Worcestershire Health and Well-being Board

Acute Hospital Services: Emerging Concerns and Actions

Agenda item 7

Date	12 May 2015
Board Sponsor	Cllr Marcus Hart
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Relevance of paper	**Priorities** Older people & long term conditions — Yes Mental health & well-being — Yes Obesity — No Alcohol — No Other (specify below) — No **Groups of particular interest** Children & young people — Yes Communities & groups with poor health outcomes — Yes People with learning disabilities — Yes
Item for	Consideration
Recommendation	**1. That the Health and Well-being Board consider issues related to the quality of services at the Worcestershire Acute Hospitals NHS Trust, seek assurances about how concerns are being managed and highlight any additional action required.**
Background	2. In the last few months there have been concerns about the quality of services at the Worcestershire Acute NHS Trust. These have emerged through routine performance and quality monitoring by the Clinical Commissioning Groups (CCGs); whistleblowing by staff; information from other organisations - for example the Ambulance Trust; visits by Health Education West Midlands, the Systems Resilience Group, West Midlands Quality Review Service, and an independent consultant; and an inspection by the Care Quality Commission (CQC). 3. The outcome of the Systems Resilience Group (SRG) visit to Worcestershire Royal Emergency Department on 05

February 2015 was reported to the Arden, Herefordshire and Worcestershire Quality Surveillance Group. In the wake of this a Risk Summit was convened on 25 March 2015, chaired by NHS England and the Trust Development Authority.

4. Collectively the processes outlined above have highlighted a range of issues – these fall broadly into three categories:
   i. Performance
   ii. Workforce
   iii. Leadership and culture

5. The Trust Development Authority (TDA) has recently appointed an Improvement Director to support the Trust and has set up a Quality Oversight Committee to oversee resolution of the issues.

Performance

Key targets

6. The Trust is failing a number of key national targets, and these performance concerns are long standing – they include:

   - **Urgent care**: 91% of people seen and treated in the Emergency Departments within 4 hours in 2014/15 compared to a target of 95%; and only 85% in the last quarter. In addition there were 26 waits in the Emergency Departments of more than 12 hours after a decision to admit during 2014/15.

   - **Elective care**: 84% of people with completed admission for treatment within 18 weeks of referral in 2014/15 compared to a target of 90%.

   - **Cancer care**: 91% of people seen within 2 weeks of referral compared to a target of 93%.

   - **Financial**: the Trust recorded a deficit of £26m in 2014/15.

Urgent care

7. In the light of poor urgent care performance there have been successive visits to the Worcestershire health and care system by the Department of Health's Helping People Home team, the West Midlands Quality Review Service, and an independent consultant. There have in addition been visits specifically to the Trust by Health Education West Midlands and the SRG. Collectively these have identified a range of problems with the Trust's processes for managing people within the acute hospitals. These include:

- Providing care for people in Emergency Department corridors in the absence of current protocols.

- Routing of emergency admissions through the Emergency Departments rather than using medical and surgical assessment units.

- People being admitted to hospital without assessment from a senior clinician, and medical staff not sufficiently engaged in the pathway of care.

- Lack of clarity about the respective roles and responsibilities of Emergency Department and ward teams, inadequate handover procedures, and lack of systems to accurately track people onto the wards.

- Lack of quality controls for basic clinical procedures.

- Poor discharge lounges.

- Unsafe transfers – people being discharged before they are medically stable and/or without proper handover to community services.

- Recommendations and improvement plans not being properly implemented.

8. The CQC's unannounced inspection of the Trust's Emergency Departments on 24 March 2015 also found a range of problems. The full report of their inspection has not yet been issued and has been requested by the Chairman of the Health and Well-being Board. In the wake of the inspection the CQC have imposed conditions on The Trust's registration and issued three specific warning notices relating to failure to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

9. The Trust appears to have responded positively to these findings and actions are underway to address them. These include:

    - Increasing Emergency Department capacity at Worcester Royal by 12 spaces and reconfiguring the Clinical Decision Unit (CDU), Medical Admissions Unit (MAU), and emergency admission wards.

    - Agreeing protocols with the Ambulance Trust for patient handover and care of people in Emergency Department corridors in exceptional circumstances.

    - Eliminating the routine use of non-cubicle space as for

patient care.

- Developing emergency pathways of care for Medicine, Surgery (general and some specialty), and Gynaecology to reduce the workload on the Emergency Departments.

- Senior clinical review of all admissions within 12 hours.

- Establishing a fully functioning discharge lounge.

10. Those visits that have taken a wider perspective have also highlighted actions required across the health and care system in order to improve urgent care. These include:

    - Ongoing efforts to prevent Emergency Department attendances and emergency hospital admissions.

    - The introduction of seven day working.

    - Streamlining of hospital discharge pathways, increases in capacity where necessary and better measurement of where any delays are occurring.

    - Better forward planning for periods of peak activity – for example winter and public holidays.

    - Examining the resilience of the market for long term care.

11. The problems and improvements required in urgent care, both within the Trust and across the wider system, were considered at the Risk Summit and are now well understood. The actions arising from the various visits, the CQC inspection, and the Risk Summit itself are being drawn together into a single comprehensive plan – implementation of which will be monitored by the SRG. The actions agreed at the Risk Summit are appended.

Mortality

12. Provisional data presented at the Risk Summit suggested that the Trust overall has a high mortality rate. The most recent annual period for which data was available was December 2013 to November 2014 during which the Trust's overall mortality rate seemed to be about 10% higher than expected from the average across all Trusts. This data needs to be explored before the position can be confirmed. This will be undertaken by the TDA in discussion with the CCGs and the Director of Public Health.

13. The Risk Summit discussed a particular concern about the mortality rate in emergency surgery at the Alexandra hospital. There are longstanding problems with recruitment and retention of surgical staff at the site and there has been a loss of recognition for training. A pathway has been established to transfer those people requiring the most complicated emergency surgery to the Worcester Royal site.

14. Following the Risk Summit the Trust and the CCGs conducted a risk assessment of emergency surgery at the Alexandra hospital. Their conclusion is that less complicated emergency surgery should continue at the site for the time being, with clarification and improvement of the pathway for transfer of more complex individuals. To take pressure of acute surgical beds, a Modular Theatre has been established at the Alexandra hospital in order to transfer routine elective orthopaedic operations from the Worcester Royal. The situation will be kept under careful review pending the development of options for the longer term.

Other issues

15. Information presented at the Risk Summit recorded a number of other performance concerns – these are:

    - Worcestershire County Council is awaiting the outcome of investigations into 12 **Safeguarding Adults alerts** that have been made in the last 6 months in relation to aspects of care at the Trust. These will be analysed by the Director of Adult Social Services to identify any common themes and reported on to the Safeguarding Adults' Board.

    - For the past two years concerns have been raised with the Trust about **failure of mandatory training** of staff in key aspects of people's care – for example the identification and management of venous thromboembolism. This is being addressed by the Trust, overseen by the TDA and monitored by the CCGs. There has been some improvement but further progress remains outstanding.

    - There have been concerns about **staffing levels** nursing shifts at the Trust. This position has been improving but there remain wards where fewer than 80% of nursing staff are present during a shift. This is being addressed by the Trust, including with mitigation where shifts fall short, overseen by the TDA and monitored by the CCGs.

- The Trust is performing poorly against quality standards for management of **fractured neck of femur**. These include admission of people to an orthopaedic ward within 4 hours, surgery on the day or day after admission, medical staffing levels, dedicated trauma lists, the recovery programme and 30 day follow up. This is being addressed by the Trust, overseen by the TDA and monitored by the CCGs.

- The Trust does not yet have seven day **transient ischaemic attack** ('mini stroke') services in place as required by the regional and local stroke services specifications. This is being addressed by the Trust, overseen by the TDA and monitored by the CCGs.

- The Trust reported two **'never events'** during 2014/15. These are mistakes that should never occur – for example wrong site surgery or misplaced nasogastric tubes.

Workforce

16. The Trust is experiencing increasing difficulty recruiting and retaining staff in some specialities. This is in part due to the ongoing review of Future of Acute Hospital Services in Worcestershire, which has created uncertainty for staff.

17. The most public manifestation of this was the resignation of five Emergency Department consultants in January. The Trust has now recruited to the five vacant posts.

18. Otherwise the problems are most pronounced in emergency surgery as well as women and children's services at the Alexandra hospital. In addition to ongoing monitoring of the mortality rate emergency surgery, the CCGs are monitoring perinatal and infant mortality rates to ensure that outcomes do not deteriorate.

Leadership and culture

Bullying and harassment

19. Staff in the Trust, as well as in other organisations, have raised a series of concerns about bullying and harassment. In response the TDA has commissioned an independent investigation, which has been undertaken by the Good Governance Institute. It was due to be completed on 30 April and a copy of the report has been requested by the Chairman of the Health and Well-being Board.

Partnership working

20. The Trust does contribute to local partnerships, however recent months have been characterised by differences between the Trust and other organisations on a range of

issues. An example of this has been the **counting and reporting of delayed transfers of care**. The methodology that the Trust has been using to count delays has not had the support of partners, and the data that has been reported has not been recognized by other organisations. This has artificially inflated the figures, and made it more difficult to understand and agree where the issues lie in urgent care. This should be resolved through the recent introduction of a protocol and procedure for counting, validating and reporting delayed transfers of care.

Duty of candour

21. The Risk Summit noted a concern that the Trust Board had not been fully informed about the range and seriousness of some of the quality concerns. The Trust reported that a recent assessment of the Board had been positive. The TDA are following this up.

Conclusion

22. A range of concerns are presented above. The Health and Well-being Board does not have a mandate to deal with these directly. However it does have a responsibility to ensure that they have been properly recorded and to seek assurances that they are being addressed by the appropriate organisations. The Adults' and Children's Safeguarding Boards have also been informed so that they can seek their own assurances where relevant.

Appendices

23. Risk Summit actions

Glossary

Systems Resilience Groups are a forum for local health and care commissioners and providers to collectively plan to ensure that there is sufficient capacity to manage demand. The Worcestershire SRG is chaired by NHS England.

The Arden, Herefordshire and Worcestershire Quality Surveillance Group is a forum for local partners to share intelligence and concerns about local providers and co-ordinate commissioning, supervisory and regulatory actions. It is chaired by NHS England.

Risk Summits bring key stakeholders together to share and review information and plan action in response to serious concerns about the quality of care of a provider organisation.