deaths, Q1 2019/20 – Appendix A • Summary of Serious Incidents (SIs) meeting Never Event criteria reported between 15/06/19 and 12/07/19	
Recommendations:	To discuss the contents of this report.	
Approved by:	Prof. Simon Ball	Date: 12/07/2019

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 25 JULY 2019

CLINICAL QUALITY MONITORING REPORT
PRESENTED BY MEDICAL DIRECTOR

1. Introduction

The aim of this paper is to provide assurance of the clinical quality to the Board of Directors, following the July 2019 Clinical Quality Monitoring Group (CQMG) meetings and the Clinical and Professional Review of Incidents Group (CaPRI) meetings. The Board of Directors is requested to discuss the contents of this report and approve any actions identified.

2. Mortality - CUSUM

UHB had 7 CCS diagnosis groups that had higher than expected number of mortalities in March 2019:

- Coronary atherosclerosis and other heart disease – 9 observed deaths, compared to 5 expected.
- Pneumonia (except that caused by tuberculosis or sexually transmitted disease) – 289 deaths compared to 252.8 expected.
- Aspiration pneumonitis; food/vomitus – 58 deaths compared to 45 expected.
- Intestinal obstruction without hernia – 25 deaths compared to 14 expected.
- Fracture of neck of femur (hip) – 26 observed deaths, compared to 22.1 expected.
- Intracranial injury – 31 observed deaths compared to 21.3 expected.
- Complication of devise; implant or graft – 13 observed deaths compared to 7.1 expected.

The case-lists for these are subject to internal review processes.

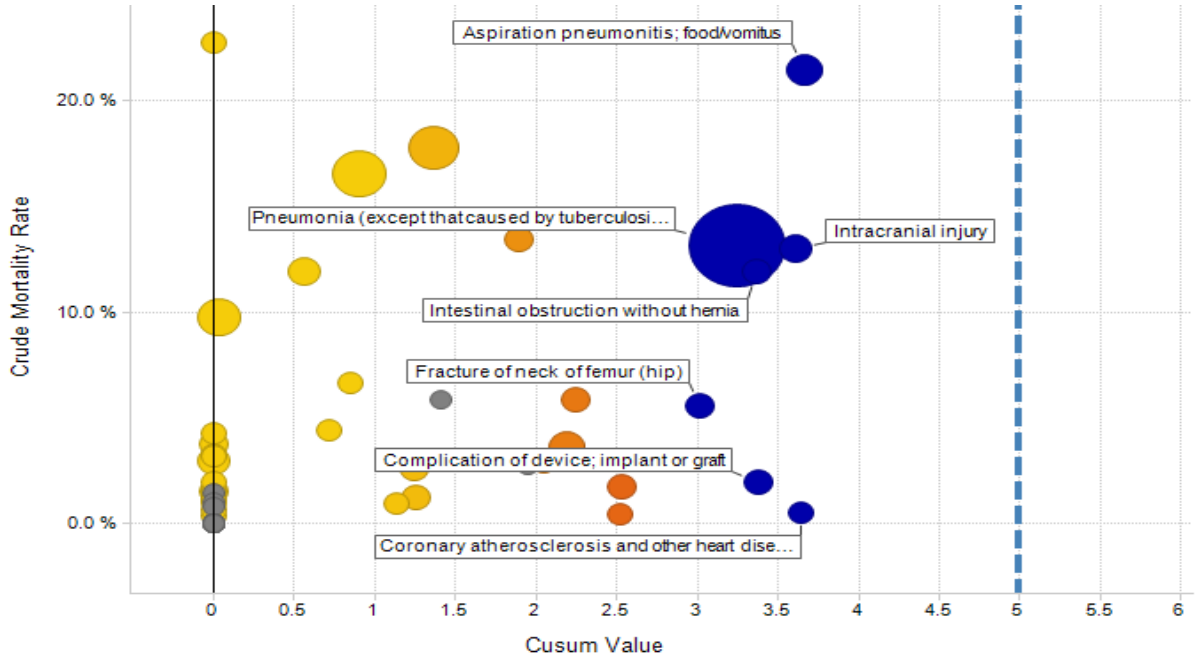


Figure 1: CCS Groups for UHB, March 2019

The overall mortality rates for UHB as measured by the CUSUM is within the acceptable limits (see Figure 2 below).

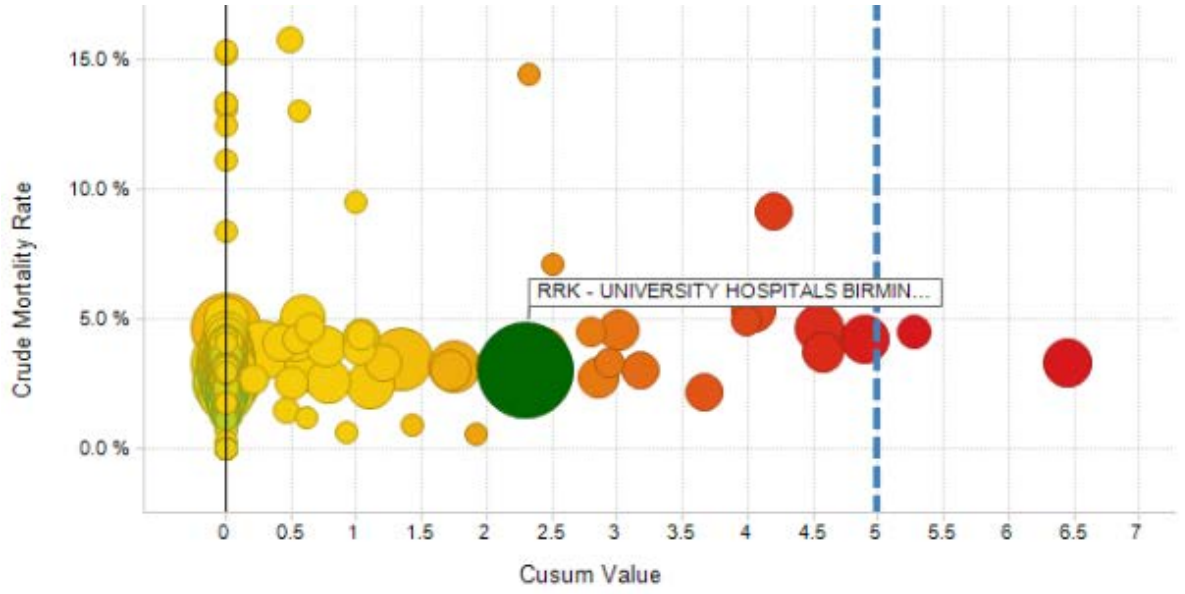


Figure 2: Mortality CUSUM at Trust level, March 2019

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

UHB's SHMI performance for the period April 2018 to December 2018 was 92.6. The expected level is 100. There were 5125 deaths compared with 5534 expected.

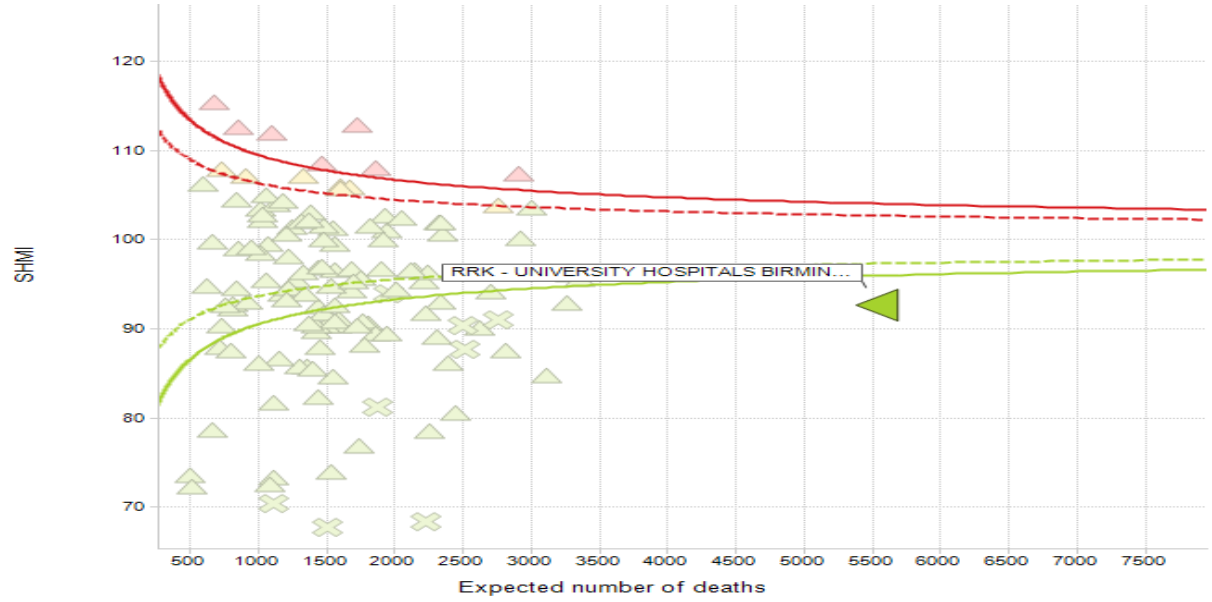


Figure 3: Trust SHMI April 2018 to December 2018

SHMI Apr 18 to Dec 18

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	88.8	1377.28	1223	48458	4.05	2.52%	-154
HEARTLANDS HOSPITAL	91.29	1582.81	1445	75371	3.00	1.92%	-138
QUEEN ELIZABETH HOSPITAL BIRMINGHAM	101.18	1919.33	1942	55789	5.35	3.48%	23
SOLIHULL HOSPITAL	77.4	620.15	480	21162	5.08	2.27%	-140
Grand total	92.61	5534.05	5125	202661	4.12	2.53%	-409

4. Trust HSMR (Hospital standardised mortality ratio)

UHB HSMR; between April 2018 to March 2019 was 106 due to 4222 observed deaths compared to 3972 expected.

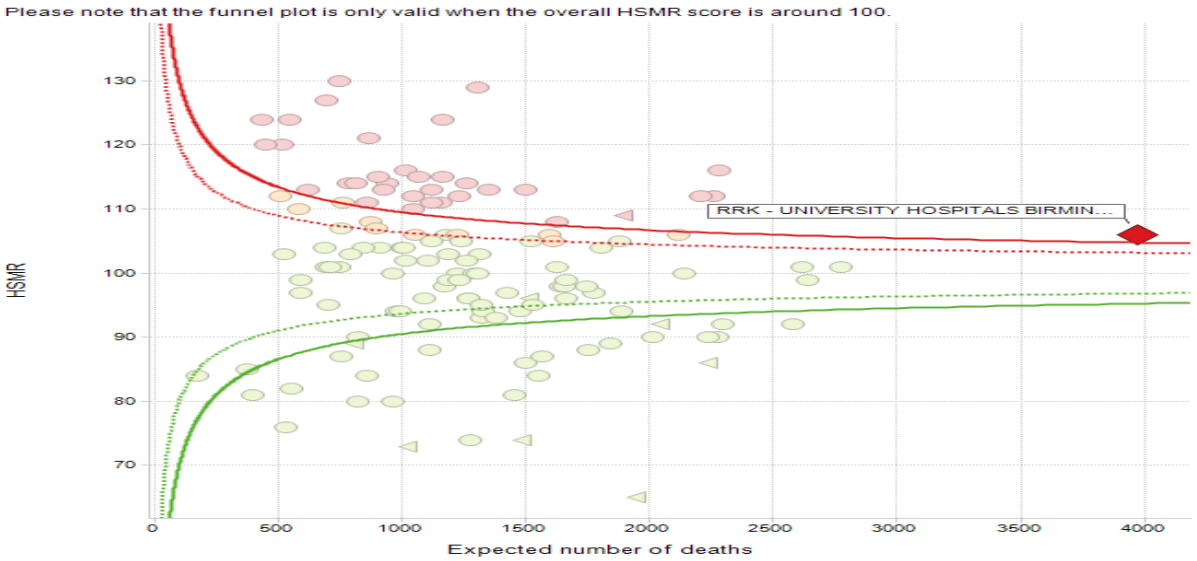


Figure 4: Trust HSMR April 2018 to March 2019

Apr-18 to Mar-19 HSMR

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	40306	1061.23	1173	110.53	4.75	2.91%	112
RR105 - GOOD HOPE HOSPITAL	33474	972.14	1014	104.31	5.71	3.03%	42
RR109 - SOLIHULL HOSPITAL	20700	468.99	419	89.34	5.84	2.02%	-50
RRK15 - QUEEN ELIZABETH HOSPITAL BIRMINGHAM	43633	1446.47	1586	109.65	6.04	3.63%	140
Grand total	141917	3972.84	4222	106.27	5.52	2.97%	249

5. Learning from Deaths

In line with national Learning from Deaths requirements, a summary of the results of reviews of inpatient deaths during Quarter 1, 2019/20 was completed and is at Appendix A. The report includes information for all hospital sites for benchmarking purposes.

6. Never Events

The Trust has not reported any serious incidents that met Never Event criteria between 15th June 2019 and 12th July 2019. One Never Event (injection into incorrect eye) investigation is in progress.

7. Recommendations

The Board of Directors is asked to:

Discuss the contents of this report.

Prof. Simon Ball,
Medical Director

Appendix A

Learning from Deaths
Quarter 1, 2019/20

1. Introduction

1.1. The purpose of this report is to provide the Board of Directors with a summary of the all inpatient deaths between 1st April and 30th June.

2. The Trust's process for reviewing inpatient deaths

2.1. The Trust has agreed a final process for escalating reviews of inpatient deaths and outcomes of Medical Examiner/M&M reviews.

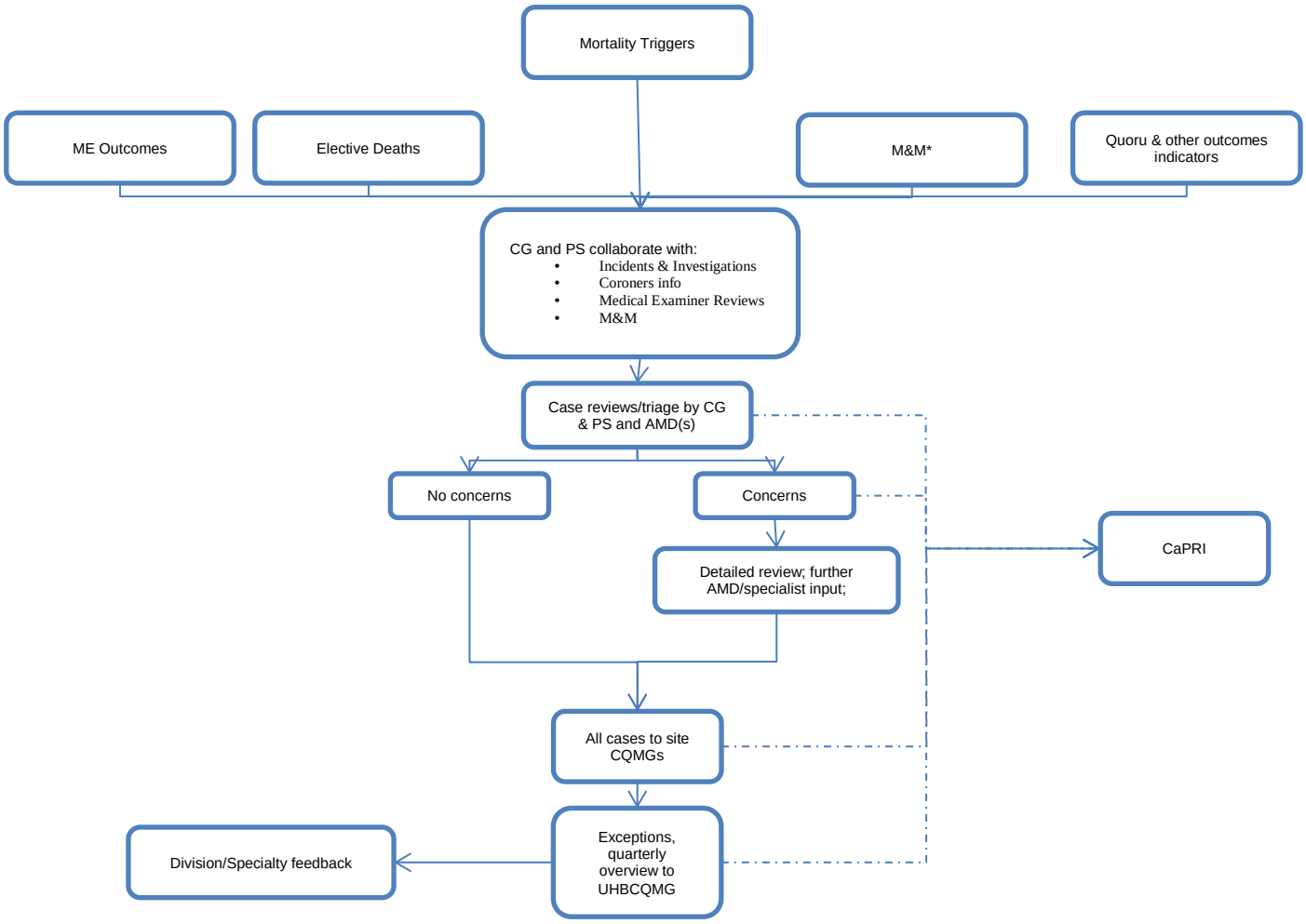


Figure 1: Trust Mortality Review Process

3. External Measures

3.1. 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:

- The total number of inpatient deaths in the Trust
- The total number of deaths receiving a front line review
- The number identified to be more likely than not due to problems in care

3.2. 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. 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.

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

- Score 1: Definitely avoidable
- Score 2: Strong evidence of avoidability
- Score 3: Probably avoidable
- Score 4: Possibly avoidable but not very likely
- Score 5: Slight evidence of avoidability
- Score 6: Definitely not avoidable

3.4. 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. 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.

3.5. The graph below shows: the total number of deaths within the Trust during the last quarter; the total number of deaths reviewed by the Medical Examiners; and the number considered potentially avoidable.

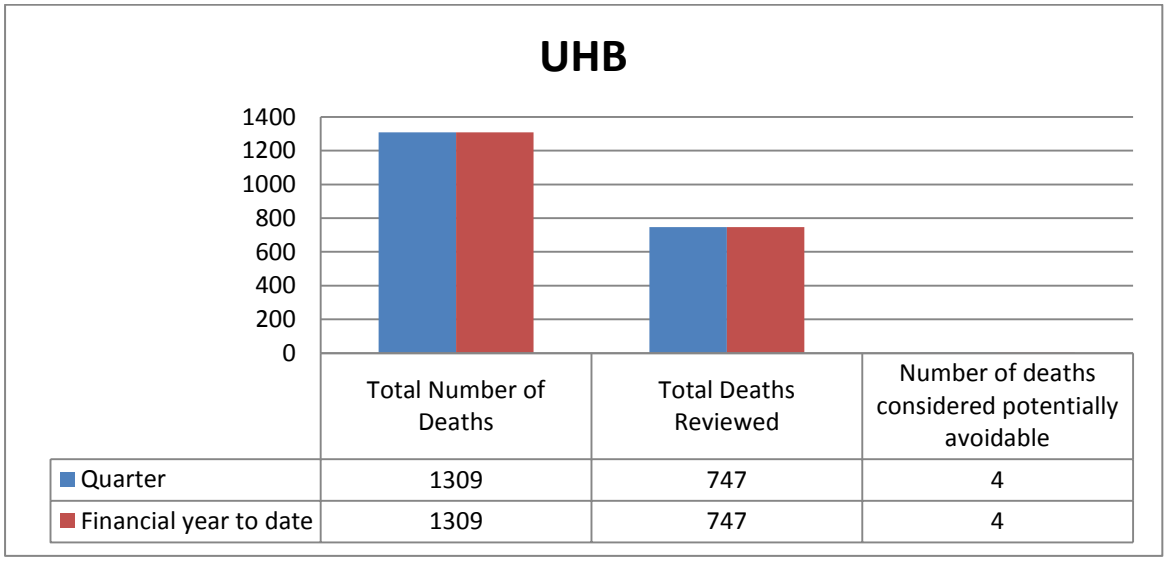


Figure 2: Number of front line reviews of deaths and those considered avoidable (a score of 3 or less on the RCP Avoidability of Death scoring system) based on front line Medical Examiner reviews.

3.6. Four deaths received a score of 3 or less which is the criteria for being classified as potentially avoidable:

- The first of these refers to a death in a patient who suffered a brainstem stroke and subsequently died following complications of an elective neurosurgical coiling procedure. The ME was not clear regarding the likelihood of this complication which led to the patient's death. This was escalated to CaPRI and is under investigation as a serious incident.

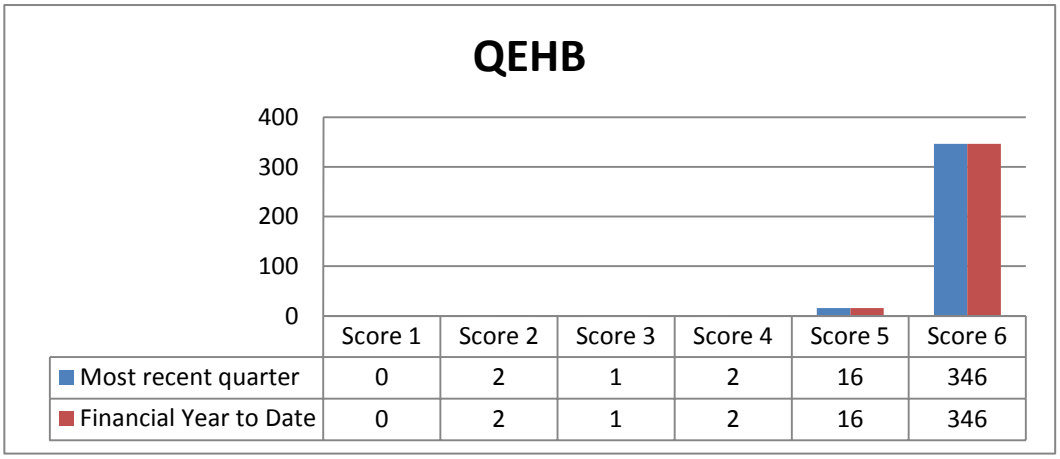
- The second relates to a patient with Atrial Fibrillation in whom warfarin was withheld following surgery. The patient subsequently suffered an ischaemic stroke and died. This has been discussed at CaPRI and is under further specialist review, however the initial opinion from two specialist reviews is that it is likely this was unavoidable.

- The third case relates to a patient who suffered a perforated stomach during an endoscopy and subsequently died. This was discussed at CaPRI and the decision made to complete a Divisional RCA.

- The fourth relates to management of the anticoagulation in a patient who subsequently developed a catastrophic brain haemorrhage. This has been presented to CaPRI and is being investigated as a serious incident.

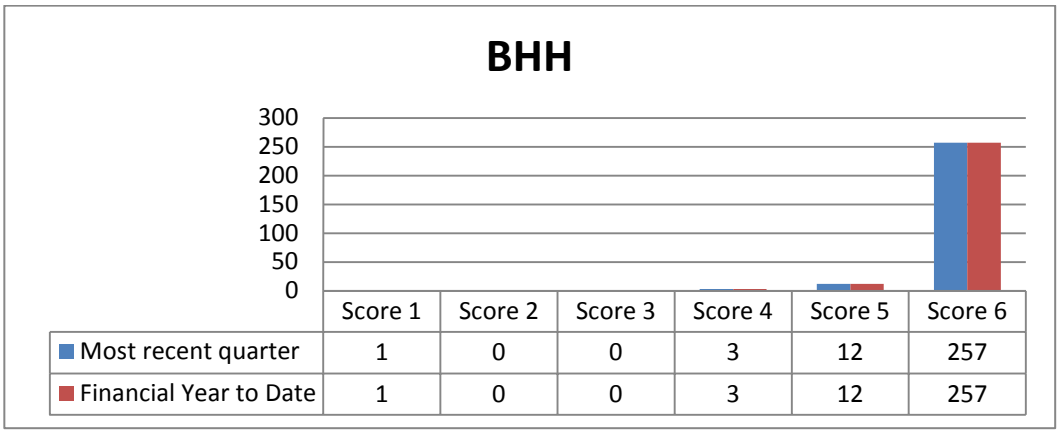
3.7. The graphs below show the breakdown of scoring against the avoidability measure across the four sites.

3.7.1. Avoidability scoring at QEH



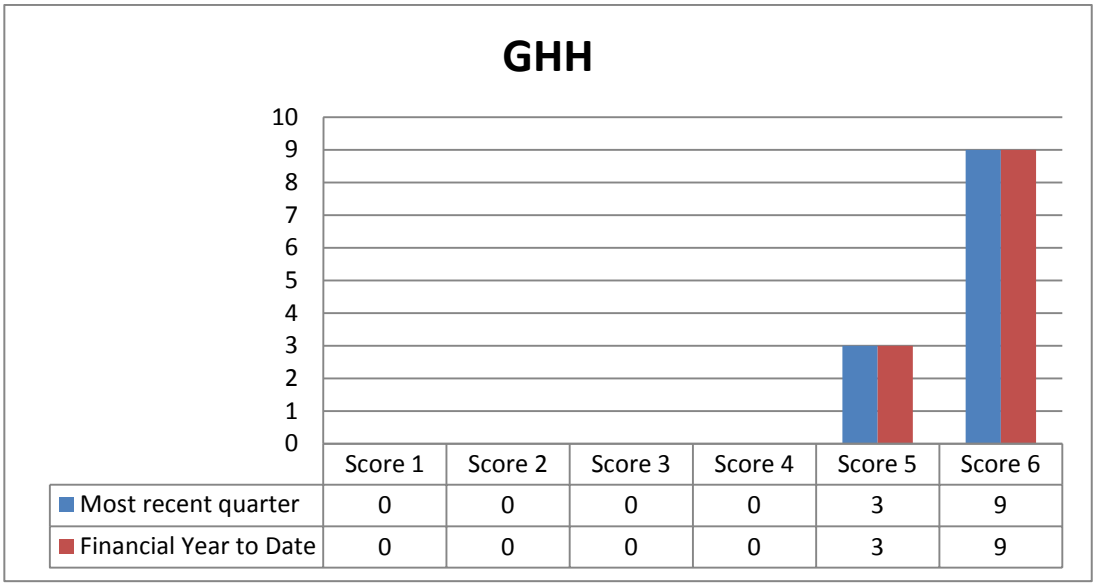
	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	2	1	2	16	346
Financial Year to Date	0	2	1	2	16	346

3.7.2. Avoidability scoring at BHH



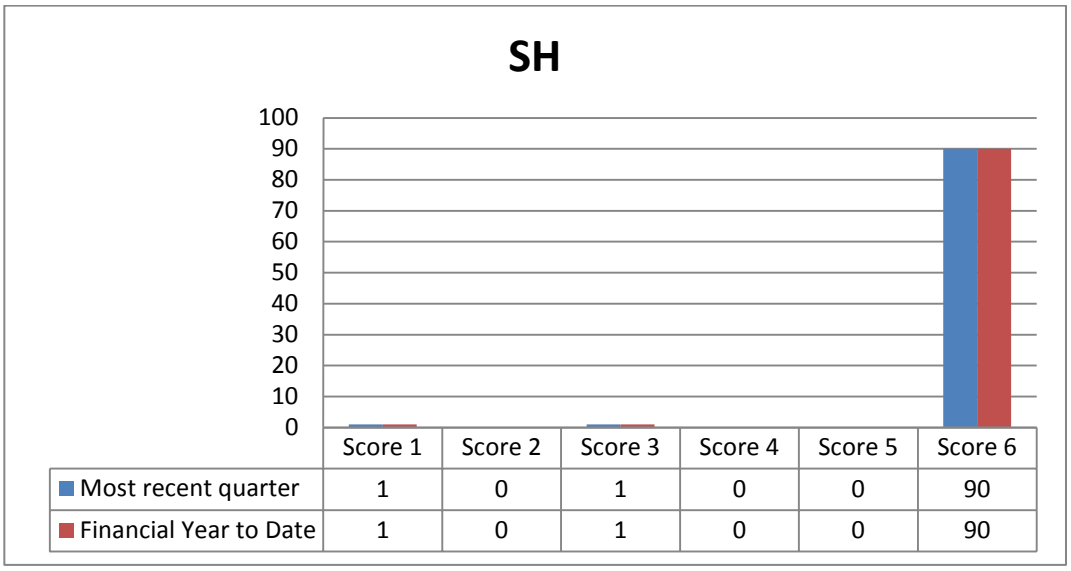
	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	1	0	0	3	12	257
Financial Year to Date	1	0	0	3	12	257

3.7.3. Avoidability scoring at GHH



	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	0	0	0	3	9
Financial Year to Date	0	0	0	0	3	9

3.7.4. Avoidability scoring at SH

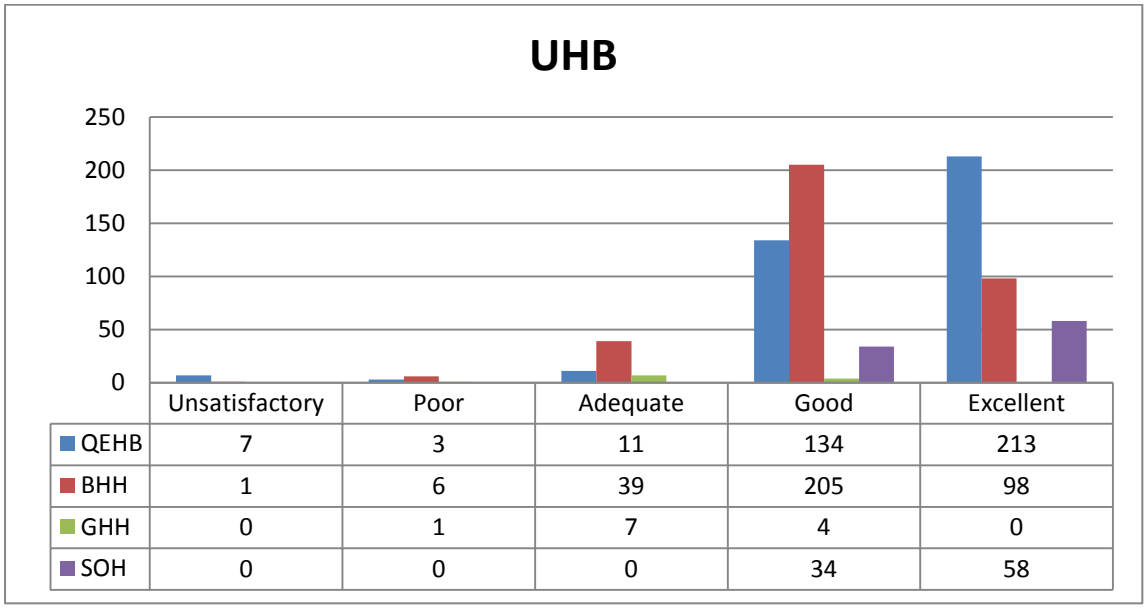


	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	1	0	1	0	0	90
Financial Year to Date	1	0	1	0	0	90

4. Internal Measures: Medical Examiner Outcomes

4.1. This shows performance against parts of the Medical Examiner review form which are only monitored and reported internally. Many of these measures relate to quality of care provided, regardless of the effect on the patient's outcome, whereas the external measures are primarily focused on outcomes.

4.2. Scoring of care, as per the RCP Summary Category of Care scoring system, is detailed below across each site to provide an overall view of performance this quarter.



	Unsatisfactory	Poor	Adequate	Good	Excellent
QEHB	7	3	11	134	213
BHH	1	6	39	205	98
GHH	0	1	7	4	0
SOH	0	0	0	34	58

4.2.1.1. The RCP Summary Category of Care scoring system is defined as follows:

- Excellent care: This was excellent care with no areas of concern.
- Good care: This was good care with only one or two minor areas of concern and no potential for harm to the patient
- Adequate care: This was satisfactory care with two or more minor areas of concern, but no potential for harm to the patient
- Poor Care: Care was suboptimal with one or more significant areas of concern, but there was no potential for harm to the patient
- Unsatisfactory care: Care was suboptimal in one or more significant areas resulting in the potential for, or actual, adverse impact on the patient.

4.2.1.2. Themes from quality of care scoring:

- Communication; in particular patients feeling 'listened to'
- Nutrition/hydration

5. Deaths in Patients with Learning Disabilities

5.1. There were 11 deaths in patients with Learning Disabilities within quarter 1 at UHB. None of these had any significant recognised care concerns causing harm and none required further escalation.