

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

Title:	PATIENT SAFETY EXCEPTION 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 April 2019 Clinical Quality Monitoring Group meetings 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:	<ul style="list-style-type: none"> • Latest performance for a range of mortality indicators (CUSUM, SHMI, HSMR). • Learning from Deaths, Quarter 4, 2018/19 update. • Summary of Serious Incidents (SIs) meeting Never Event criteria reported between 14/02/19 and 09/04/19. 	
Recommendations:	The Board of Directors is asked to: Discuss the contents of this report.	
Approved by:	Prof. Simon Ball	Date: 15/04/2019

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

**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 presentation of this data at the April 2019 Clinical Quality Monitoring Group meetings. The Board of Directors is requested to discuss the contents of this report and approve any actions identified.

2. Mortality - CUSUM

UHB:

Two CCS (Clinical Classification System) diagnosis groups had higher than expected number of mortalities between October and December 2018:

- Respiratory failure; insufficiency; arrest (adult) – 19 observed deaths compared to 11.97 expected.
- Chronic ulcer of skin – 6 observed deaths compared to 3.81 expected.

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

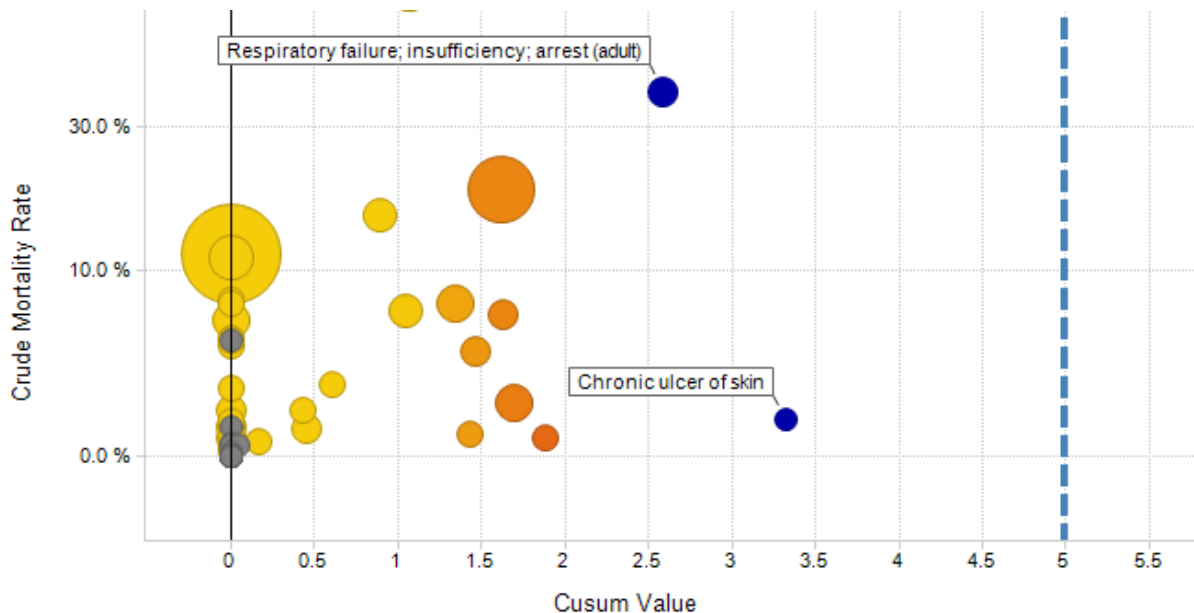


Figure 1: CCS Groups for UHB, December 2018

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

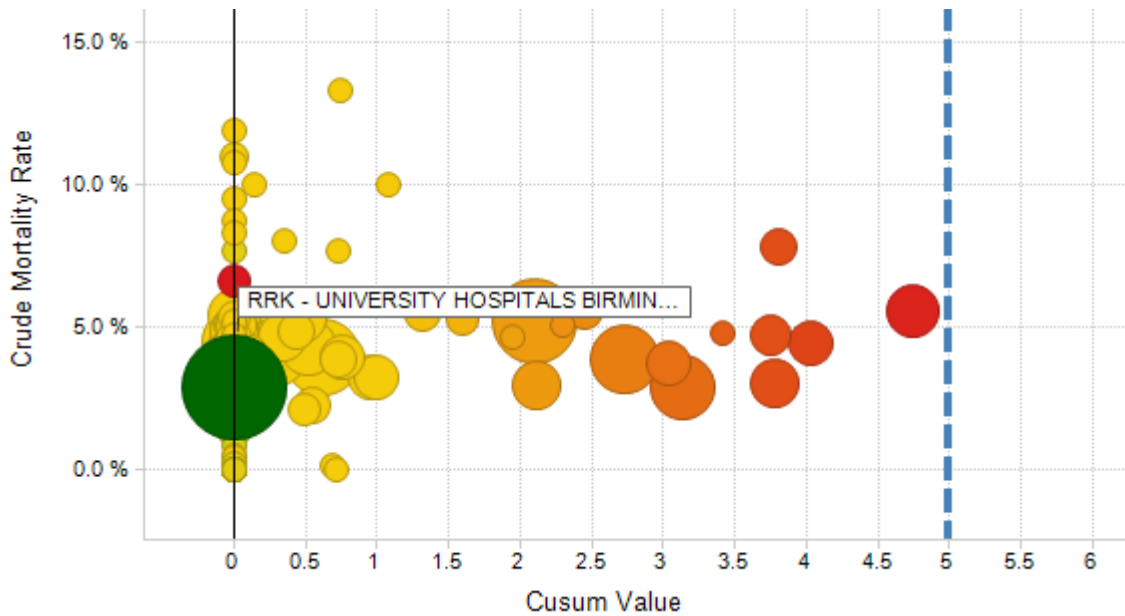


Figure 2: Mortality CUSUM at Trust level, December 2018

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

UHB's SHMI performance for the period April 2018 to November 2018 was 92. The expected level is 100. There were 4,523 deaths compared with 4,890 expected.

Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.

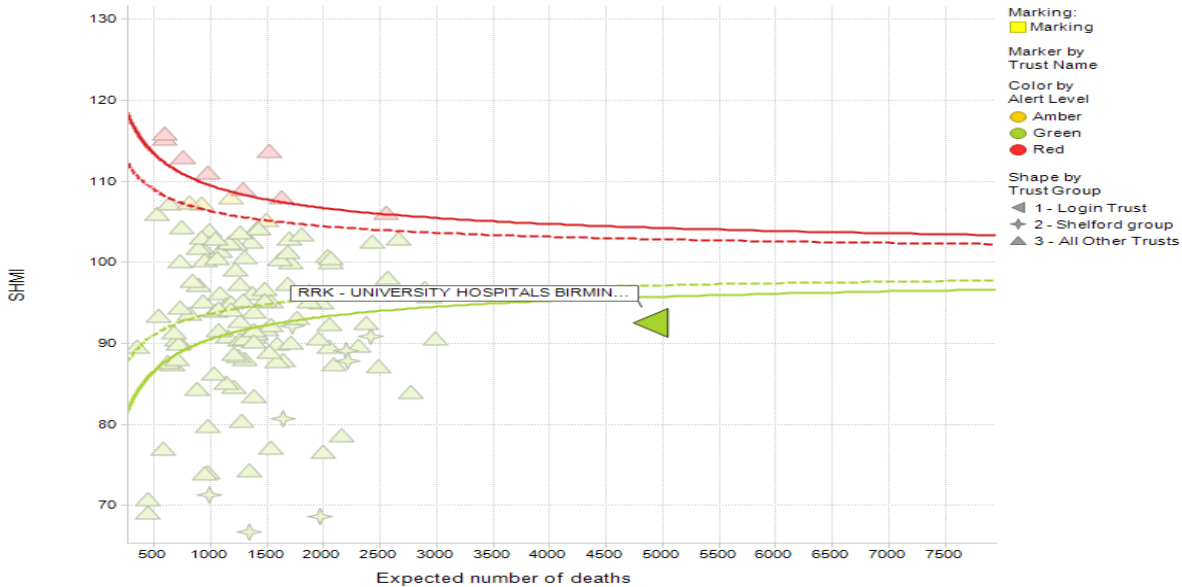


Figure 3: Trust SHMI April 2018 to November 2018

SHMI Apr 18 to Nov 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	87.92	1220.42	1073	43209	4.05	2.48%	-147
HEARTLANDS HOSPITAL	92.61	1396.21	1293	67570	2.98	1.91%	-103
QUEEN ELIZABETH	100.53	1696.08	1705	49736	5.31	3.43%	9
SOLIHULL HOSPITAL	77	545.48	420	18735	5.06	2.24%	-125
Grand total	92.49	4890.12	4523	180954	4.10	2.50%	-367

4. Trust HSMR (Hospital standardised mortality ratio)

UHB HSMR; between April 2018 to December 2018 was 102 due to 3003 observed deaths compared to 2932 expected.

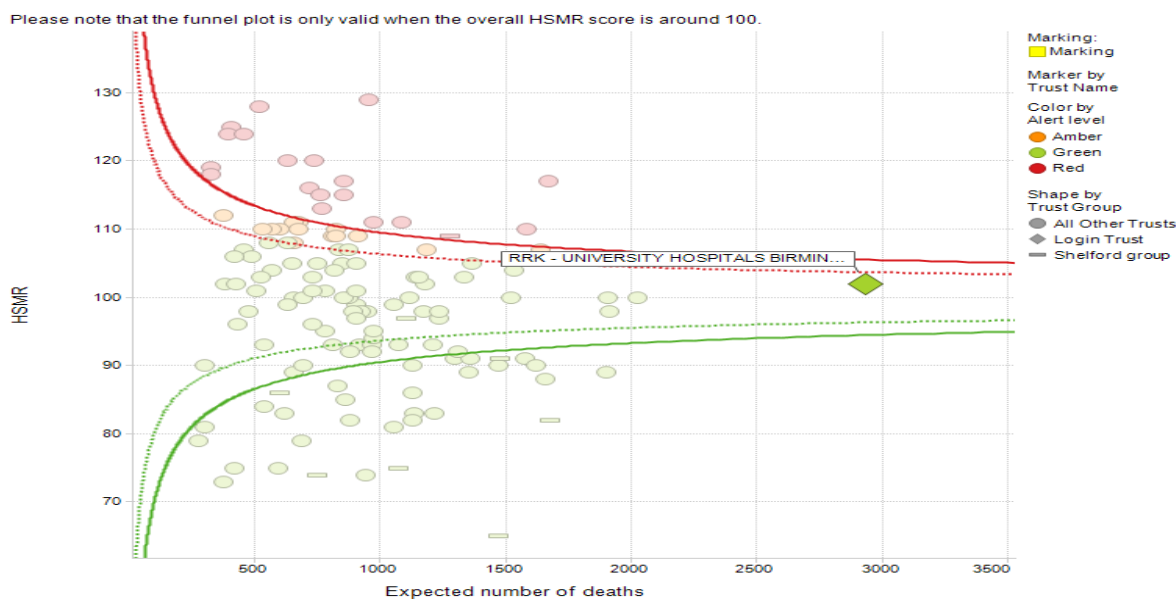


Figure 4: Trust HSMR April 2018 to December 2018

April-18 to December-18 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	30425	790.98	852	107.71	4.73	2.80%	61
RR105 - GOOD HOPE HOSPITAL	24977	721.46	719	99.66	5.67	2.88%	-2
RR109 - SOLIHULL HOSPITAL	15168	335.53	287	85.54	5.81	1.89%	-49
RRK15 - QUEEN ELIZABETH HOSPITAL BIRMINGHAM	32850	1063.33	1122	105.52	5.93	3.42%	59
Grand total	106273	2932.35	3003	102.41	5.46	2.83%	71

5. Learning from Deaths Quarter 4, 2018/19

In line with national *Learning from Deaths* requirements, a summary of the results of reviews of inpatient deaths during Quarter 4, 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 not reported any Never Events between 14th February 2019 and 9th April 2019. One investigation is in progress and the other Never Event investigation is complete and actions are in progress.

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 4, 2018-19

1. Introduction

1.1. The purpose of this report is to provide CQMG with:

1.1.1. A summary of the all inpatient deaths between 1st January and 31st March; and

1.1.2. A summary of the data that will go to the Board of Directors in April 2019.

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.

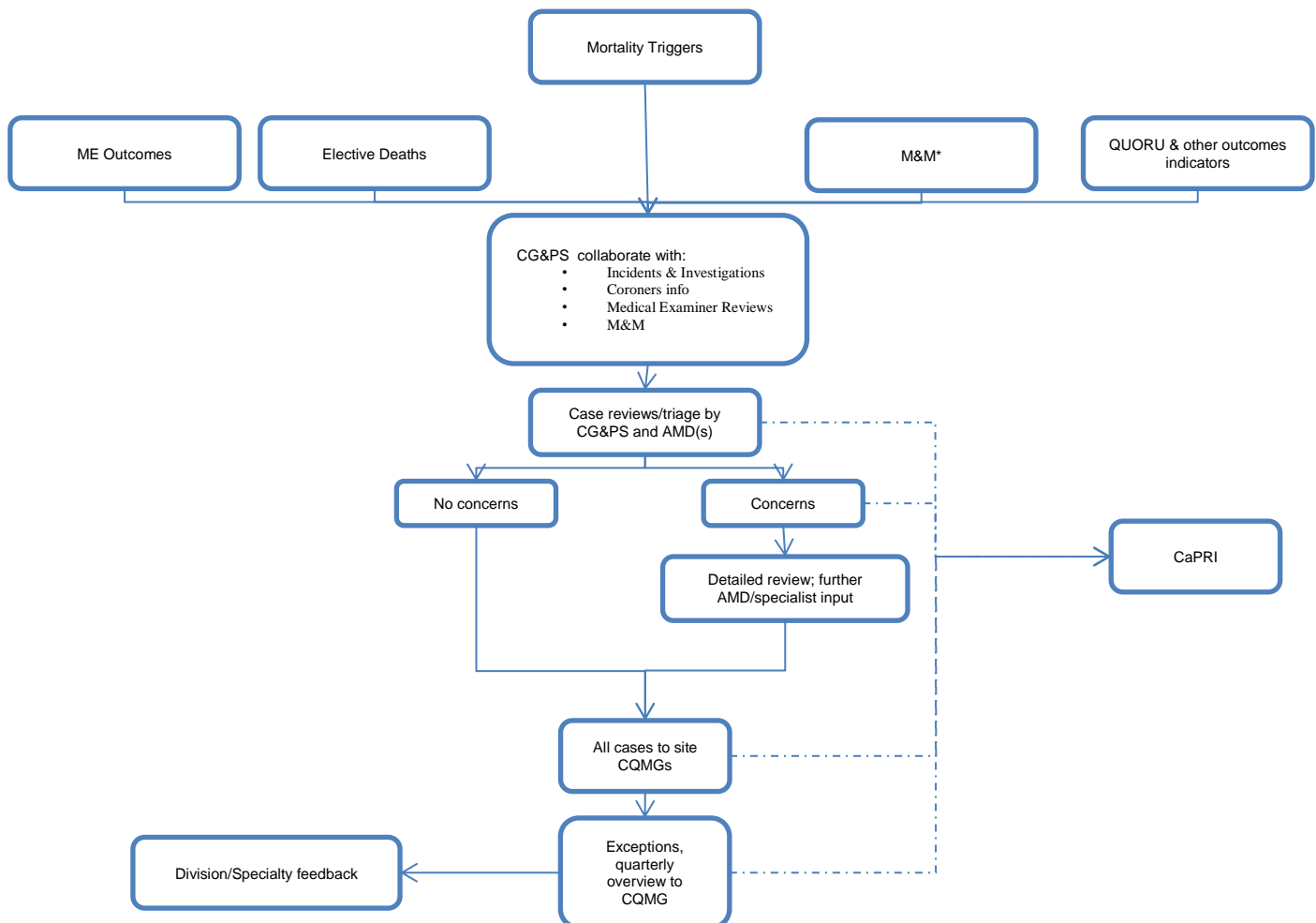


Figure 1: Trust Mortality Review Process

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:

3.1.1. The total number of inpatient deaths in the Trust.

3.1.2. The total number of deaths receiving a front line review.

3.1.3. 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.

3.2.1. 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.

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

3.3.1. Score 1: Definitely avoidable.

3.3.2. Score 2: Strong evidence of avoidability.

3.3.3. Score 3: Probably avoidable.

3.3.4. Score 4: Possibly avoidable but not very likely.

3.3.5. Score 5: Slight evidence of avoidability.

3.3.6. 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.

3.4.1. 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.

3.5. The below graph shows the total number of deaths within the two Trusts within the last quarter, the total number of deaths reviewed by the Medical Examiners, and the number considered potentially avoidable.

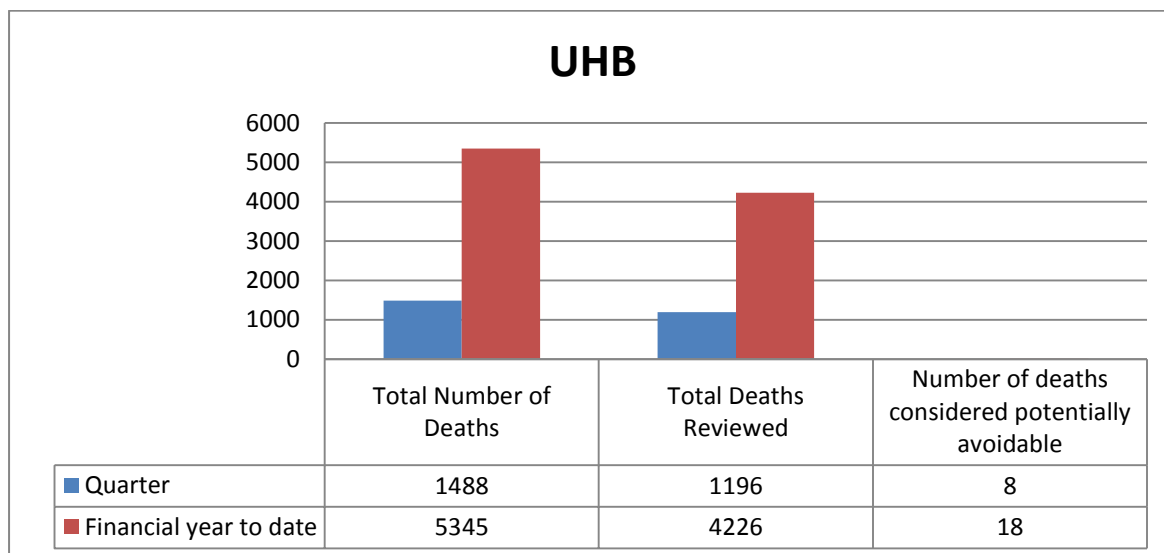


Figure 2: Number of front line reviews of deaths and those considered avoidable (a score of 3 or less on the RCP Avoidability of Death scoring system or score of 2 or higher on CESDI scoring system) based on front line Medical Examiner reviews.

3.5.1. 8 deaths received a score of 3 or less which is the criteria for being classified as potentially avoidable.

3.5.1.1. The first of these refers to a death which was potentially avoidable had the patient accepted their diagnosis and treatment for this. The patient continued to refuse treatment for their condition despite being informed of the likely consequences by staff. No concerns or actions regarding care for the Trust.

3.5.1.2. The second relates to a patient who was not followed up after an initial review in heart failure clinic. Patient re-attended two months later and subsequently died. This is being reviewed at a local level prior to presentation to the Trust's Clinical and Professional Review of Incidents group (CaPRI).

3.5.1.3. The third case relates to a patient who was a long corridor wait in the Emergency Department, and there was a potential lack of oxygen administered contributing to deterioration and death. Currently under investigation as a Serious Incident (SI).

3.5.1.4. The fourth relates to a concern regarding escalation to ITU and timeliness of ITU intervention for a critically unwell patient with influenza who died within 24 hours of admission. This has been presented to CaPRI with an outcome for further review at a local level.

3.5.1.5. The fifth case relates to a patient who had incorrect management of anti-coagulation which potentially contributed to a stroke. This was raised as an incident at the time and is under investigation as an SI.

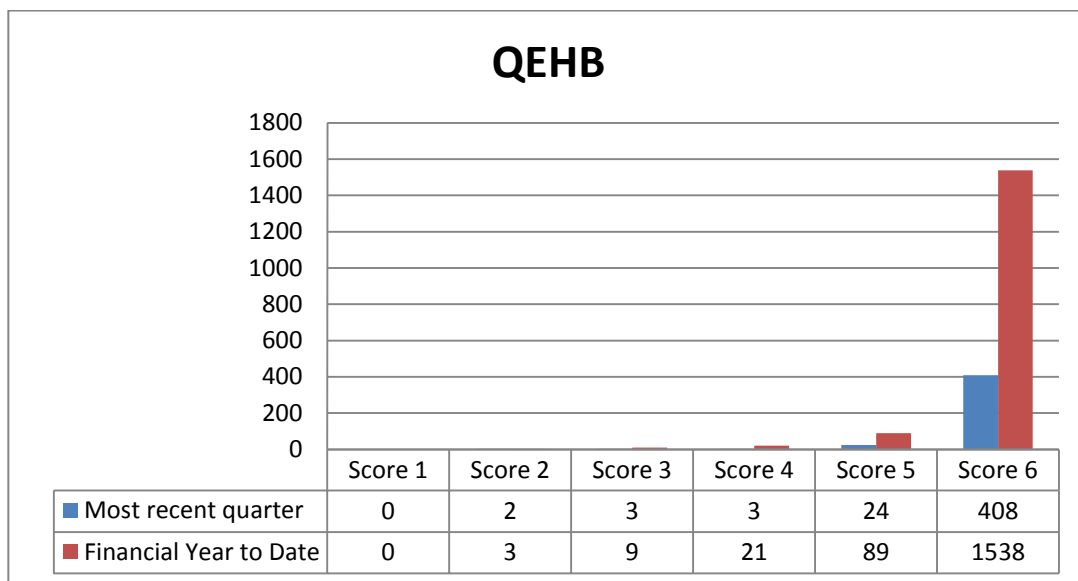
3.5.1.6. The sixth case refers to a patient who had a potentially delayed recognition and escalation of sigmoid volvulus, leading to deterioration to the point they were unfit for surgery. This was presented to CaPRI where the decision was made to investigate as an SI.

3.5.1.7. The seventh case refers to a patient who had delayed recognition and escalation of an incarcerated hernia/bowel obstruction. This was presented to CaPRI where the decision was made to investigate as an SI.

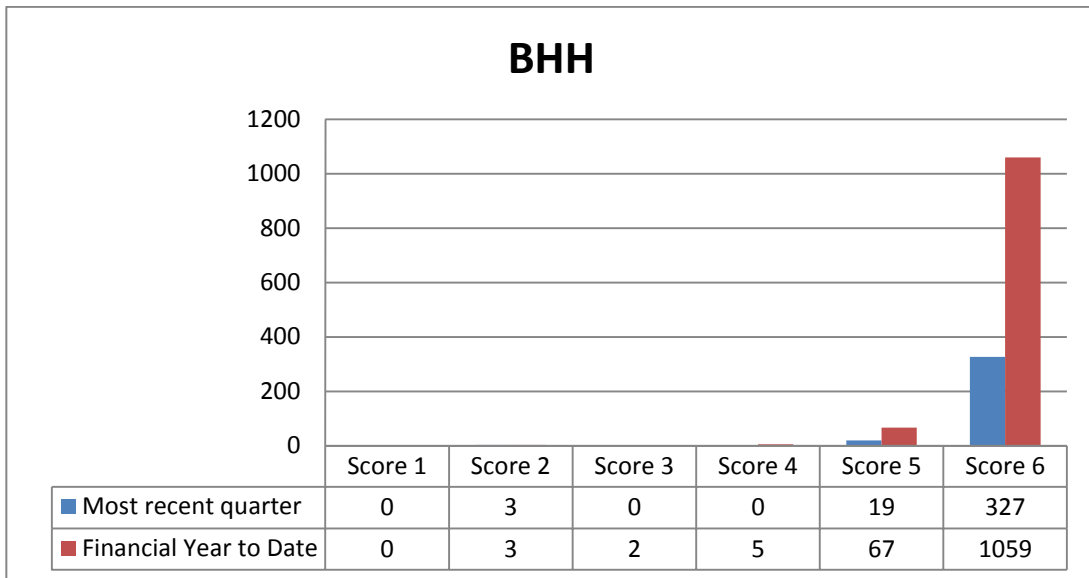
3.5.1.8. The eighth case refers to a case with concerns regarding the observations of a patient who was a long stay in resus in ED, who died after over 12 hours in ED. This is currently being scoped with the relevant clinical teams for presentation to CaPRI.

3.6. The below graphs show the breakdown of scoring against the avoidability measure across the 4 sites.

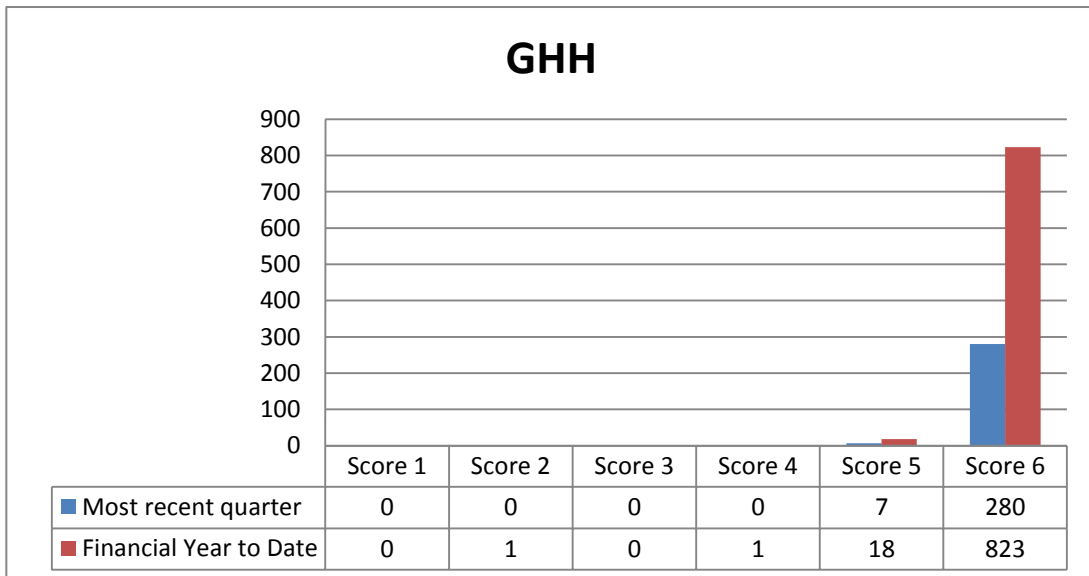
3.6.1. Avoidability scoring at QEHB



3.6.2. Avoidability scoring at BHH



3.6.3. Avoidability scoring at GHH



3.6.4. Avoidability scoring at SOH

