Agenda Item 11

University Hospitals of Leicester NHS
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 27 NOVEMBER 2013

REPORT OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

UPDATE ON CURRENT ISSUES

PURPOSE OF REPORT

1 The purpose of this report is to update the Health Overview and Scrutiny Committee on the following issues:-

- The proposed development of UHL's emergency floor;
- UHL's hospital mortality rates;
- The forthcoming CQC hospital inspection programme;
- UHL's financial position 2013/14.

2 The following Trust postholders will be in attendance at the Committee meeting to present this report:-

- Dr K Harris – Medical Director
- Mr A Seddon – Director of Finance and Business Services
- Ms N Topham – Project Director, Site Reconfiguration

EMERGENCY FLOOR

3 At its meeting held on 11 September 2013, the committee received a report and presentation from the local NHS setting out plans to improve emergency care in Leicestershire, with particular reference to arrangements for Winter 2013.

4 The report and presentation included information on UHL's proposal to develop a single emergency floor.

5 At that time, the Trust's preferred option required the movement of a number of outpatient specialties to either the Leicester General Hospital or Glenfield Hospital.

6 Members welcomed the proposals for the development of a single emergency floor, while noting that the proposed changes to the location of a number of outpatient clinics fell within the definition of 'a substantial variation in the provision of such services' and would therefore normally be the subject of formal consultation.

7 However, the Committee was of the view that the proposed changes would enhance the provision of emergency and outpatient services in terms of accessibility and clinical outcomes and believed that the proposed changes were in the best interests of the patients and the public.

8 It was therefore suggested that the Committee waive its rights to be formally consulted on condition that the Trust undertook to provide it with a detailed project plan outlining a range of information stipulated by the Committee.

9 Since September, the Trust has continued to review options for development of the emergency floor.

10 A report on the preferred solution is to be submitted to the public Trust Board meeting on 28 November 2013. At the time of writing, this report has yet to be finalised. The report will be published on 22 November 2013.

11 Those representatives of the Trust attending the Committee meeting on 27 November 2013 will report orally on the preferred solution for the development of the emergency floor.

12 At this stage, it remains the Trust's intention to finalise and submit the Full Business Case to the NHS Trust Development Authority (TDA) in June 2014. The Trust anticipates that work will start in the Autumn of 2014, but this is subject to TDA approval.

UHL'S HOSPITAL MORTALITY RATES

13 Hospital mortality is a complex subject and is defined in a number of ways.

14 Crude mortality is the number of deaths divided by the number of admissions – not adjusted for case mix.

15 Hospital standardised mortality ratio (HSMR) is the number of in-hospital deaths divided by the number of 'expected' deaths (expected is calculated from case mix and socio-demographic information, BUT not severity of the diagnosis). It is expressed as a number greater or lesser than 100, with 100 being the England average.[1]

16 Then there is the standardised hospital mortality index (SHMI)[2], which is like HSMR but with deaths 30 days post-discharge included.

17 No one measure is perfect, but all give useful signals and are used to alert for problems.

18 At the public Trust Board meeting held on 31 October 2013, the Trust Board received a comprehensive report prepared by Dr K Harris, Medical Director, on the outcome of a review of hospital mortality rates at the Trust.

19 UHL's mortality in 2012/13 as assessed by HSMR was 101, slightly above the average of 100 but 'within expected'. Further work is being undertaken to understand this.

20 The latest SHMI for UHL covering the same time period is 106 which, again, is 'within expected'.

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[1] Source : Dr Foster: www.drfosterhealth.co.uk
[2] Source: Heath and Social Care Information Centre www.hscic.gov.uk

21 UHL's ambition is to be significantly better than average and this is one of the key drivers behind the 'Saving Lives' workstream of the Trust's Quality Commitment, which aims to save 1000 extra lives over the next 3 years.

22 In this regard, significant progress has been made with the implementation of the Respiratory Pathway, to manage patients with severe respiratory illness like pneumonia.

23 Within the overall Trust results, there are differences between hospitals: in 2012/13, the Leicester Royal Infirmary's HSMR was 114, the Leicester General Hospital's 81 and the Glenfield Hospital's 82.

24 It is of note that in 2012/13, 64% of the emergency and sickest patients were treated at the Leicester Royal Infirmary, compared to 20.5% at the Leicester General Hospital and 15.5% at the Glenfield Hospital.

25 The Dr Foster hospital guide for 2013 will publish both Trust and site – specific mortality rates for 2012/13 and this will show the Leicester Royal Infirmary, home to the Leicester, Leicestershire and Rutland Emergency Department, as having a 'higher than expected HSMR'.

26 Dr K Harris, Medical Director, will expand on this subject when presenting the report at the Committee meeting.

CQC WAVE 2 ACUTE HOSPITAL INSPECTION PROGRAMME

27 The Care Quality Commission has developed a new model for monitoring a range of key indicators about NHS Acute and Specialist Hospitals. These indicators relate to the 5 key questions they will ask of all services – are they safe, effective, caring, responsive and well-led?

28 The results of the CQC intelligent monitoring report (October 2013) identifies that UHL has 5 indicators in the category of 'risk', and 5 at an 'elevated risk' out of a total of 150 indicators. This places UHL in the risk category of 1 overall, the highest risk.

29 Consequently, the CQC have given notice that UHL will be within the next wave of inspections commencing in January 2014. The Trust has recently received notification that inspection of the Trust will start on 13 January 2014.

30 The core site visit is likely to last between 2 and 5 days, and the inspection take around 2 weeks in total, but this includes the CQC team's preparation day and any follow-up work needed.

31 As well as inspecting all 3 hospital sites, the CQC inspection team will inspect 8 key service areas: A&E; acute medical pathways including the frail and elderly; acute surgical pathways; critical care; maternity; paediatrics; end of life care and outpatients.

32 The inspections will be a mixture of announced and unannounced and may include inspections in the evenings and weekends, when the CQC states that they know people can experience poor care.

33 The CQC will decide whether hospitals are rated as outstanding; good; requires improvement; or inadequate. If a hospital requires improvement or is inadequate, the CQC will expect it to improve. Where there are failures in care, the CQC will work with Monitor and the NHS Trust Development Authority to make sure that a clear programme is put into place to deal with the failure and hold people to account.

34 A response to each of the indicators identified as elevated risk/risk is detailed below.

- **Dr. Foster: Deaths in low risk diagnosis groups (Elevated Risk)**

35 There were 81 patients who died in 2012/13 that were coded as having a 'low risk diagnosis'. The types of diagnosis included in this group are: abdominal pain, transient cerebral ischemia, chest pain, abdominal hernia, normal pregnancy, crushing injury/internal injury. Preliminary review of the data suggests that some patients were subsequently confirmed as having a 'higher risk diagnosis' (stroke, myocardial infarction). Others appeared to have other co-morbidities that significantly affected their outcome (e.g. patient admitted with 'internal injury' also had alcoholic cirrhosis of the liver and oesophageal varices).

36 The details of each of the patients in this group are now being cross referenced with the relevant Morbidity and Mortality reviews to ensure that any areas for learning have been acted upon. At the same time, the clinical coding will be checked as one patient was coded with a 'primary diagnosis of abdominal pain' but was admitted to the coronary care unit.

- **Maternity outlier alert: Puerperal sepsis and other puerperal infections (Elevated risk)**

37 In August 2013 the CQC wrote to notify UHL of the fact that analysis of maternity indicators undertaken by the Care Quality Commission had indicated that rates of puerperal sepsis and other puerperal infections within 42 days of delivery at our Trust have remained significantly high since the previous alert for this indicator was closed in April 2012.

38 A case-note review, the review of audit data regarding serious septic illness and the review of audit data regarding post-caesarean section wound infection all confirmed good clinical outcomes and failed to identify any concerns regarding quality of care. However, there were a number of issues identified that need to be addressed.

39 These include:

- A need to improve coding of septic illness diagnoses to more accurately reflect the clinical diagnoses
- A need to validate and benchmark the data being collected with regard to severe septic illness on our E3 database

- A need to identify and implement at least one Quality Outcome Indicator to be included as a regular item on our maternity dashboard
- A review of pathways of care for women after discharge from hospital in conjunction with primary care colleagues

40 An action plan is being implemented to address these points.

- **A&E waiting times more than 4 hours (Elevated risk)**

41 Performance against the 4 hour wait is subject to regular detailed reporting at the Trust Board. It is well recognised that the current Emergency Department is too small, having been designed for around 115,000 patients a year rather than 160,000 that come through the Department. A scheme for investment in the Emergency Department has been developed.

42 Working with partners a "single front door" process was introduced in July 2013 guiding patients to the most appropriate care.

43 Executives across the healthcare community have been meeting on a weekly basis to work on sustainable solutions that will improve performance, patient experience and staff satisfaction. This work is now focused in particular upon improving the flow of patients by expediting discharge. This is a multi-agency task and is key to improving performance. This is because the Trust's calculations have shown that it is some 75 acute beds short of the required capacity with little scope to increase that capacity due to staffing and space constraints.

- **Whistleblowing alerts (Elevated risk)**

44 From the reporting period UHL have received three whistleblowing concerns; one in relation to overcrowding in the Emergency Department and two in relation to cleanliness at the LRI and LGH.

45 UHL provided the CQC with a response for each concern raised. The Director of Clinical Quality liaised with the Medical Director, Chief Nurse, Interim Director of Operations and Senior Management team of the Acute Division and Emergency Department to be able to provide a comprehensive response to address the issues raised with regards to standards of care.

46 The Lead Nurse Infection Prevention and the Deputy Director of Facilities compiled a response with regards to the standards of cleanliness across the hospital sites.

- **Serious Education Concerns (Elevated risk)**

47 The Trust is aware of and is addressing ongoing issues with medical education. The Medical Director presented a report to the Executive Team on a recent Local Education Training Board's Education Review for Trainee Doctors which focused on areas such as Paediatrics, Obstetrics and Gynaecology, Anaesthetics, Trauma and Orthopaedics, and all Foundation Trainees. This year there are 48 areas of improvement, of which 13 areas are

RAG rated 'red' to indicate urgent action being required. Some of the areas of improvement can be categorised into the following areas:

- Education Resources
- Identification of Different Levels of Medical Staff
- Trainee Rotas:
    - Foundation Year 1 doctors working core level doctor rotas is a concern.
    - Doctors advised that they were often required to work longer than the duty rota
    - Excessive hours being worked over consecutive days
- IT Systems
- Phlebotomy
- Service Level Induction

48 A number of these issues have already been resolved by the Trust, for example there are plans for a new library at the LRI site, and there will be an Educational Lead for each Clinical Management Group and implementation of the colour coded ID badge holders and lanyards for Medical Staff.

- **Composite indicator: In-hospital mortality- Paediatric and congenital disorders and perinatal mortality (Risk)**

49 Better understanding of the methodology is required in order to investigate properly as this is a composite indicator of two groups of patients (paediatric/congenital disorders and perinatal mortality) and different methods are used for creating the outcomes for each of the groups

50 The 'risk' is associated with the first part of the indicator and not the perinatal mortality. The indicator assessed as at 'risk' is a combined indicator and includes paediatric and congenital disorders plus perinatal mortality.

51 The Risk only relates to the Paediatric and Congenital Disorders.

52 Within the indicator are 5 main diagnostic groups:

- Cardiac and circulatory congenital anomalies
- Other congenital anomalies
- Genitourinary congenital anomalies
- Digestive congenital anomalies
- Nervous system congenital anomalies

53 The Trust believes that the group that is 'alerting' is 'other congenital anomalies' and within that group there is a subgroup which is alerting – congenital diaphragmatic hernia (there were 5 deaths in 34 patients).

54 The Children's Mortality and Morbidity Lead for both the LRI and GH has reviewed all paediatric cardiac deaths in 2012 with the PICANET lead. Within this review were 3 of the congenital diaphragmatic hernia patients (2 of the patients died subsequent to being transferred back to their original hospitals). All 3 babies had been accepted for ECMO and known complications of ECMO and subsequently died.

55 The majority of Trusts where babies are managed with these conditions will only have those babies that require relatively minor operations and specifically in respect of the Congenial Diaphragmatic Hernia babies (closing of the diaphragm area where the hernia is) - so their mortality numbers will be next to nil whilst, because the Trust houses an ECMO service (and consequently receives the complex babies), numbers will be substantially higher.

56 The Trust's congenital anomalies mortality is unlikely to compare favourably with the majority of hospitals in England because the Trust receives babies with the worst type of congenital abnormality, both because the Trust is a cardiac centre but more so because of ECMO (there are only 4 such centres in the UK). Deaths have been reviewed and any learning acted upon and outcomes are monitored both by PICANET and NICOR (previously CCAD).

- **PROMs EQ-5D score: Groin Hernia Surgery (Risk)**

57 UHL's patients reported a similar health gain to the England average for 2011/12 (UHL 0.85 England 0.88). For 2012/13, the provisional data published on the HSCIC website, shows UHL's performance dropping to 0.39 (England average remains at 0.88). This drop appears to be disproportionate and UHL has requested validation of the data by Quality Health 9the data provider).

- **TDA - Escalation Score (Risk)**

58 The TDA Accountability Framework sets out five different categories by which Trusts are defined depending on key quality, delivery and finance standards.

59 The five categories are (figures in brackets are number of non FT Trusts in each category as at July 2013):

Category 1: No identified concerns (18 Trusts)
Category 2: Emerging concerns (27 Trusts)
Category 3: Concerns requiring investigation (21 Trusts)
Category 4: Material issue (29 Trusts)
Category 5: Formal action required (5 Trusts)

60 Confirmation was received from the NHS Trust Development Authority during October that the University Hospitals of Leicester NHS Trust was escalated to Category 4 – Material issue. This decision was reached on the basis of the significant variance to financial plan for quarter one and continued failure to achieve the A&E 4hr operational standard.

- **Composite risk rating of Electronic Staff Record items relating to staff turnover (Risk)**

61 Using the Electronic Staff Record as its data source, the CQC calculate turnover as the number of leavers in the last 12 months divided by the average headcount in the last 12 months. During 2012/13 specifically, this figure has been distorted by the transfer of 406 facilities and switchboard staff to the employment of Interserve. This quantity equates to approximately three months' turnover.

62 Turnover rates are regularly monitored and reported to the Trust Board on a monthly basis via the Quality and Performance Report. No specific issues have recently been highlighted. In addition, the National Workforce Assurance Tool does not indicate that turnover is a specific issue at the Trust when compared to peers.

- **Composite risk rating of ESR items relating to staff stability (Risk)**

63 The same data set is used by the CQC for staff turnover; however, the stability index measures the number of employees with greater than 12 months service divided by the number of employees 12 months ago. This is equally distorted by the turnover attributed to the TUPE transfer of facilities staff (98.77% of those transferring had more than 12 months service).

64 Dr K Harris, Medical Director, will expand upon the information set out in this section of the report at the Committee meeting on 27 November 2013.

FINANCIAL POSITION 2013/14

65 At the end of September 2013, the Trust was reporting a deficit of £16.6m, approximately £16m adverse to the planned deficit of £0.6m.

66 The Trust's 2013/14 Annual Operation Plan (AOP), approved by the Trust Board in March 2013, included reference to an underlying deficit, estimated at £12m.

67 Reflecting this position and the level of delivery risk in 2013/14, the Trust Board's approval of the AOP in March 2013 was accompanied with a request to Commissioners and the NHS TDA for 'strategic transitional financial support' of £15m. This was intended to cover:

- restoration of the annual plan contingency to the intended level of £10m;
- provision against further slippage in recovery of the financial 'run rate';
- funding towards the commencement of strategic site reconfiguration projects – designed to address the long term financial sustainability of the Trust's clinical services.

68 2013/14 year to date results are disappointing. Continued overheating of emergency demand has led to adverse operational and financial consequences. Delivery of key emergency access targets has been compromised, despite investment of substantial non-recurrent financial resources.

69 There has been considerable expert external support, changes in clinical management and operational processes and solid Commissioner support, but A&E performance remains amongst the bottom quartile of NHS acute Trusts. A successful nursing recruitment campaign – with c500 posts vacant - remains a fundamental challenge for the Trust.

70 To cope with the additional emergency demand, and to ensure safe staffing levels, the Trust has resorted to substantial use of bank and agency staffing.

Nursing ratios were reviewed and enhanced in the light of the Francis report recommendations and existing local acuity reviews. Partly as a result, the Trust has averaged over £3.5 million per month in non-contractual payments, primarily for locum doctors, nurses and other healthcare workers, despite an increase in permanent headcount.

71 Cost controls have been stretched and, in part, found wanting. Revised procedures have been implemented over the last two months, in particular over the use of agency nursing staff, and the Trust is seeing improvements in the underlying run rate. Enhanced controls of non-pay have been announced more recently – with a theme being stronger compliance with existing processes. However, these controls have to be balanced against the need to maintain safe staffing levels.

72 In the light of the deteriorating in-year performance, all business areas (formerly Clinical Divisions, now Clinical Management Groups) have produced detailed recovery plans, which are subject to review by the Executive Team.

73 There is a range of possible financial outcomes for the 2013/14 year, depending on both the Trust's cost control performance and the availability of funding from both local Commissioners and, potentially, national sources.

74 At the time of writing this report, the Trust's Executive Team is in the process of conducting a 2013/14 year-end reforecast. The results are soon to be published in the form of a report to be submitted to the public Trust Board meeting on 28 November 2013.

75 Mr A Seddon, Director of Finance and Business Services, is attending the meeting on 27 November 2013 and will then update the Committee on the latest position.

CONCLUSION

76 The Committee is invited to receive and comment upon this report. Representatives of the Trust will be in attendance at the Committee meeting (as identified in paragraph 1.2 above) to respond to the comments and questions of Members.

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