CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – JUNE 2015

Author: Stephen Ward Sponsor: Karamjit Singh Date: Thursday 4 June 2015

Paper D

Executive Summary

Context

A new version of the Chief Executive's monthly update report to the Trust Board is attached. It includes:

- a new Quality and Performance dashboard;
- commentary on key issues relating to our Strategic Objectives and Annual Priorities 2015/16.

Questions

1. Is the Trust Board satisfied with our performance and plans on the matters set out in the report?

Conclusion

1. The Trust Board is asked to consider and comment upon the issues identified in the report.

Input Sought

We would welcome the Board's input regarding the format of this new version of the Chief Executive's monthly update report to the Trust Board.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Not applicable]
Board Assurance Framework	[Not applicable]

3. Related Patient and Public Involvement actions taken, or to be taken: N/A

4. Results of any Equality Impact Assessment, relating to this matter: N/A

5. Scheduled date for the next paper on this topic: July 2015 Trust Board

6. Executive Summaries should not exceed 1 page. [My paper does comply]

7. Papers should not exceed 7 pages. [My paper does not comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **4 JUNE 2015**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – JUNE 2015**

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1. Introduction

1.1 My monthly update report this month is different to the usual format. It includes:-

- a new Quality and Performance Dashboard, attached at appendix 1;
- commentary on key issues relating to our Strategic Objectives and Annual Priorities 2015/16. This is a component of the ongoing work to improve Board governance. The report is designed to summarise key issues and share with the Board the things that are "on my mind".

1.2 I would welcome feedback on this report which will be taken into account in preparing further such reports for future meetings of the Trust Board.

2. Delivering Caring at its Best : Our 5 Year Strategy

2.1 Following the Trust Board Thinking Day held on 14th May 2015, the Director of Marketing and Communications and I have further refined this document which features elsewhere on this agenda for consideration and approval by the Board.

2.2 I will present our 5 year strategy to staff at large scale events taking place in June and July 2015, and will take the opportunity to discuss with staff how we can work together to maximise the chances of delivering our vision and overcome their day to day frustrations at work. The Listening into Action methodology will be used at these events.

3. Quality and Performance Dashboard – April 2015

3.1 A new Quality and Performance Dashboard is attached at appendix 1 to this report.

3.2 As will be seen, there are some elements of this dashboard which remain under development but I hope that it allows Board members to see at a glance how we are performing against a range of key measures.

3.3 The more comprehensive monthly Quality and Performance report will continue to be reviewed in depth at meetings of the Integrated Finance, Performance and Investment Committee and Quality Assurance Committee. The Quality and Performance report continues to be published on the Trust's website.

4. Strategic Objective : Safe, High Quality, Patient Centred Healthcare

Developing an 'UHL Way' of undertaking Improvement Programmes

4.1 On 20th May 2015, we submitted our bid to the NHS Trust Development Authority (TDA) to participate in its Development Programme.

4.2 Whilst quality improvement activities are occurring regularly across the Trust, many of them achieving significant measurable improvements for patients and staff, these tend use a variety of approaches rather than being part of a consistent, continuous methodology incorporated into the way staff routinely work.

4.3 We consider the Development Programme offers an excellent opportunity to develop and implement an evidence-based framework and methodological approach to change in order to achieve our goal of high quality and safer services which reduces variation and eliminates waste. This will connect with our commitment to Listening into Action and facilitate the cultural change needed towards a high reliability organisation, characterised by high levels of safety and performance in the face of considerable hazards and operational complexity.

4.4 We expect to learn if we have been shortlisted for the Programme shortly and I will update the Trust Board orally at the Board meeting on the progress of our application.

Implementing the new Patient and Public Involvement Strategy

4.5 As mentioned at the Trust Board meeting held on 7th May 2015, I am pleased to confirm that we have agreed to spend £35,000 in 2015 to fund a new post of Patient and Public Involvement Manager to ensure we can implement the new Patient and Public Involvement Strategy systematically and to allow us to strengthen our approach to patient and public involvement generally.

4.6 In addition to this investment, we have now developed a further strand of the Listening into Action approach, to be called "Involvement into Action". This strand will apply the LiA methodology to patient and public involvement activity. Evidence from other trusts is that combining the patient and front line staff voice through LiA can be particularly powerful in driving change.

Quality Performance

4.7 We have made a strong start to the year on most quality metrics: 3 C.diff cases, no MRSA bacteraemia, no never events, only two serious untoward incidents and three avoidable grade 3 pressure ulcers. However, there was a sharp spike in grade 2 ulcers to 10cases and the Acting Chief Nurse will comment on this. The Friends and Family Test shows 94-96% satisfaction across all areas.

5. Strategic Objective : Services which consistently meet National Access Standards

April 2015 Performance

5.1 On other measures, our 4 hour emergency care performance was at 92.4%, compared to 86.9% in April 2014. RTT compliance was achieved for Non-Admitted and Backlog over 18 weeks, whilst Admitted improved again to 88%, staying on track to deliver in May 2015. We do not yet have cancer performance data as this is validated one month in arrears of other data but, nevertheless, performance remains unsatisfactory in this area and we are to redouble our efforts in order to achieve compliant performance.

5.2 Cancelled operations and Diagnostic waits were once again within target. However, Fractured Neck of Femur performance remained well below target. This is subject to investment and, again, we are to redouble our efforts in order to improve performance.

6. Strategic Objective : Integrated Care in Partnership with Others

LLR Better Care Together – Strategic Outline Case

6.1 On 17th April 2015, we received the formal response of the NHS TDA and NHS England to the LLR Better Care Together Strategic Outline Case (SOC). A copy of that response is attached as appendix 2 to this report.

6.2 I am pleased to report that, overall, the response is very positive. This is very important as the SOC forms the "wrapper" for the business cases for our £320m investment programme, the first element of which (the Emergency Floor) features elsewhere in this report. Board members will note that the NTDA are seeking a faster recovery in our financial position and this issue is addressed in Section 10 of this report.

6.3 As Board members will note, elsewhere on this agenda is the first regular update from the Better Care Together Programme which is being presented by the Director of Strategy.

New Care Models Programme : New Models of Acute Care Collaboration

6.4 The Five Year Forward View identified a number of new care models that will help transform the way in which care is delivered across the NHS.

6.5 29 areas have now been selected as vanguard sites for three of these models:

- multi-specialty community providers (MCPs);
- integrated primary and acute care systems (PACS);
- models of enhanced health in care homes.

6.6 On 20th May 2015, NHS England invited expressions of interest from hospitals to participate in a fourth group – new models of acute care collaboration.

6.7 In discussion with partners, we are exploring the possibility of applying to participate in this new programme in order to take forward initiatives such as the Leicestershire/Northamptonshire acute partnership, details of which have been reported previously to the Trust Board.

Capacity Planning

6.8 The Board will recall that earlier in the year the BCT Partnership Board agreed a set of principles and processes that would be used to determine to the required capacity across the system, including acute beds. We are utilising that approach to determine our internal bed capacity plans. The outcome of the work will be reported to the Trust Board in July and a more comprehensive system-wide report will be presented to the Partnership Board, also in July.

7. <u>Strategic Objective Enhanced Delivery in Research, Innovation and Clinical Education</u>

Preparation for Bio-Medical Research Unit (BRU) Re-Bidding

7.1 We have met recently again with representatives of Loughborough University, the BRU Clinical Directors and members of their teams to continue to develop our approach to securing the renewal of BRU status.

8. <u>Strategic Objective : A Caring, Professional and Engaged Workforce</u>

8.1 We are continuing to explore the basis on which we can establish the elective and trauma orthopaedics services as an autonomous team pilot.

8.2 The pilot will allow us to explore:-

- management and governance based on significant devolved powers;
- staff and stakeholder involvement and control;
- encouraging the right culture;
- empowerment of frontline staff;
- incentivisation of desirable behaviours.

8.3 There is a few months' work to do to work up these ideas but there appears to be real potential here to remove day to day barriers and frustrations. I will update the Trust Board further as the ideas are worked up.

9. Strategic Objective : A Clinically Sustainable Configuration of Services, operating from Excellent Facilities

Emergency Floor

9.1 On 21st May 2015, the Trust's Emergency Floor Full Business Case – a £43.3M investment to create a purpose-built emergency floor – was approved. In consequence, demolition work started in earnest on 22nd May 2015 and we received widespread, positive coverage in the media of our plans.

9.2 We are incredibly excited to have got this far and would like to thank everyone who has been involved in designing and supporting this process, staff in particular but also our stakeholders, partners and local politicians. This much needed development will be the UK's first 'frailty friendly' Emergency Department, especially designed to meet the rising demands of an ageing population and will improve the experience, not only for the people of Leicester, Leicestershire and Rutland, but also for our hard working staff.

9.3 As the Board is aware, this is just the beginning: over the next five years, we will see the creation of an integrated children's hospital; major improvements to our maternity service; the consolidation of intensive care and the creation of two super ITUs at the Leicester Royal Infirmary and Glenfield Hospitals; the move of vascular services to Glenfield, new Planned Treatment Centre and last, and by no means least, a new multi-storey car park at the Leicester Royal Infirmary.

ITU and Vascular Services

9.4 As reported to the Integrated Finance, Performance and Investment Committee on 28th May 2015, progress continues to be made with the relocation of intensive care services from the Leicester General Hospital.

9.5 To facilitate the movement of other specialties from the General, which will need access to level 3 ICU services, the Vascular service currently based at the Royal will move to Glenfield by Spring 2016. This move creates a cutting-edge and complete cardiovascular service for our patients all on one site. It will improve patient experience with increased access to services, and the development of a Hybrid Theatre will ensure we continue to provide highly specialised care to our patients. For our staff, they will be working with improved facilities that will attract large cohorts of junior doctors as we are able to offer a full range of cardiovascular interventions.

Children's Congenital Heart Services

9.6 A considerable amount of work continues to be undertaken to develop and secure the future of the East Midlands Congenital Heart Centre. In particular this involves planning both short and long term capital investments and developing networks with neighbouring providers. Both of these elements are important to ensure compliance with new national standards. More detail on our plans is included in an update recently issued to staff and stakeholders. I have attached this as appendix 3 to this report.

10. Strategic Objective : A Financially Sustainable NHS Organisation

The Trust's 5 Year Financial Strategy

10.1 At its Thinking Day on 14th May 2015, the Trust Board discussed the Trust's Financial Strategy and Long Term Financial Model (LTFM).

10.2 A draft revision to the Financial Strategy and LTFM has been produced and this is to be reviewed by the Integrated Finance, Performance and Investment Committee on 28th May 2015 and at the Trust Board at this meeting – please see separate paper which features elsewhere on this agenda.

10.3 In summary, the work undertaken has improved the Trust's deficit trajectory, but the year in which UHL returns to surplus remains the same – 2019/20. A surplus of £4.6M is projected in 2019/20, an improvement of £4.1M on the previous projection.

Month 1 Financial Performance and Cost Improvement Programme

10.4 Financial performance in the first month of the new financial year is of concern. We are £0.7M adrift of plan, primarily due to pay overspends.

10.5 The adverse performance to plan has been discussed at the meeting of the Executive Performance Board held on 26th May 2015 and remedial action is in hand. The Integrated Finance, Performance and Investment Committee is to consider the position at its meeting on 28th May 2015 and a separate report on month 1 financial performance also features elsewhere on this agenda. It is essential that we get back on plan as soon as possible but we must do this in a way that does not

compromise safe staffing levels. A formal financial recovery approach is being put in place to work with CMGs to rectify their position.

10.6 Cost improvement programme delivery in month is in line with plan at £2.7M. Work continues to identify the remainder of cost improvement programme schemes for 2015/16, to achieve the target of £43M. Total schemes identified to date amount to £41M. This is a considerably stronger position than at the same point last year.

11. Strategic Objective : Enabled by Excellent IM&T

Electronic Patient Record Programme

11.1 On 21st May 2015, a 'confirm and challenge' meeting was held with representatives of the NHS TDA to discuss the Trust's Electronic Patient Records Business Case.

11.2 The Trust's Business Case was well received. In the light of the TDA's advice, we are to refine the Business Case ahead of a formal submission to the TDA and Department of Health for consideration and approval.

11.3 It is evident that the approval process will take longer than we had originally envisaged and, in consequence, we will re-profile the project timetable to allow for anticipated slippage of a number of months.

12. Conclusion

12.1 The Trust Board is invited to consider and comment upon the contents of this report and the attached appendices.

John Adler
Chief Executive

26th May 2015

Quality & Performance

		2014/15 Final		Apr-15		
		Plan	Actual	Plan	Actual	Trend*
Safe	S1: Clostridium Difficile	81	73	5	3	●
	S2A: MRSA (All)	0	6	0	0	●
	S2B: MRSA (Avoidable)	0	1	0	0	●
	S3: Never events	0	3	0	0	●
	S4: Serious Incidents	N/A	41	N/A	2	●
	S11: Falls per 1,000 bed days for patients > 65 years	7.1	6.9	7.1	5.6	●
	S12: Avoidable Pressure Ulcers Grade 4	0	2	0	0	●
	S13/14: Avoidable Pressure Ulcers Grade 2 & 3	216	160	14	13	●
Caring	C1: Inpatient and Day Case friends & family - % positive	N/A	96%	N/A	96%	●
	C2: A&E friends and family - % positive	N/A	96%	N/A	96%	●
Well Led	W11: % of Staff with Annual Appraisal	95%	91.4%	95.0%	90.1%	●
	W13: Statutory and Mandatory Training	95%	95%	95%	93%	●
Effective	E1: Mortality Published SHMI	100	103	100	103	●
	E9: 30 day readmissions (March)	N/A	8.5	N/A	8.5	●
	E10: Neck Femurs operated on 0-35hrs	72%	61.4%	72%	55.7%	●
	E12: Stroke - 90% of Stay on a Stroke Unit (*March)	80%	81.3%	80%	*83.3%	●
Responsive	R1: ED 4hr Waits UHL+UCC	95%	89.1%	95%	92.4%	●
	R3: RTT waiting Times - Admitted	90%	84.4%	90%	88.0%	●
	R4: RTT waiting Times - Non Admitted	95%	95.5%	95%	95.6%	●
	R5: RTT waiting Times - Incompletes	92%	96.7%	92%	96.9%	●
	R7: 6 week – Diagnostics Test Waiting Times	1%	0.9%	1%	0.8%	●
	R8: 2 week wait - All Suspected Cancer (*March)	93%	92.2%	93%	*91.5%	●
	R10: 31 day target - All Cancers (*March)	96%	94.6%	96%	*97.0%	●
	R14: 62 day target - All Cancers (*March)	85%	81.4%	85%	*83.8%	●
	R22: Operations cancelled (UHL + Alliance)	0.8%	0.9%	0.8%	0.8%	●
	R25: Delayed transfers of care	3.5%	3.9%	3.5%	1.2%	●
	R27: Ambulance Handover >60 Mins	0	3,067	0	286	●
	R28: Ambulance handover >30mins & <60mins	0	11,315	0	1,029	●

Enablers

		YTD		This month		
		Plan	Actual	Plan	Actual	Trend*
People	W6: Staff recommend as a place to work (*Qtr 4)	N/A	54.2%	N/A	*54.9%	●
	C6: Staff recommend as a place for treatment (*Qtr 4)	N/A	69.2%	N/A	*71.4%	●
Finance	Surplus/deficit	(£4.3m)	(£5.0m)	(£4.3m)	(£5.0m)	●
	Cashflow forecast (balance at end of month)	£3.0m	£19.8m	£3.0m	£19.8m	●
	CIP	£2.7m	£2.7m	£2.7m	£2.7m	●
	Capex	£2.0m	£1.1m	£2.0m	£1.1m	●
Estates & facility mgt.	Cleaning standards (metric to be confirmed)	xxxx	xxxx	xxxx	xxxx	

* Trend is green or red depending on whether this month's actual is better or worse than the average of the prior 6 months

Please note: The above metrics represent the Trust's current priorities and the code preceeding many refers to the metrics place in the Trust's Quality & Performance dashboards. Please see these Q&P dashboards for the Trust's full set of key metrics.

Appendix 2a

Midlands & East (Central Midlands)
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Trishthompson@nhs.net

Distribution List:

Toby Saunders, Managing Director, West Leicestershire CCG
John Adler, Chief Executive, UHLT

Sent via E-mail

17th April 2015

Dear John and Toby

Leicester City, Leicestershire and Rutland Strategic Outline case - "Better Care Together"

This letter sets out the conclusions of the meeting on 30th March 2015 when you presented the strategic outline case (SOC) which supports the delivery of the health community's strategy "Better Care Together". This letter aims to do four things:

1. Set out the status of the SOC with the processes of the TDA and NHSE.
2. Set out the conclusions of the meeting including identifying further work.
3. Describe the risks associated with the delivery of the SOC.
4. Set out the board timetable for public consultation and any significant business cases which require external approval.

Before detailing the outcome of the meeting, it is important that we recognise the progress made in LLR in developing the "Better Care Together" strategy and associated SOC. You have clearly benefitted from the national "Challenged Health Economy" investment as you have made rapid progress during 2014/15. There has been significant progress in the development of the cross-community leadership and this will be a cornerstone to delivery of the strategy. We recognise there has already been a significant amount of effort to successfully secure broad community and political support for the strategy, and we are impressed with the infrastructure you have put in place to ensure that progress is maintained.

2. Set out the status of the SOC with the processes of the TDA and NHSE

The TDA and NHSE have separate and distinct accountability arrangements with the LLR health economy. Both UHLT and Leicestershire Partnership Trust are accountable to the TDA for the quality of their services, the delivery of national standards and developing sustainable futures. NHS England is accountable for the commissioning system of CCGs but also direct commissioning of a range of services.

You described how the SOC is owned by the LLR health community and is supported both politically and by the community, and it is clear that you appreciate the ownership for the strategy and the SOC remains within LLR

The TDA will take the SOC through it capital approvals infrastructure as a means of ensuring all future Trust capital cases are reviewed in its context and that the sustainable future of both providers, through their five year plans, is linked closely to the "Better Care Together" strategy. The TDA will still require each business case to be assessed in their own right (the new emergency floor scheme is already in the final stages of approval). The TDA will also use the SOC to support applications to the Department of Health ITFF committee to secure financial support for the ongoing operations of UHLT. It is important to note that the rate of planned improvement in the finances of UHLT is not sufficient and that the TDA has asked UHLT to provide a programme of accelerated development to bring forward the time when the Trust will be in surplus.

You will need to work with NHS England and specifically Andrew Morton to ensure that the appropriate approval process regarding access to primary care capital is followed.

Similarly it will be important to ensure that any proposals regarding specialised commissioned services are agreed with the appropriate teams within NHS England so that these can be factored in NHS England's own governance process.

We specifically discussed access to the transition support described in the SOC. We recognise the importance of the cost of change, double running and creating capacity to undertake the level of change required. There is no national funding currently available to support the described transition costs within the TDA. The expectation is that the resources required are generated by the Health Economy within the resources allocated through commissioners. Two of the three CCGs had requested the drawdown of their previous years surpluses and this was currently being considered by NHS England. There will be development costs built into the capital cases which will be approved through the TDA. Should resources become available we believe you do have a case for external support.

3. Set out the conclusions of the meeting including identifying further work.

The following were the key conclusions of the meeting;

1. The financials needed to be refreshed in light of the current allocations and the contractual negotiations and any possible additional external support (surplus draw down).
2. The commitment to the "Better Care Together" infrastructure and plans is supported including the wider patient and public engagement of the strategy prior to public consultation.
3. There needs to be clear evidence of delivery of change in 2015/16. Specifically, we expect LLR to deliver its plans to achieve national performance standards, that bed reductions in UHLT do not compromise the delivery of emergency care, and that the required reductions in emergency admissions set out in the Better Care Fund plan are delivered.
4. There is a requirement of the health community to deliver its financial plans.

4. Describe the risks associated with the delivery of the SOC.

The risks to the SOC were determined as follows:

1. A failure to lead the programme through collective effort and a coherent managed programme of work
2. A failure to create the appropriate level of capacity
3. A failure to reduce system service demand for acute hospital services
4. A failure to progress the primary and social care strategies
5. A failure to manage the financial challenges

The expectation is that through the programme board and the accountable bodies these risks are recognised and strategies are implemented to mitigate these risks.

5. Set out the board timetable for public consultation and any significant business cases which require external approval.

Prior to consultation NHS England will need to run a formal Assurance Check point although this will be managed in conjunction with the TDA. This will need to be underpinned by a pre-consultation business case which clearly sets out how the Government four tests for service reconfiguration are being met, namely:

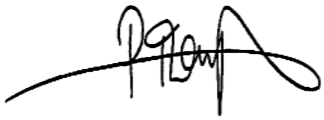
1. Based on clinical evidence
2. Good public and patient engagement
3. Consideration of patient choice
4. Support from GP commissioners

In addition the Assurance checkpoint will cover other aspects of good practice. The detail of the scope of the pre-consultation business case and the requirements of the Assurance checkpoint would be discussed outside the meeting with the Programme Director and members of Trish Thompson's team.

The attached annex sets out the agreed board timetable we agreed for the public consultation and significant business case. We recognise there are a significant number of depended variables, including the decision making processes of ourselves (your regulators). However, we remain full partners in the "Better Care Together" delivery programme.

Finally, in conclusion, can we say that we were very impressed with the strategy and SOC and will continue to support the programme both with LLR but also within our own organisations.

Yours sincerely



Trish Thompson
Interim Director of Commissioning Organisation (Central Midlands)

Jeff Worrall
Portofolio Director

Appendix 2b

Consultation timeline

Week commencing	06/04	13/04	20/04	27/04	04/05	11/05	18/05	25/05	01/06	08/06	15/06	22/06	29/06	06/07	13/07	20/07	27/07	03/08	10/08	17/08	24/08	31/08	07/09	14/09	21/09	28/09	05/10	12/10	19/10	26/10	02/11	09/11	16/11	23/11	30/11	07/12	14/12	21/12	28/12	04/01	11/01	18/01
Legal advice by																																									
Complete EIAs by																																									
Develop consultation narrative																																									
Draft copy																																									
Share draft internally																																									
Agree draft copy																																									
Draft copy to PPI																																									
Feedback from PPI																																									
Paper and draft copy to Delivery Board																																									
Paper and draft copy to Chief Officers																																									
Paper and draft copy to CLG																																									
Update and progress paper to Partnership Board																																									
Briefing update and progress paper to HWBs, HOSCs, Healthwatch, Governing boards																																									
Briefing update to MPs (tailored by constituency)																																									
Briefing update to Mercury Patients Panel																																									
Amends (if necessary) following DB, Chief officers, and CLG feedback																																									
First draft design with real copy																																									
Share draft design with real copy internally																																									
First designer amends																																									
Comms and engagement review draft																																									
2nd design amends																																									
Comms and engagement sign off/amends																																									
SRO final sign off/ameds																																									
Chief officers sign off/amends																																									
Final designer amends																																									
Absolute final sign off																																									
Print																																									
Print delivered and packaged for distribution																																									
Create online version of survey																																									
Update website to include info from brochure																																									
Briefing/training for PPI to share messages																																									
Distribution																																									
Consultation starts																																									
Consultation																																									

Delivery Board						11th				8th					13th				10th					14th				12th				9th					14th					
Partnership Board							21st									23rd								17th									19th									
Clinical Leadership Group										11th									13th							8th									10th								
City HWB												25th											3rd																				
County HWB						14th									16th																													
Rutland HWB															15th																													
City HOSC																																											
County HOSC										10th														9th																				
Rutland HOSC																																												
City Healthwatch																																											
County Healthwatch (board meeting)																																				12th							
Rutland Healthwatch																																											
ELR CCG Governing board																21st								15th																				
West CCG Governing board															14th				11th				8th																				
City CCG Governing board										9th									11th								13th																
UHL governing board																		6th				3rd				1st																	
LPT Governing board																	30th								24th																		
Mercury Patients Panel																																											

PPIRG						13th				10th					15th				12th				9th				14th				11th										

Appendix 3

University Hospitals of Leicester NHS
NHS Trust

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26th May 2015

To all staff and stakeholders in the EMCHC

Dear colleagues,

I am sure that you are aware that we have been asked to start thinking about how we go about implementing the standards developed by NHS England for Congenital Heart Disease. We have had a lot of internal discussion and have already started a business case to support us in getting to the best possible place; this includes making immediate changes now and planning a children's hospital at the LRI for the future.

We are moving the East Midlands Congenital Heart Centre to the Royal Infirmary because we know that one of the key standards is the co-location of all children's services on one site and our Trust Board have agreed that this is a priority for us. We have therefore started the work but it takes quite a long time to write a business case and to get funding allocated. It is likely therefore that the children's hospital will not be complete until the first half of 2018.

We had a meeting with NHS England recently when they were clear with us about the timescales for implementation of the standards. Co-location of all children's services will need to happen within 3-5 years, so our timescale meets this requirement. The integrated children's hospital will bring together specialisms, wards, clinics and outpatient departments in the same distinct footprint with their own dedicated entrance and facilities designed around the needs of our younger patients. In addition to significant Trust investment, we plan to launch a major charitable campaign so that we can create facilities which are truly state of the art.

Prior to the main development at the LRI, we are committed to undertaking an interim development so that the EMCHC can continue to flourish in the short term. This will begin later this year.

Compliance with minimum numbers of surgeons (4) and minimum numbers of procedures (125 each) will also need to happen within 3- 5years. It is likely that the minimum standard of 4 surgeons may change to a minimum of 3, as the majority of surgeons feel that the important factor is how many procedures a surgeon does, not how many are on a rota. We will achieve this standard if we work better with local hospitals and if our commissioners require adults and children with congenital heart disease to be referred to centres as near to their homes as possible. We have been lobbying for this for some time and it does now appear to be the direction of national policy.

We have also been keen to establish networks and this is also now being actively encouraged by NHS England. At a recent meeting we agreed with providers in the West Midlands - University Hospitals of Coventry and Warwick, Birmingham Children's Hospital, the Royal Wolverhampton Hospital and University Hospital of Birmingham - that we will form a network. We are going to agree a set of principles to underpin how we work that supports all providers in the network. Importantly, we have agreed that there will be 2 Level 1 surgical centres – ourselves and Birmingham Children's. The network will work together to ensure that there is sufficient numbers of patients distributed throughout it and all providers will advocate for each other. We are also going to speak with Great Ormond Street Hospital and the provider network in the South region as the more consistent we can be around how the networks will function, the greater the chance of making it work.

We have to have a response ready to go to NHS England by the 5th June.. Kate Shields (our Director of Strategy) will be taking the lead for this along with Matt Boazmann (Director of Strategy for BCH).

This is a really exciting time for congenital heart services in Leicester. For the first time in a long time we have a REAL opportunity to define our future and to make and sustain partnerships that will help us to grow.

If any of you have any questions that you would like answering please Kate Shields directly (kate.shields@uhl-tr.nhs.uk). If any of you would like to be involved in this work, please let Jon Currington (Head of Tertiary Partnerships at UHL) know (jon.currington@uhl-tr.nhs.uk) and we will make sure that we link you into work that is going on.

With best wishes

Yours sincerely,

John Adler
Chief Executive