Clinical Strategy
Overview and Process

Health Overview and Scrutiny Committee

22nd July 2015

Dr. Suneil Kapadia

Caring for You

United Lincolnshire Hospitals NHS
NHS Trust

LHAC and ULHT
A commissioner led process and clinical strategy – our internal process

- LHAC sets out the health and social care vision for Lincolnshire
- ULHT Clinical Strategy sets out the vision for acute services within ULHT
- **Linked work … but we need to shape our own destiny**

The case for change

- The driving factors for change include;
  - Safety
  - Quality
  - Constitutional standards
  - Staffing
  - Unplanned loss of core business
  - Finance

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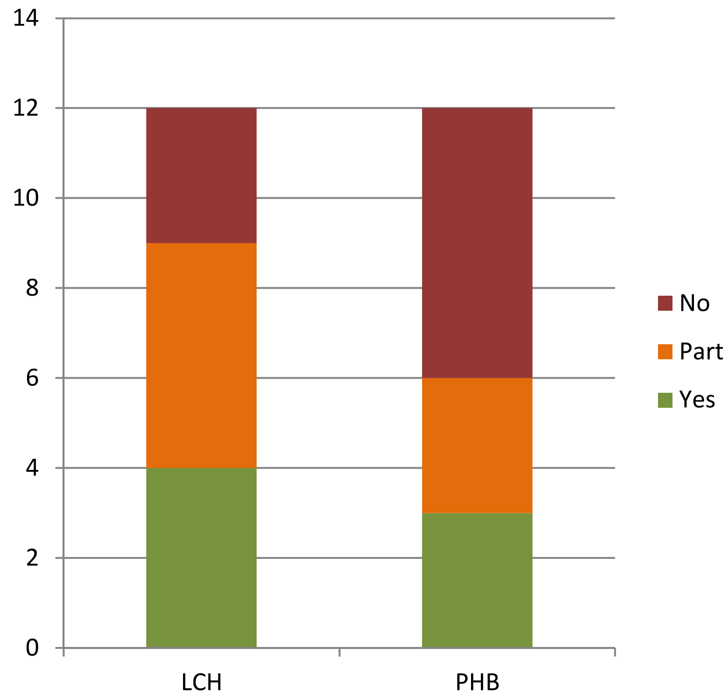
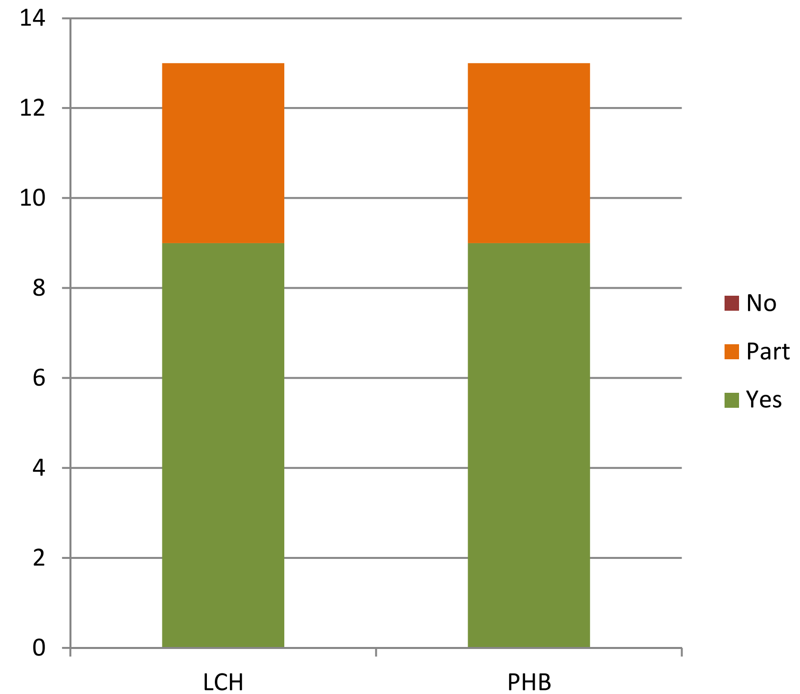
Safety and quality

- 12 Acute Paediatric standards



- 13 Obstetric (& Obstetric Anaesthesia) standards



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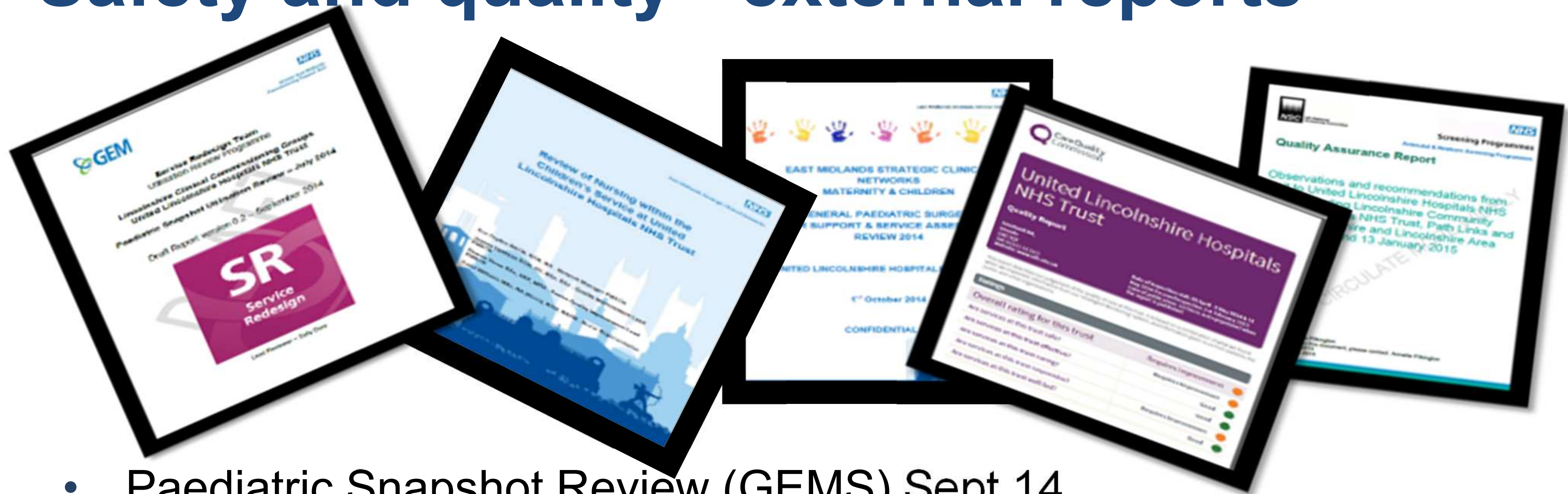
Safety and quality - external reports



- Paediatric Snapshot Review (GEMS) Sept 14
- Childrens Services Ward Nursing Review (East Midlands Clinical Senate) Dec 14
- General Paediatric Surgery Peer Review (GEMS) Oct 14
- Neonatal SI Review Feb 15 [coroners case]
- CQC Report; Apr 14 and Feb 15
- Antenatal Screening Programme report (UK National Screening Committee) Jan 15

Safety and quality - external reports

The CQC report stated:

- "General nurse staffing recruitment was still an issue, with some wards not attaining the required number of nurses to meet best practice guidelines, due to vacancies"
- The children's services ward nursing review (Dec 2014) identified the need for 25 additional paediatric nurses to meet the safer staffing guidelines
- Clinical Senate Report published 2014 stated their recognition that a consultant led maternity service is dependent on the availability of paediatricians to resuscitate and look after new born babies and supported the consolidation of consultant led maternity services at Lincoln Hospital.

Quality and standards

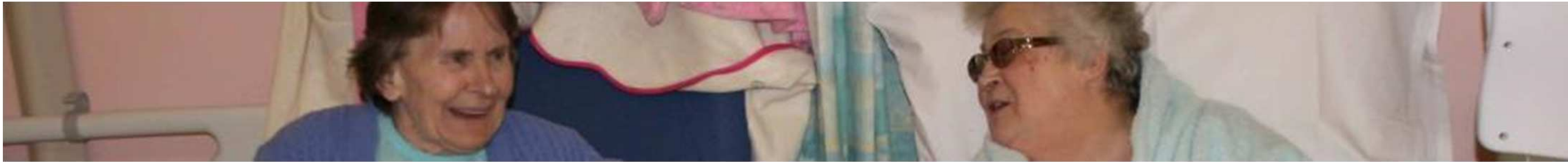
Cancelled operations

Jan-March 2015

- 930 cancelled Ops (on and before the day)

Jan-March 2014

- 421 cancelled Ops (on and before the day)



Quality and standards

United Lincolnshire Hospitals NHS Trust: Monitor Compliance Framework Targets - Month 11 February 2014/15

nitor Compliance Framework 2014/15 - Governance Indicators

Indicator	Threshold	Weighting	Monitoring Period	Apr-14	May-14	Jun-14	Quarter 1 Actual	Jul-14	Aug-14	Sep-14	Quarter 2 Actual	Oct-14	Nov-14	Dec-14	Quarter 3 Actual	Jan-15
e of 18 weeks from point of referral to ggregate - admitted	90%	1.0	Quarterly	82.36%	88.12%	85.37%		85.10%	84.48%	80.10%		81.72%	76.18%	81.60%		81.29%
e of 18 weeks from point of referral to ggregate - non-admitted	95%	1.0	Quarterly	92.28%	92.66%	93.03%		94.42%	92.76%	92.29%		90.93%	89.92%	91.19%		88.92%
e of 18 weeks frm point of referral to ggregate - patients on an incomplete	92%	1.0	Quarterly	92.62%	91.78%	84.33%		87.03%	83.96%	81.14%		77.50%	81.10%	84.70%		84.58%
n waiting time of four hours from ission/transfer/discharge	95%	1.0	Quarterly	94.67%	94.24%	91.32%		92.80%	94.80%	95.23%		92.86%	92.14%	84.27%		84.51%
day wait for first treatment from: erral for suspected cancer *	85%	1.0	Quarterly	84.70%	78.20%	80.20%		82.40%	73.40%	74.60%		74.70%	72.40%	76.60%		75.10%
eening Service referral *	90%			92.30%	96.9%	100.00%		93.80%	88.20%	90.00%		95.50%	80.80%	86.40%		79.20%
day wait for second or subsequent nprising: Surgery *	94%	1.0	Quarterly	96.00%	96.00%	95.20%		97.10%	89.50%	100%		88.90%	92.10%	83.30%		92.70%
ug treatments *	98%			100%	100%	98.40%		99.10%	98.20%	98.00%		98.10%	97.50%	99.00%		100%
*	94%			90.50%	92.70%	88.80%		72.70%	94.20%	87.00%		94.30%	86.40%	82.40%		91.50%
day wait from diagnosis to first	96%	0.5	Quarterly	96.50%	97.90%	97.90%		98.10%	96.00%	94.90%		95.30%	95.20%	96.30%		94.70%
eek wait from referral to date first ing: all urgent referrals (cancer	93%	0.5	Quarterly	92.20%	84.00%	83.40%		89.90%	84.10%	88.00%		91.80%	90.30%	84.60%		91.30%
tic breast patients (cancer not initially	93%			80.50%	50.00%	53.70%		95.00%	80.60%	75.80%		88.20%	81.60%	25.10%		71.90%
difficile objective (cumulative)	62	1.0	Quarterly	7	15	22		28	33	43		48	53	55		58
MRSA objective (cumulative)	0	1.0	Quarterly	0	0	0		0	0	0		0	0	1		1
gainst compliance with requirements ss to health care for people with a ility	n/a	0.5	Quarterly	Compliant	Compliant	Compliant		Compliant	Compliant	Compliant		Compliant	Compliant	Compliant		Compliant
be hind																
			Risk Rating	6.5	7.5	7.5	7.5	7.5	7.5	7.0	8.0	8.0	8.0	9.0		9.0

Monitor Governance sk Rating Calculation	
0	Green
0	Amber/Green
0	
0	Amber/Red
0	
0	Red

GOVERNANCE RISK RATING

Monitor assign a Governance Risk Rating to reflect quality of services at a Trust. Higher levels of governance risk may serve to trigger greater regulatory action.
The Risk Rating is calculated from performance against service indicators.
Each of these indicators is given a weighting and compliance with all indicators would achieve a Risk Rating of 0.
For each non-compliant indicator the weighted score is applied and the total of these formulate the Risk Rating.
The numerical score is RAG rated using the table to the left.
Monitor may apply a red Governance Risk Rating where any indicator with a rating of 1.0 is breached for three successive quarters.
For each of the non-compliant indicators a failure in one month is considered to be a quarterly failure.

Why do we need to change?

Financial sustainability

- National
- £8 billion gap by 2020

- Lincolnshire
- £350m gap by 2018

- ULHT
- £15m for 2014/15
- £40m+ for 2015/16

- W&C
- Obstetric premiums £1,000 per birth (tariff £1,500 for a normal birth)

- Overspend in staffing:
- Medical
- Nursing
- £2.2m April, May & June 2015
- £2.6m April, May & June 2015

Clinical strategy for ULHT

To reconfigure services the focus has to be:
Emergency care

Emergency care networks

Emergency 999

Urgent 111

"The smart call to make..."

Advice by Phone

GP and Primary Care

Urgent Care Centre

Paramedic at Home

Community Pharmacy

Emergency Centre

Major Emergency Centre*

Emergency care network

Meeting your urgent care needs as close to home as possible

Taking you to the most appropriate hospital and maximising your chances of survival and a good recovery from life threatening conditions

* Includes specialist services such as those for heart attack, stroke, major trauma, vascular surgery, critically ill children

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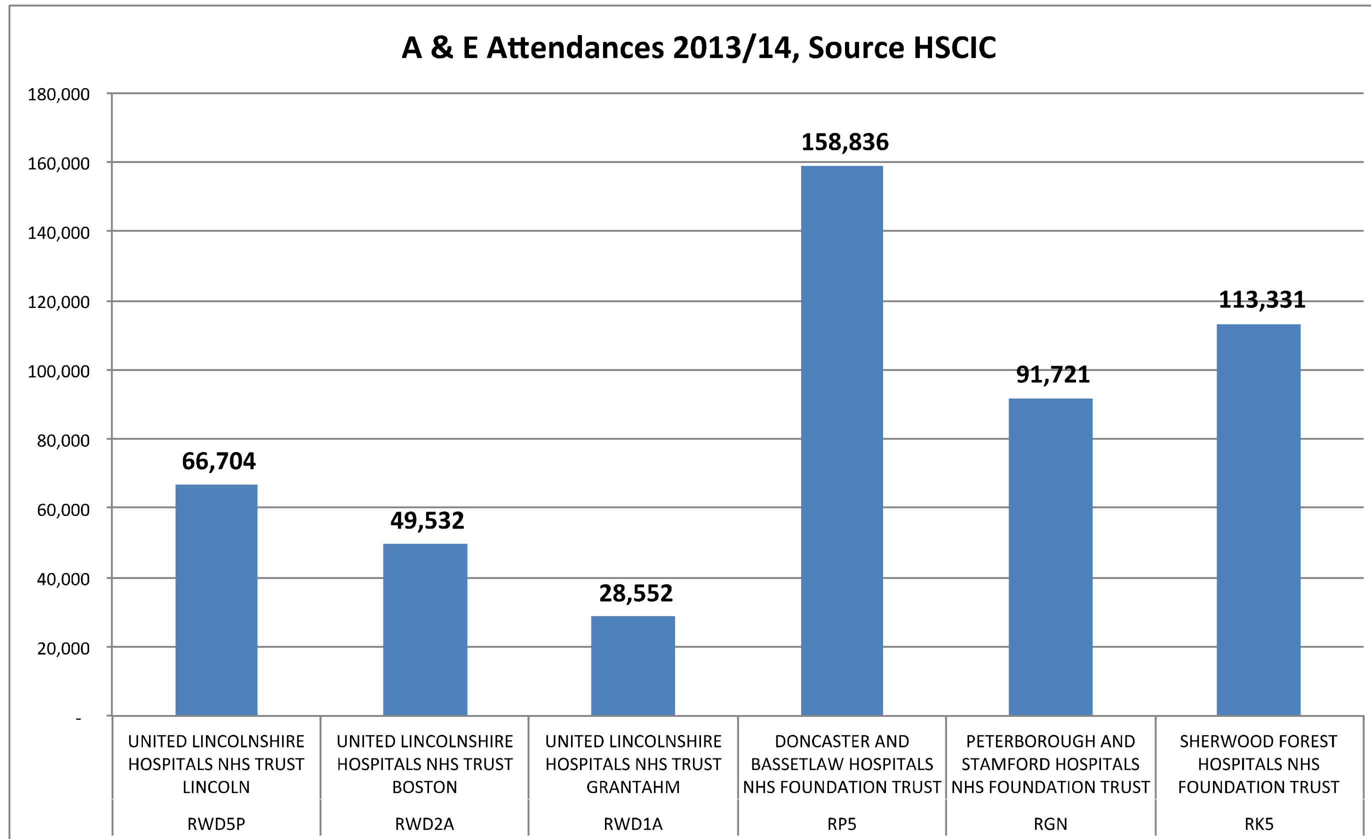
Different types of centre

- In addition, a Specialist Emergency Centre (SEC) will have many of the following facilities
  - Heart Centre
  - Hyper-acute Stroke Unit
  - Renal
  - Vascular Surgery
  - W & C
- An Emergency Centre (EC) will be able to manage the vast majority of patients that are brought to hospital by ambulance
- An Urgent Care Centre (UCC) would receive a more restricted range of ambulance patients

However ULHT provides small levels of A&E activity compared to providers with a single A&E

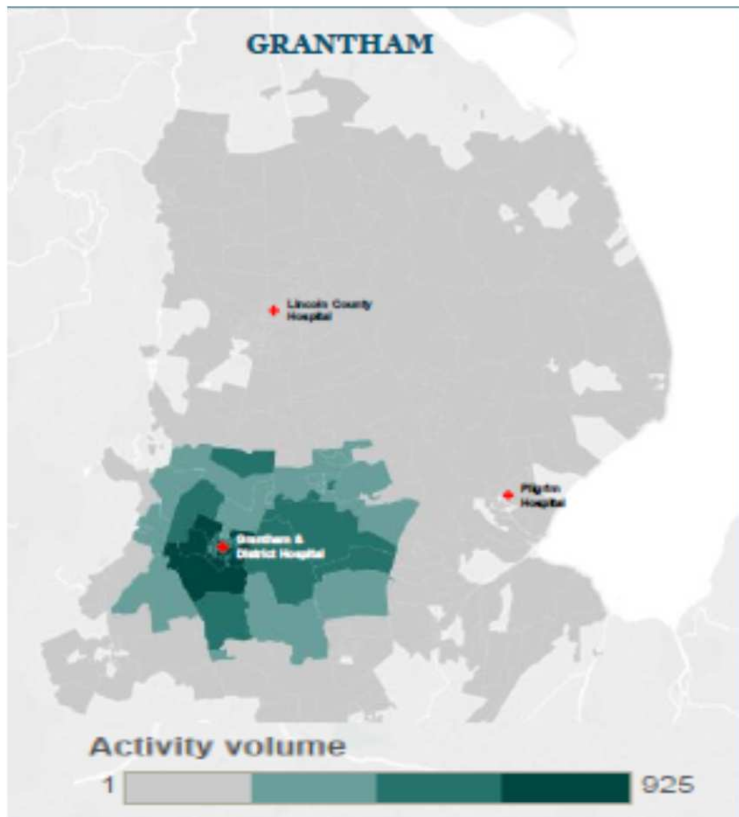


Emergency Care – we are not planning in isolation

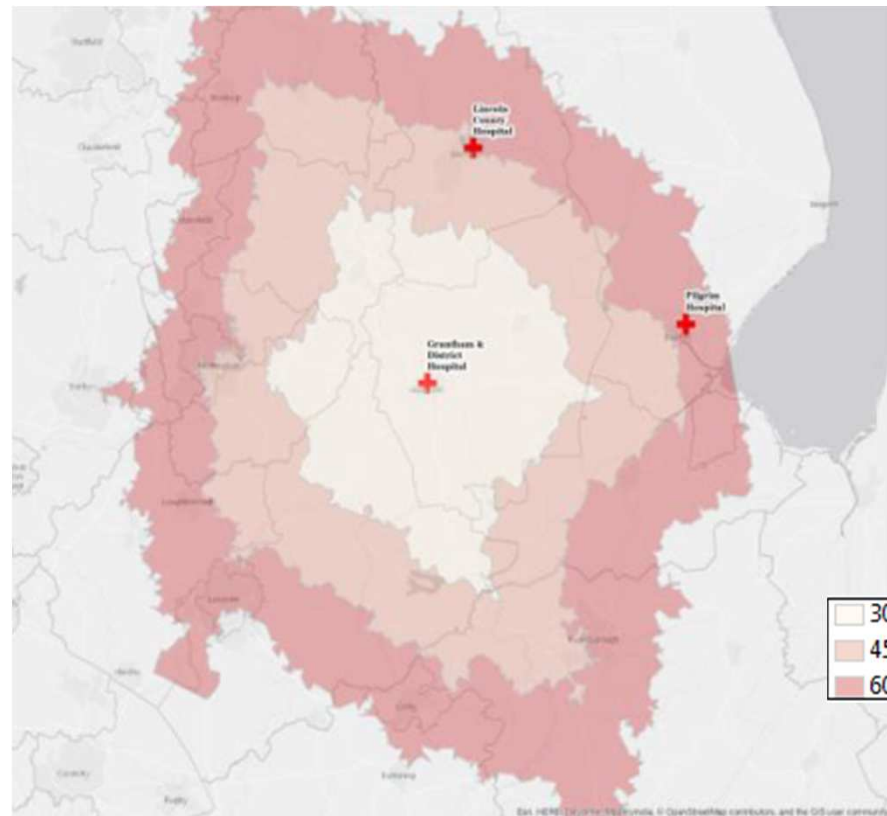
Leeds
York
Hull
Preston
Great Britain
Doncaster
Grimsby
Oldham
M1
Scunthorpe
Bolton
Sheffield
Liverpool
Sherwood Forest
Lincoln
Peak District National Park
Skegness
Stoke-on-Trent
Nottingham
Boston
Derby
King's Lynn
Leicester
Norwich
Wolverhampton
Peterborough
Lowestoft
ENGLAND
Corby
Redditch
Map data ©2015 Google

Travel times – Grantham Hospital

Distance patients currently travel to access Grantham Site



Geographical spread of where patients could travel from to remain within the agreed travel times to access Grantham Site



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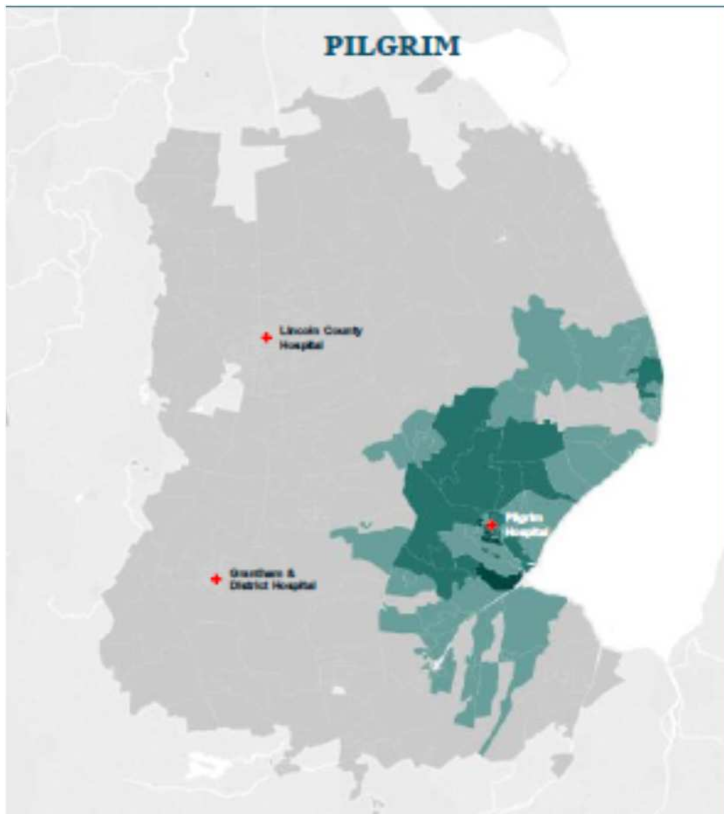
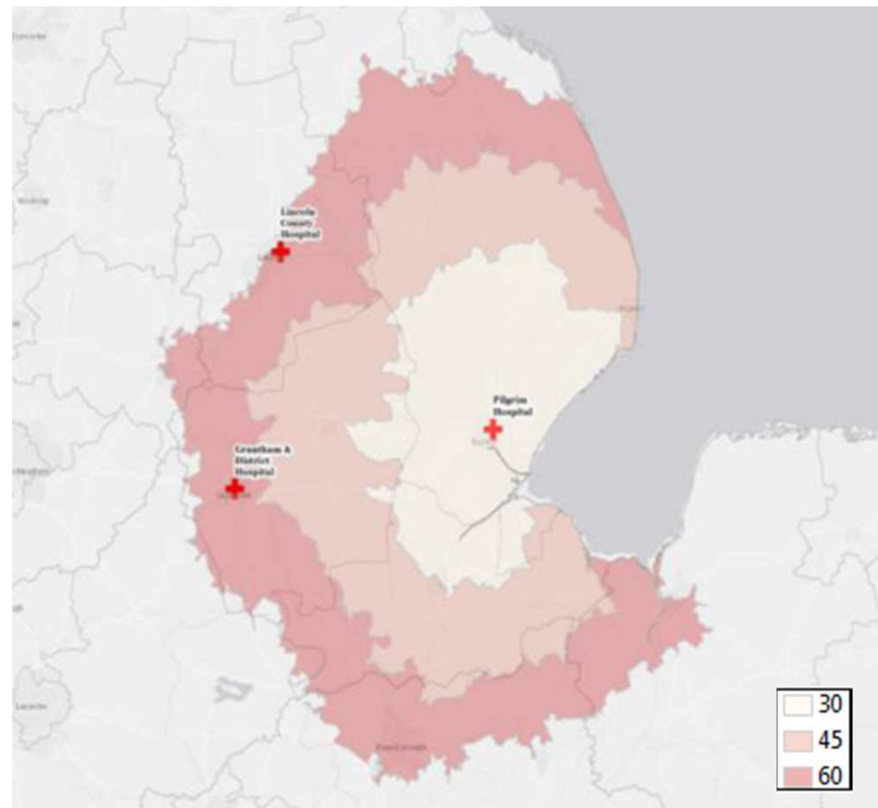
Travel times – Pilgrim Hospital

Distance patients currently travel to access Pilgrim Site



Geographical spread of where patients could travel from to remain within the agreed travel times to access Pilgrim Site



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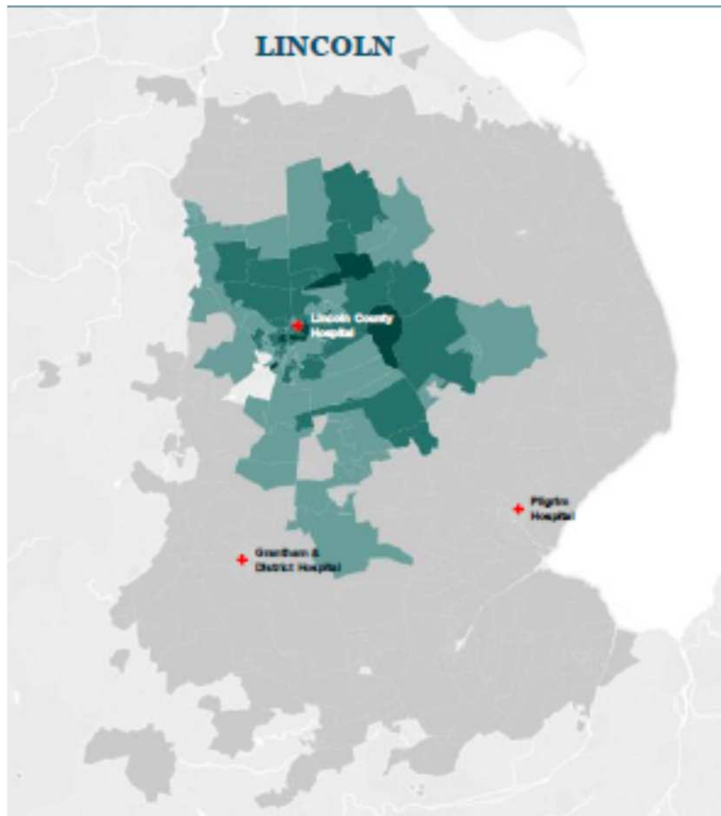
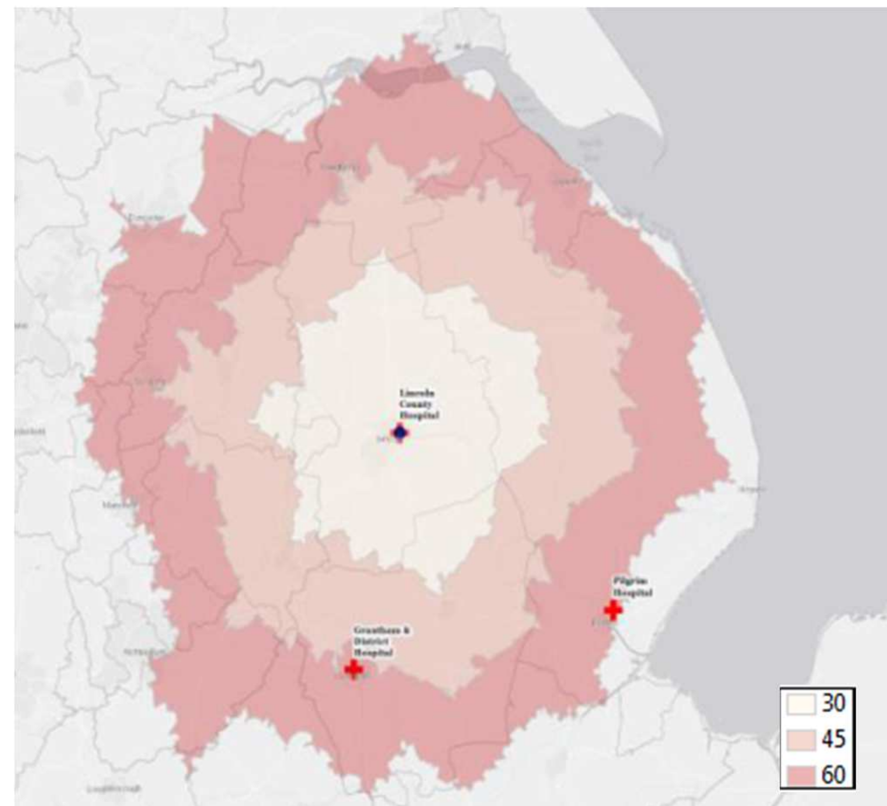
Travel times – Lincoln Hospital

Distance patients currently travel to access Lincoln Site



Geographical spread of where patients could travel from to remain within the agreed travel times to access Lincoln Site



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Women's and children's

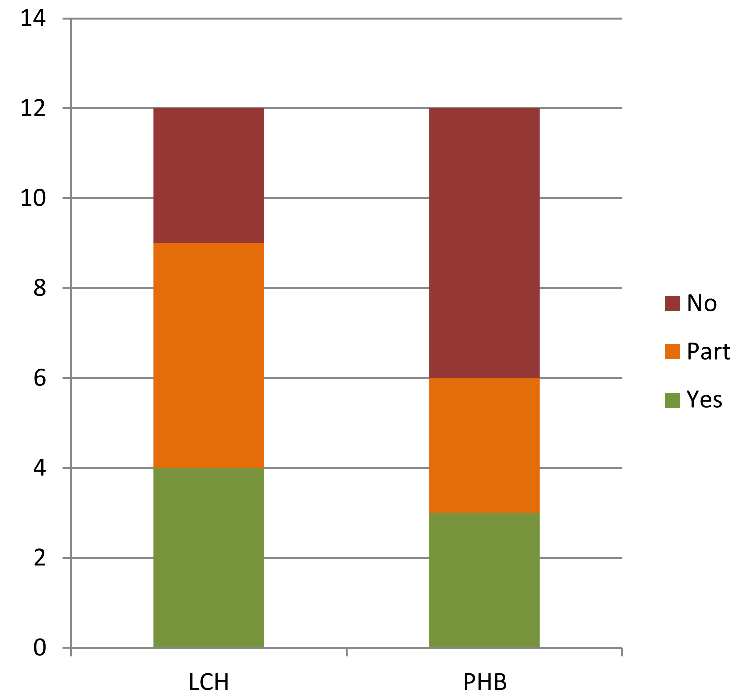
CASE FOR CHANGE

	Long Day 08.30 to 21.00	Night 20.30 to 09.00
Sun 1st Mar	Elmantaser locum	Fran
Mon 2nd	Elmantaser locum	Helen
Tue 3rd	Elmantaser locum 11 - 21.00	Helen
Wed 4th	Fran	Helen
Thur 5th	Fran	Asgerally locum
Fri 6th	Locum needed	Asgerally locum
Sat 7th	Fran	Abel Locum
Sun 8th	Fran	Abel Locum
Mon 9th	Doreen	Abel Locum
Tue 10th	Doreen	Manu locum
Wed 11th	Locum needed	Manu locum
Thur 12th	Miguras locum	Ismail locum
Fri 13th	Miguras locum	Ismail locum
Sat 14th	Sarah Moran locum	Helen
Sun 15th	Sarah Moran locum	Helen
Mon16th	Miguras locum	Fran
Tue 17th	Miguras locum	Fran
Wed 18th	Miguras locum	Locum needed
Thur 19th	Helen	Locum needed
Fri 20th	Doreen	Lara locum
Sat 21st	Harikrishnan locum	Fran
Sun 22nd	Harikrishnan locum	Fran
Mon 23rd	Locum needed	Helen
Tue 24th	Doreen	Helen
Wed 25th	Doreen	David locum
Thur 26th	Manu	David locum
Fri 27th	Manu	Fran
Sat 28th	Manu locum	Fran
Sun 29th	Helen	Fran
Mon 30th	locum needed	Adeyemi locum
Tue 31st	locum needed	Adeyemi locum

March 2015 LCH Neonatology
& March 23rd PHB O&G

VACANT SHIFT

LOCUM



Quality and standards

Staffing: as at 31/3/2015:

Consultant posts filled by Locum staff by hospital site=	
Grantham	6
Lincoln	15
Pilgrim	16
Total =	37

Consultant post filled by Locum staff for W&C & A&E	
Grantham	3
Lincoln	5
Pilgrim	3
Total =	11
% of overall total of Locum Cons.	30%

Nursing Vacancies	WTE
Grantham	8.14
Lincoln	109.72
Pilgrim	108.25

Women & Children's rota

- "HOT Week" Clinical sessions required:
  - 214.7 for 2 sites
  - 139 for 1 site
  - Reduction of 75.7 pa's
  - Staffing made achievable

The Case for change

W&C Staffing Issues – Medical & Nursing

Multi-professional Recruitment and Retention challenges across all specialities

- Inability to maintain medical rotas on two acute sites across specialities
- Unable to meet RCN paediatric & neonatal nurse to patient ratio
- Unable to facilitate mandatory training for mandated roles

Estates

Obstetrics & Neonatology

– Not Meeting National Standards / Maintenance Backlog (CQC 2015 Report)

Identified in external reports

The Case for change

- Difficult to maintain quality and safety
- Both sites have estates which do not comply with current standards
- Difficult to recruit to current vacancies
- Continuing to provide comprehensive, clinically effective and safe services on two sites is problematic
- **NHS England and Clinical Senate advocating co-location of services**

CASE FOR CHANGE

Controls to mitigate risks

- Risk assessments on risk register- Managed as per governance process
- Chief Nurse Safe Staffing Review identified Investment required for both Neonatology & Paediatric Nurses and escalated to trust board
- Risk summit for Neonatal provision of care – Action closure of 10 cots
- 10 Paediatric beds closed (5 LCH 5 PHB)
- Investment received of 10 WTE paediatric nurses
- Active rota management by consultants and management team on a daily basis

These controls are not sustainable

A short list of options drawn from earlier LHAC work

– Option 1:
  - One site maternity & neonatal unit + Midwifery Led Unit(s), paediatric inpatient and gynaecology care

– Option 2:
  - Two-site maternity & neonatal unit + Midwifery Led Unit(s), paediatric inpatient and gynaecology care

Do single specialty sites work?

- **Cardiology**
  - Patients arriving via A&E department in 2014/15:
    - 486 st-elevation primary's (all confirmed STEMI)
    - And:
    - 500 non-st elevation acs
  - Mortality 2014/15
    - 30 day Mortality Rate is 5.7%, national average 8.1% and 7.9% for cardiac centres
    - Before 2013 mortality rate was 10% (East coast ~13%)

Quantifying urgent maternity issues

April 2014 to February 2015 (11 months)

Total number of births = 5212

- Post Partum haemorrhage > 500 mls = 1,150 (22.1%)
- Post Partum haemorrhage > 1000 mls = 322 (6.1%)
- Post Partum haemorrhage > 2500 mls = 23 (0.4%

- Cord Prolapse = 7 in total (4 at Pilgrim and 3 at Lincoln) between April 2013 and March 31 2015 (2 years)
  - Baby needs to be delivered within 30 minutes (aim for 15 mins)
  - Immediate diagnosis and treatment required, and alleviation of cord pressure by providing support to the baby until delivery can be completed

Most sites in Lincolnshire that could host an MMU are within 60 minutes drive of an obstetric unit

Car travel times (minutes) from acute and community hospitals in Lincolnshire to Lincoln and Pilgrim hospitals, and to nearby obstetric units

	Lincoln County Hospital	Pilgrim Hospital	Peterborough City Hospital	Scunthorpe General Hospital	Diana Princess of Wales Hospital	Queen Elizabeth Hospital	NUH – Queen's Medical Centre
Lincoln	-	64					
Pilgrim	61	-	50			58	
Grantham	51	49	41				43
Louth	41	45			26		
John Coupland	38	86		39			
Johnson	68	27	30				
Skegness	63	32					

Source: Google maps, taken at around 5pm on a Wednesday

ULHT preferred option

1 SEC, 1 EC and 1 Bespoke urgent care centre

All three sites will have

- Urgent Care Centre and Ambulatory Emergency Care at the front door of each hospital

The EC will be expected to receive & treat all emergencies

except

- Vascular and acute Cardiology which will go to the specialist emergency centre

Issues to consider

- Transport infrastructure
- Public opinion
- Pre-hospital care in the future
- De-stabilisation of hospital services
- Market share
- Future standards and expectations
- One hospital in centre of Lincolnshire

The direction for Lincolnshire Health Economy

- The direction that is emerging from the work in progress is pointing towards:

Next Steps

- July /August 2015
  - Hospital site service configuration options drafted
  - Staff engagement forum 17th August
- September 2015
  - Strategic Outline Case signed off by Trust Board
- September/October 2015
  - LHAC go through the NHS gateway process for the Community Strategic Outline case
- November / December 2015
  - LHAC begin public consultation

Thank you !

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