

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 25 OCTOBER 2018

Title:	CLINICAL QUALITY MONITORING REPORT
Responsible Director:	Mike Hallissey, Interim Executive Medical Director
Contact:	Mariola Smallman, Head of Medical Directors' Services, 13768

Purpose:	To provide assurance on clinical quality to the Board of Director following the September 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:	<ul style="list-style-type: none"> • Latest performance for a range of mortality indicators (CUSUM, SHMI, HSMR). • SHMI data pre and post-merger. • Learning from Deaths, Quarter 2, 2018/19 update. • Summary of Serious Incidents (SIs) meeting Never Event criteria reported between 06/09/18 and 08/10/18. 	
Recommendations:	The Board of Directors is asked to: Discuss the contents of this report.	
Approved by:	Mike Hallissey	Date: 16/10/2018

**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 25 OCTOBER 2018**

**CLINICAL QUALITY MONITORING REPORT
PRESENTED BY INTERIM 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 September 2018 UHB Clinical Quality Monitoring Group (UHB CQMG) meeting. The Board of Directors is requested to discuss the contents of this report and approve the actions identified.

2. Mortality - CUSUM

QEHB:

1 CCS (Clinical Classification System) group had higher than expected numbers of deaths in June 2018. There were 4 deaths observed for the group 'Other upper respiratory diseases' compared to 0.89 expected. The case-lists for this have been provided to an Associate Medical Director for review.

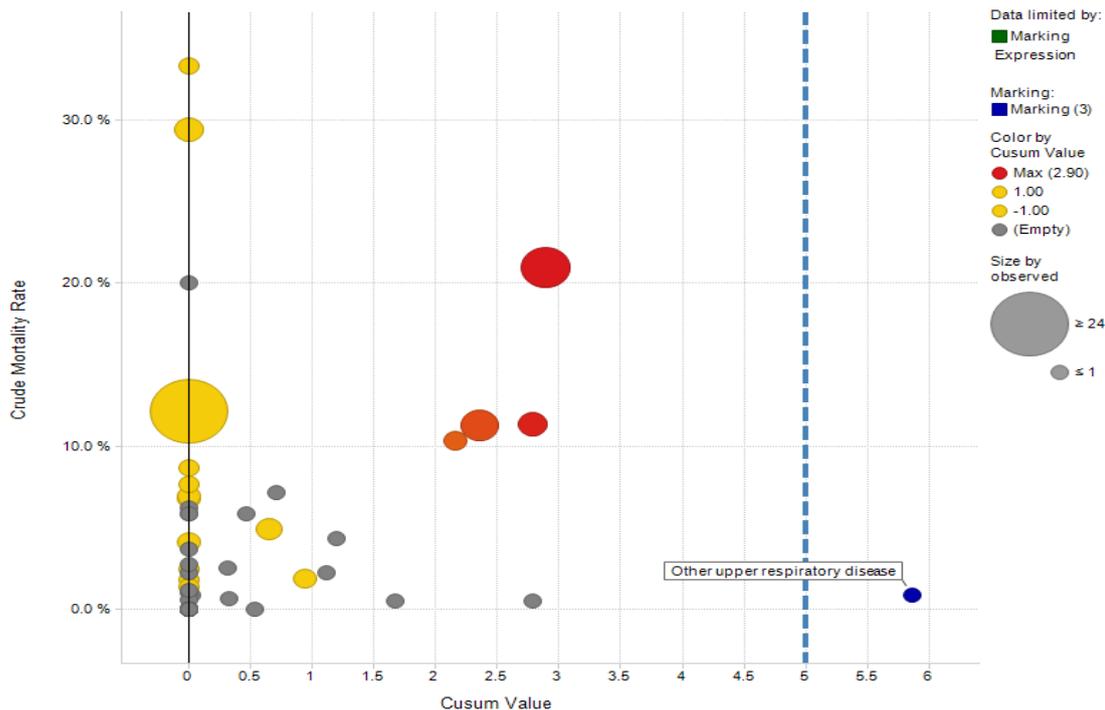


Figure 1: QEHB CUSUM in June 2018 for CCS Groups.

HGS:

2 CCS groups had higher than expected numbers of deaths in June 2018. There were 91 deaths observed compared to 72.88 expected for the 'Pneumonia (except that caused by tuberculosis)' (122) CCS group. There were 13 deaths observed compared to 7.23 expected for the 'Acute Bronchitis' (125) CCS Group. The case-lists for these will be provided to an Associate Medical Director for review.

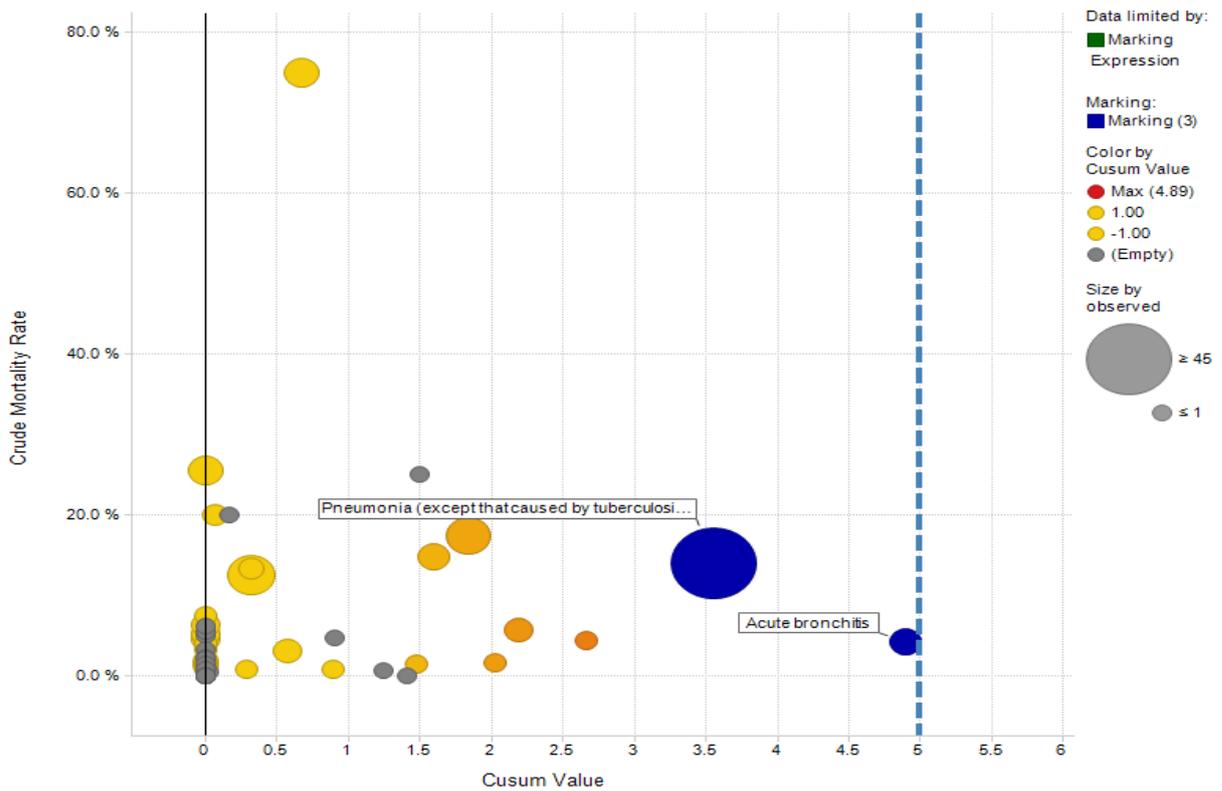


Figure 2: HGS CUSUM in June 2018 for HSMR CCS Groups

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

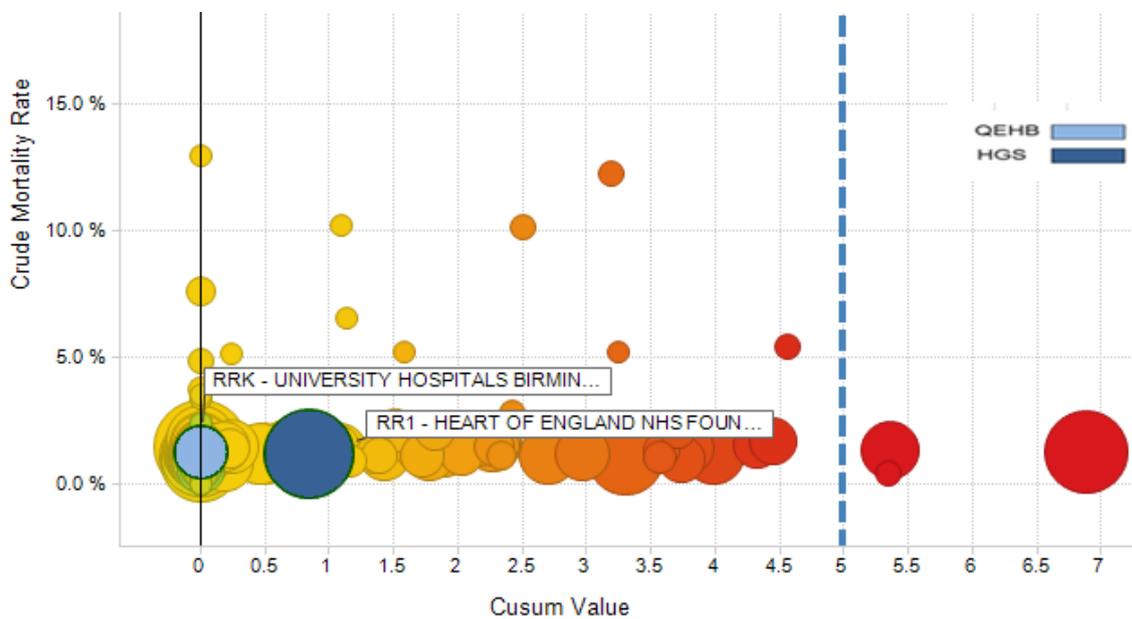


Figure 3: CUSUM for QEHB and HGS (formerly HEFT) in June 2018.

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

3.1. SHMI performance for the period April 2017 to March 2018

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.

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.

The Trust is within acceptable limits as shown in Figure 4 below.

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.

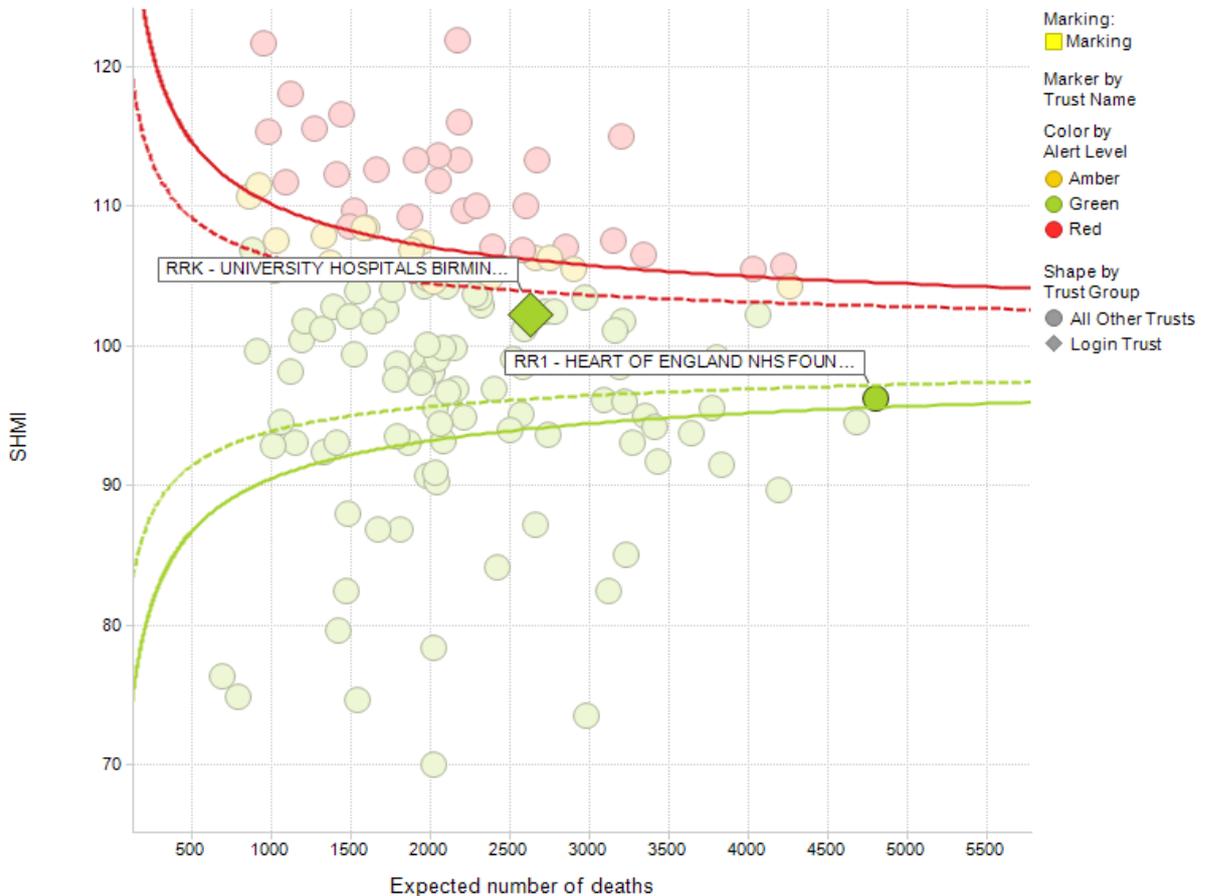


Figure 4: SHMI for QEHB and HGS

3.2. SHMI data pre and post merger

Of note, SHMI data for the enlarged organisation results in a skewed funnel plot (see Figures 5 a and b). This does not render SHMI or HSMR unusable, but reduces the chance of observing small fluctuations on funnel plots. The Informatics Department is aware of the enlarged organisation's impact on some data tools and in order to continue to produce useful and valid information, will provide analysis based on a range of variables (e.g., site, specialty, etc.).

(HSMR data has yet to be modelled for the combined organisation.)

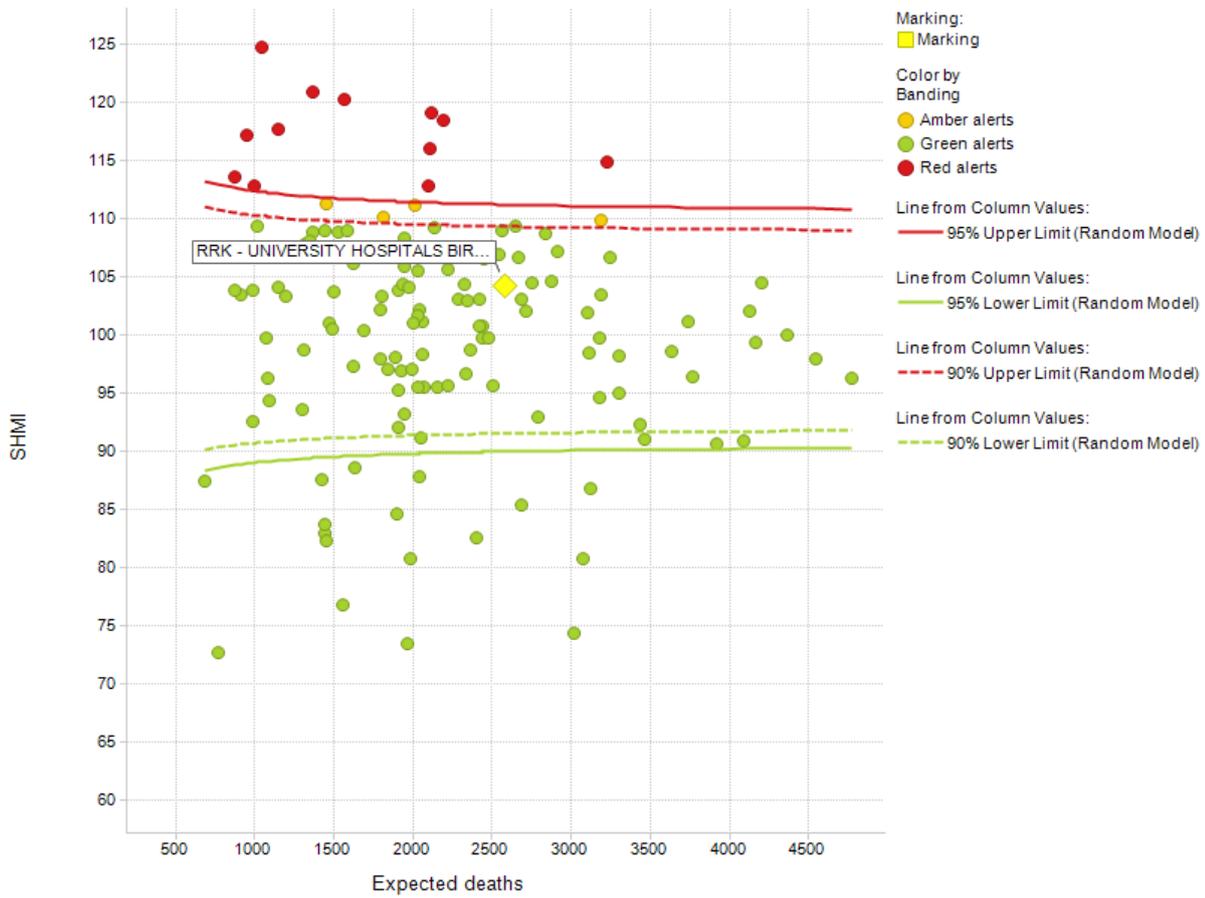


Figure 5a. SHMI data before merger

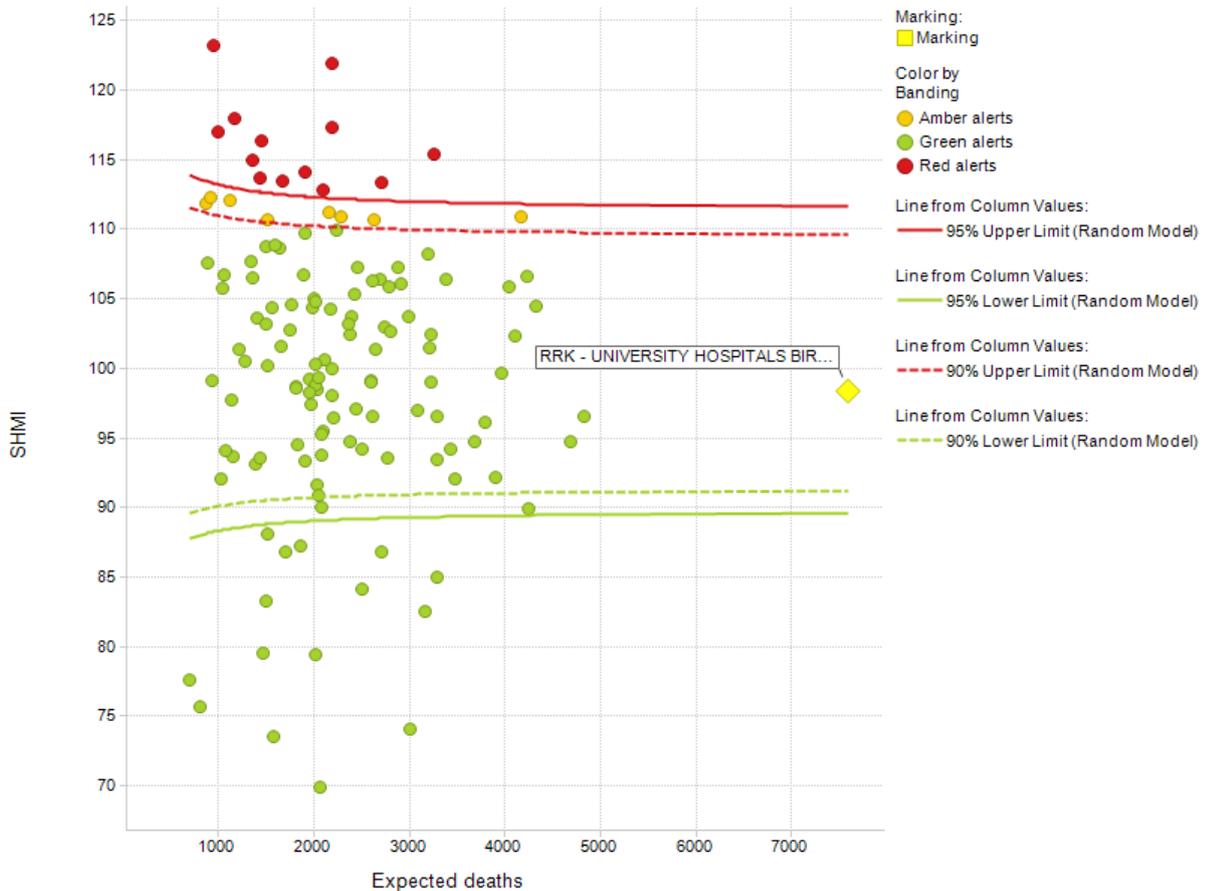


Figure 5b. SHMI data post-merger

4. Mortality - HSMR (Hospital Standardised Mortality Ratio)

QEHB

QEHB's HSMR for the period April 2018 to June 2018 was 102 which is slightly higher than expected. There were 356 deaths compared with 348 expected.

HGS

HGS's HSMR for the period April 2018 to June 2018 was 108 which is slightly higher than expected. There were 657 deaths compared with 607 expected.

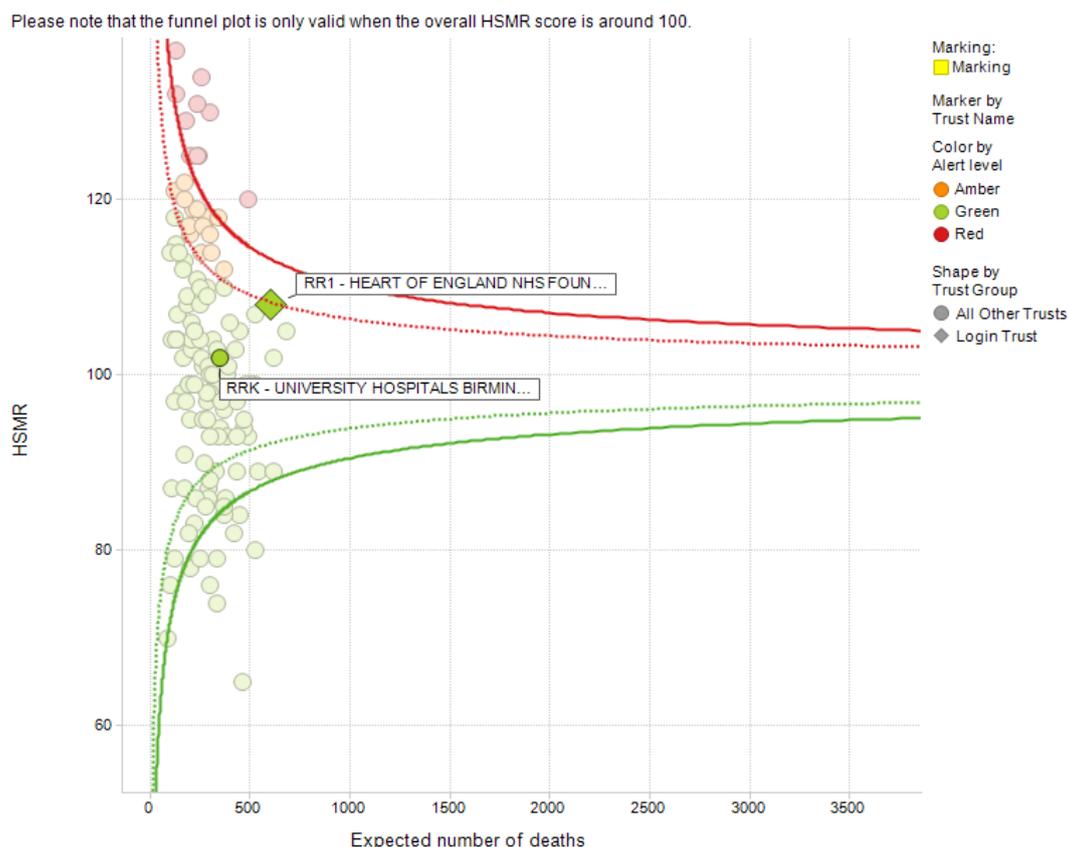


Figure 6: HSMR for QEHB and HGS

5. Learning from Deaths Quarter 2 2018/19.

In line with national *Learning from Deaths* requirements, a summary of the results of reviews of inpatient deaths during Quarter 2 2018/19 has been undertaken and appended (A). The report includes information for all hospital sites for benchmarking purposes.

6. Never Events

The Trust has reported three serious incidents that met Never Event criteria between 6th September 2018 and 11th October 2018:

- Unintentional connection of a patient requiring oxygen to an air flowmeter: the patient was moved from one side room to another and his oxygen was connected to the air flow port instead of the oxygen flow port. The incident report states that the patient did not have any signs of deterioration and was clinically

- well.
- Unintentional transfusion of blood group B+. The patient was receiving blood products post liver transplant and should have received the donor specific blood group O+. There is the potential for moderate/severe harm as the transplanted liver may start producing immune anti B causing a haemolytic anaemia. At the time of reporting the patient was still an inpatient in Critical Care.
 - Wrong implant/prosthesis. Wrong size implant inserted into breast. Removed before closure during same procedure and right size implant inserted. The patient suffered no harm and was discharged the following day.

The three Never Event incident investigations, reported to the September Board meeting, are in progress.

7. Recommendations

The Board of Directors is asked to:

Discuss the contents of this report.

Mr Mike Hallissey,
Interim Executive Medical Director

University Hospitals Birmingham FT
Learning from Deaths Quarter 2, 2018-19
01/07/2018 – 30/09/2018

1. Introduction

The purpose of this report is to provide the Board of Directors with a summary of the all results of reviews of inpatient deaths during Quarter 2 2017/18, in line with national *Learning from Deaths* requirements.

2. Process

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:

- 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.

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. 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.

2.3. 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.

2.4. 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. 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.

3. Quarter 2 Outcomes

3.1. 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.

3.2. 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:

- 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.
- Forensic deaths subject to police inquiry as the notes will be similarly unavailable.
- Deaths referred to out of areas Coroners, where the notes are also not available to the Trust.

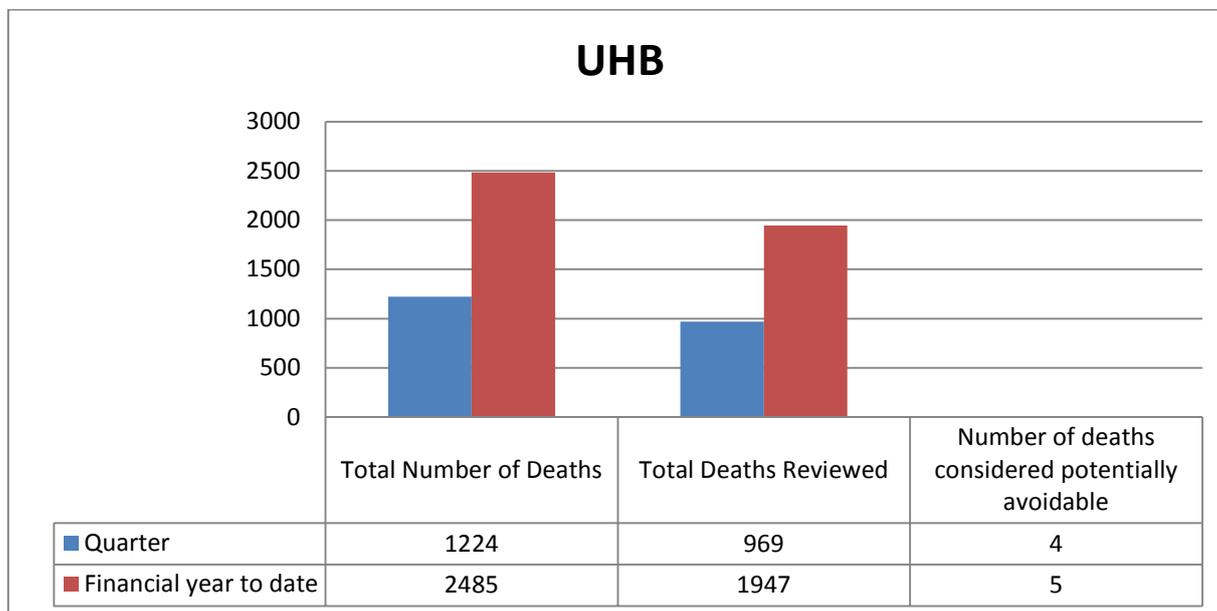


Figure 1: Number of front line reviews of deaths and those considered avoidable (a score of 3 or less on the RCP Avoidability of Death scoring system) based on front line Medical Examiner reviews.

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

3.3.1. The first of these relates to concerns raised about a patient with severe learning disabilities. There were concerns raised about the general nursing care and use of the patient’s required specialist equipment. In response to these concerns this case was presented to CaPRI on 20th September 2018 and is being investigated as an SI.

3.3.2. The second relates to a patient who underwent an extensive (6-hour) operation; the patient had previously been considered unfit for a general anaesthetic and the ME raised concerns about the decision making for surgery. There were minor issues relating to pre-operative communication, clear leadership and planning of care and these have been fed back to the clinical team involved.

3.3.3. The third relates to a patient who underwent a bowel resection for a malignant blockage. The ME raised some concerns around the outcome and the course of surgery. This was discussed extensively at M&M with the conclusion being there were

some learning points regarding use of risk scores for similar cases in the future, but the decision making was acceptable and there were no major concerns. Learning discussed and actioned locally, no further action required.

3.3.4. The final relates to a patient whose family had a number of concerns regarding ongoing care over the previous several months/years. This is being processed as a formal complaint. There is no evidence of any obvious clinical issues that would mean this is an avoidable death.

3.3.5. The graph below shows the breakdown of scoring against the RCP Avoidability of Death scoring system for Q2 at the Queen Elizabeth Hospital. Two cases received a score of 3 or less which is the criteria for being classified as potentially avoidable, as stated in 2.2.

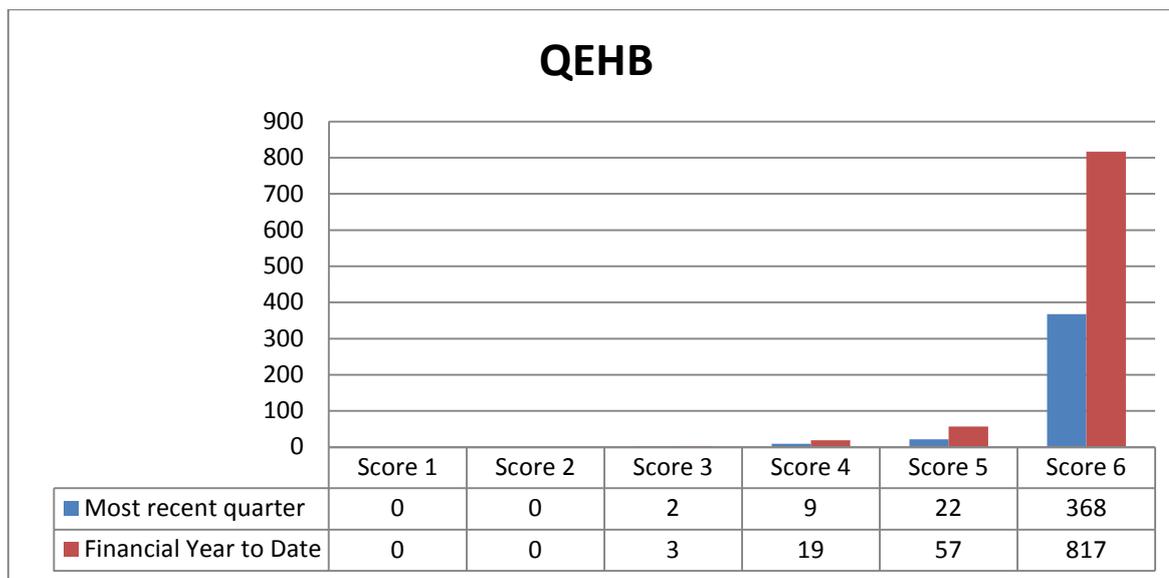


Figure 2: Breakdown of number of deaths scoring each point on the RCP Avoidability of Death scoring system at QEHB.

3.3.6. The graph below shows the breakdown of scoring against the RCP Avoidability of Death scoring system for Q1 at Heartlands Hospital. Two cases received a score of 3 or less which is the criteria for being classified as potentially avoidable, as discussed in 2.6.4. Please note this is incomplete due to the introduction of the electronic ME review system during Q1.

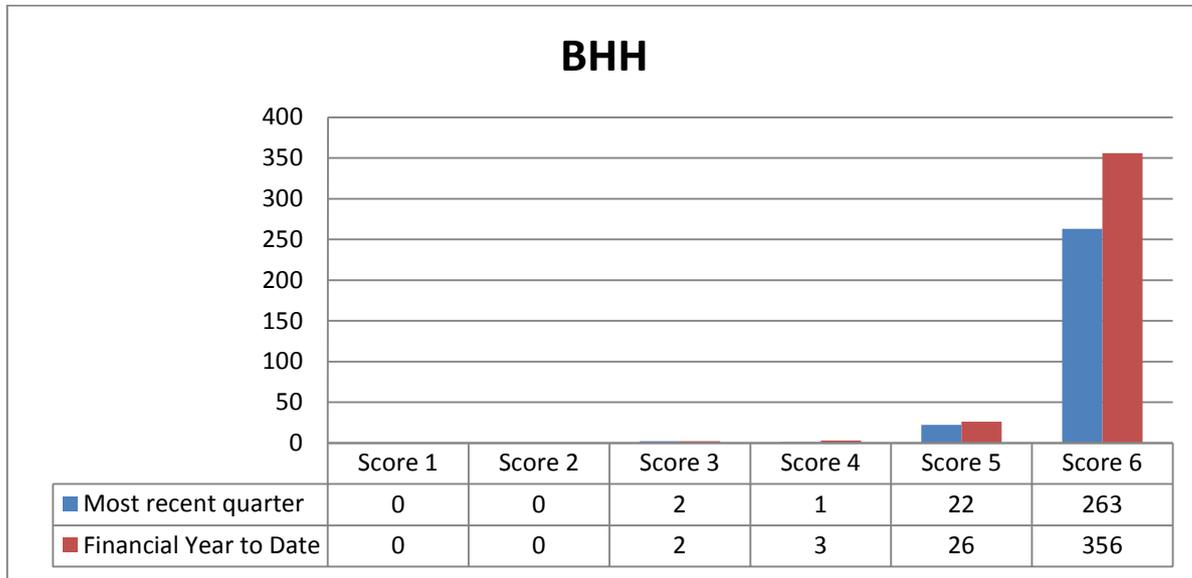


Figure 3: Breakdown of number of deaths scoring each point on the RCP Avoidability of Death scoring system at QEHB.

3.4. The graph below shows the breakdown of scoring against the RCP Avoidability of Death scoring system for Q1 at Good Hope Hospital. Please note this is incomplete due to the introduction of the electronic ME review system during Q1.

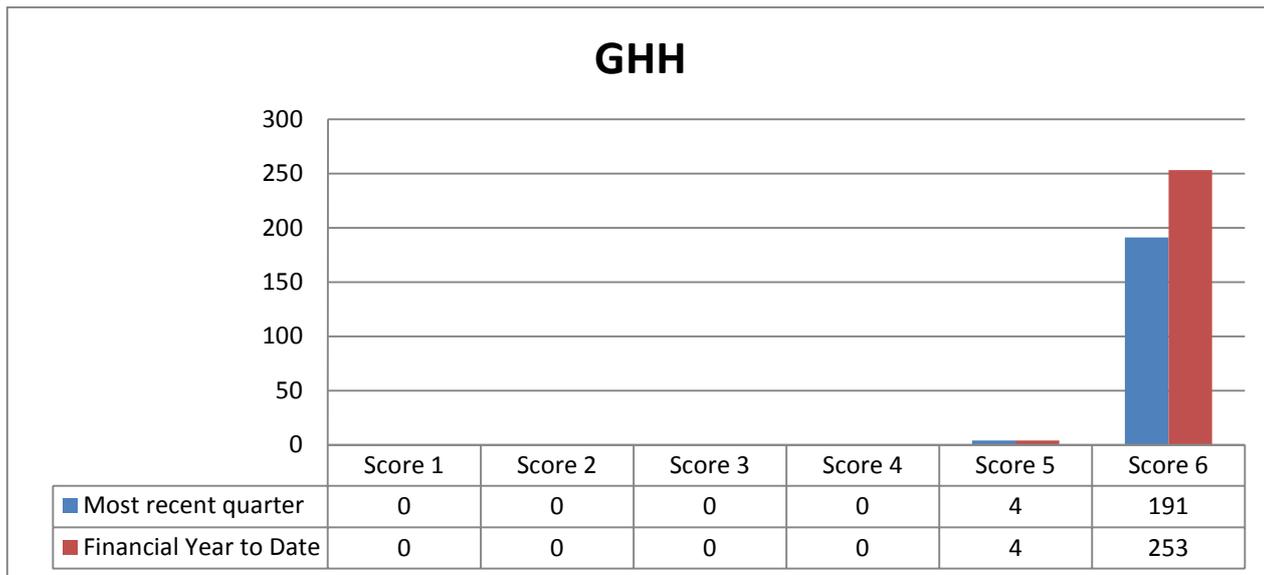
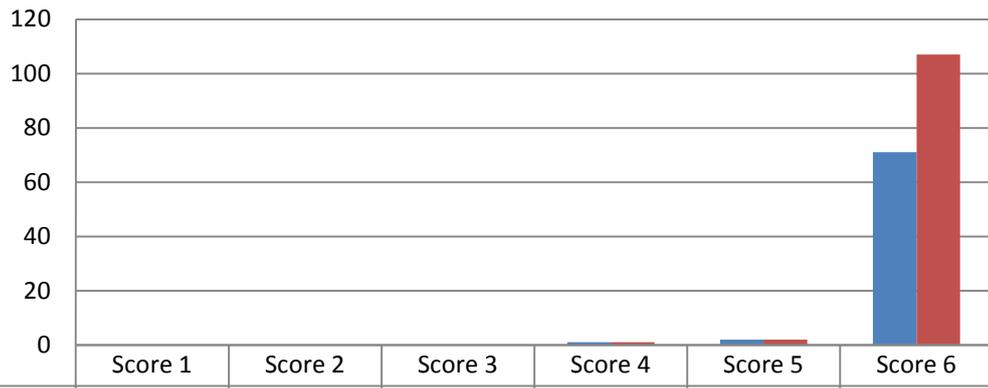


Figure 4: Breakdown of number of deaths scoring each point on the RCP Avoidability of Death scoring system at QEHB.

3.5. The below graph shows the breakdown of scoring against the RCP Avoidability of Death scoring system for Q1 at Solihull Hospital. Please note this is incomplete due to the introduction of the electronic ME review system during Q1.

SOH



	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	0	0	1	2	71
Financial Year to Date	0	0	0	1	2	107

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