UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **Trust Board**

DATE: **31st October 2013**

REPORT FROM: **Chief Nurse**

REPORT BY: **Director of Clinical Quality**

SUBJECT: **Care Quality Commission Intelligent Monitoring Report and Impending Inspection**

1.0 Introduction

1.1 The Care Quality Commission (CQC) has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions they will ask of all services – are they safe, effective, caring, responsive and well-led?

1.2 On Thursday 24th October the CQC published for the first time the results of new surveillance model, also known as the Intelligent Monitoring tool, which sets out a range of information which the CQC hold on each of the 161 acute and specialist Trusts. This information helps the CQC prioritise their inspections.

1.3 At the same time it was announced that the University Hospital's of Leicester (UHL) will be inspected using the new Care Quality Commission model some time between January to March 2014.

1.4 This paper provides details of the CQC's intelligent monitoring report in addition to the impending visit.

2.0 CQC's Intelligent Monitoring Report

2.1 The new reports give the CQC's overall view of every Trust and how they arrive at that view. This helps the CQC to decide when, where, and what to inspect under their new model. The reports draw together a range of information to give the CQC inspectors a clear picture of the areas of care that may need to be followed up.

2.2 The intelligent monitoring system is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance. The indicators relate to the five key questions CQC will ask of all services. The indicators are used to raise questions not to make judgements about the quality of care. CQC's judgements will always follow their inspections, which take into account the results of the intelligent monitoring and reports from other organisations.

2.3 The CQC has analysed each of the 150 indicators and identified one of the following levels:

- 'no evidence of risk'
- 'risk'
- 'elevated risk'

2.4 UHL has been identified as having 5 indicators at risk and 5 at an elevated risk.

2.5 An overall summary band for each Trust is then created by reviewing the proportion of indicators that have been identified as 'risk' or 'elevated risk' for each Trust out of all applicable indicators in the model.

2.6 Guidance has been produced by the CQC to explain how they have created a summary view for each NHS Trust as well as indicators definitions for each indicator they explain:-

- how the numerator and denominator have been constructed (for quantitative
- indicators)
- how we have determined 'risk' and 'elevated risk'
- time period of the data source
- data source and links to the original source (where this is available)

The CQC has also produced an additional methodology document, describing the statistical methods they have used.

2.7 The following fields have been calculated for each NHS trust by the CQC and are provided on each Trust level profile:

- **Number of risks**: total number of indicators identified as 'risk' (thresholds and rules for identifying risk are provided in the individual indicator details below).
- **Number of elevated risks:** total number of indicators identified as 'elevated risk' (thresholds and rules for identifying elevated risk are provided in the individual indicator details below).
- **Number of applicable indicators:** a count of the number of indicators that apply to the individual trust
- **Overall risk score:** a weighted sum of (number of risks) + (number of elevated risks x 2).
- **Maximum possible risk score:** the score a trust would receive if they had flagged as elevated risk for every single applied indicator in the model.
- **Proportional Score:** calculated from (overall risk score)/ (maximum possible risk score)
- **Band:** CQC has categorised trusts into one of six summary bands, with band 1 representing highest risk and band 6 with the lowest. These bands have been assigned based on the proportion of indicators that have been identified as 'risk' or 'elevated risk' or if there are known serious concerns (e.g. trusts in special measures) trusts are categorised as band 1. For the trusts assigned a category based on the proportion of indicators, we have used the following thresholds:

  Band 1 ≥ 7.5%
  Band 2 ≥ 5.5%
  Band 3 ≥ 4.5%
  Band 4 ≥ 3.5 %
  Band 5 ≥ 2.5 %
  Band 6 < 2.5 %

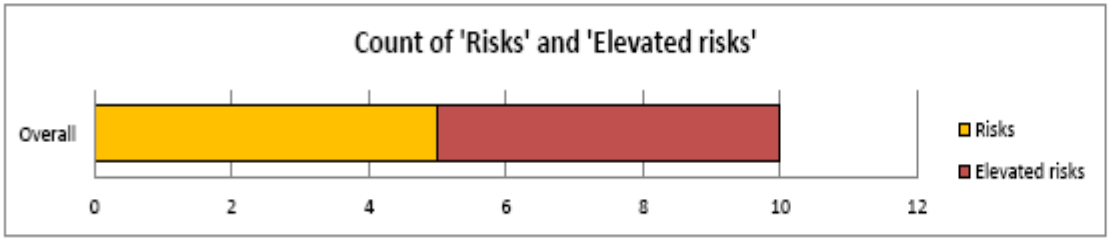
3.0 Results- October 2013

3.1 The CQC intelligent monitoring report- October 2013 is attached at Appendix 1. This can be accessed online at http://www.cqc.org.uk/.

3.2 The Trust summary for October 2013 is as follows:

University Hospitals of Leicester NHS Trust

Trust Summary



Band	1
Number of 'Risks'	5
Number of 'Elevated risks'	5
Overall Risk Score	15
Number of Applicable Indicators	83
Proportional Score	0.09
Maximum Possible Risk Score	166

Elevated risk	Dr. Foster: Deaths in low risk diagnosis groups
Elevated risk	Maternity outlier alert: Puerperal sepsis and other puerperal infections
Elevated risk	A&E waiting times more than 4 hours
Elevated risk	Whistleblowing alerts
Elevated risk	Serious Education Concerns
Risk	Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality
Risk	PROMs EQ-5D score: Groin Hernia Surgery
Risk	TDA - Escalation score
Risk	Composite risk rating of ESR items relating to staff turnover
Risk	Composite risk rating of ESR items relating to staff stability

4.0 Trust Response

4.1 A number (although not all) of the indicators are already monitored and reported in the Quality and Performance Report. These include mortality, A&E waiting times, TDA escalation score and workforce indicators. A number of the indicators have also been subject to detailed reports, and/or presentations at the Trust Board or Quality Assurance Committee.

4.2 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)**

  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).

  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)**

  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.

  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.

  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

An action plan is being implemented to address these points.

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

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

  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.

- **Whistleblowing alerts (Elevated risk)**
  From the reporting period UHL have received three whistle blowing concerns; one in relation to overcrowding in the Emergency Department and two in relation to the cleanliness at the LRI and LGH.

  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.

  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)**

  We are aware of and are addressing the ongoing issues with medical education. The Medical Director presented a report to the Executive Team on a recent Local Education Training Boards 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

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)**

Better understanding of the methodology is required in order to properly investigate 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

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.

The Risk only relates to the Paediatric and Congenital Disorders
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

We believe 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).

The Children's Mortality and Morbidity lead for both the LRI and GH has reviewed all paediatric cardiac deaths in 2012 by himself and 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.

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 0 whilst because we have ECMO (and subsequently receive the complex babies), our numbers will be substantially higher.

Our congenital anomalies mortality is unlikely to compare favourably with the majority of hospitals in England because we will get babies with the worst type of congenital abnormality, both because we are a cardiac centre but more so because of ECMO (there are only 4 centres in the UK). Our deaths have been reviewed and any learning acted upon and our outcomes are monitored both by PICANET and NICOR (previously CCAD).

- **PROMs EQ-5D score: Groin Hernia Surgery (Risk)**
  UHL's patients reported a similar health gain to the England average for 11/12 (UHL 0.85 England 0.88). For 12/13 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.

- **TDA- Escalation Score (Risk)**
  The Accountability Framework sets out five different categories by which Trust's are defined depending on key quality, delivery and finance standards

  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)

  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 ESR items relating to staff turnover (Risk)**

  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 month's turnover. In addition our figures are distorted by the significant numbers of medical trainees who transfer between East Midlands organisations. Each transfer will be recorded as a leaver.

  Turnover rates are regularly monitored and reported to the 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 our peers.

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

5.0 Wave 2 Inspection Programme

5.1 The CQC has announced that they will be inspecting 19 acute Trusts between January and March 2014. UHL is one of these 19 Trusts. A copy of the letter from Professor Sir Mike Richards (Chief Inspector of Hospitals) to John Adler is attached at Appendix 2).

5.2 The team of over 20 will be headed by a senior NHS Clinician or Executive, working alongside senior CQC Inspectors and they will spend at least 2 days inspecting our sites that deliver acute services and the following eight key service areas: A&E; acute medical pathways including the frail elderly; acute surgical pathways; critical care; maternity; paediatrics; end of life care and outpatients.

5.3 The inspection will result in a rating of one of the following; good, requires improvement or inadequate.

6.0 Conclusion

6.1 The results of the CQC's intelligent monitoring report (October 2013) identifies that UHL has 5 indicators in the category of 'risk' and 5 at an 'elevated risk' and this places UHL in the risk category of 1 overall.

6.2 UHL will be within the next wave of inspections commencing in January 2014. Further reports will be provided to the Trust Board and the Quality Assurance Committee regarding the detail of this inspection.

6.3 The Trust is already in the process of reviewing our assurance escalation and response systems to ensure those indicators that the CQC are monitoring are captured and reported.

7.0 Recommendation

7.1 The Trust Board are asked to receive the report and note the findings of the CQC surveillance published in the Intelligent Monitoring report on the 24th October and inclusion in wave 2 of the acute hospital inspection programme.