Delivering Caring at its Best: Our 5 Year Plan

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Paper F

Executive Summary

Context

The Trust last published its 'Strategic Direction' in late 2012. Since then a good deal of progress has been made on enacting the strategy within UHL and at the same time similar progress has been made across the wider health economy to create the Leicester Leicestershire and Rutland Health and Social Care 5 year plan, called, Better Care Together.
Now, in the first quarter of the new financial year we want to share how our strategy and plans have developed with staff, stakeholders and the wider public. This narrative is the vehicle for that.
Once this document has been approved it will handed over to the UHL design team to make it more readable and engaging. The first audiences are our own staff and professional partners; then we will produce a shorter, easy read version for the wider public.

A series of 'at scale staff' engagement events are being planned at which the Chief Executive will present the plan to approximately 1,000 staff of all disciplines and levels of seniority across the Trust.

Questions

1. Are the Board prepared to endorse this narrative as THE narrative for UHL's 5 year plan?
2. Are there any final changes which the Board would like to recommend?

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	[Yes]
Board Assurance Framework	[Yes]

3. Related Patient and Public Involvement actions taken, or to be taken:
   The narrative has been shared with UHL's Patient Partners and three local Healthwatch organisations for comment. The strategy itself and components thereof (for example the Quality Commitment) has been developed with input from stakeholders.

4. Results of any Equality Impact Assessment, relating to this matter: [Insert here]

5. Scheduled date for the next paper on this topic: The revised Chief Executive's Board report will track progress on the delivery of this plan each month

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

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

(Version 10) Delivering Caring at its Best: Our 5 Year Plan

Setting the scene:

Our NHS values haven't changed but the world has. There are more people and they live longer but often with illness; we have more information at our fingertips to help us live healthier lives but we don't always take heed; increasingly we expect our public services to take account of our busy lives and we know more about our public services than ever before.

Alongside these wider societal changes, as a major acute, teaching Trust there are some very specific issues which we need to solve if we are to deliver on our pledge to provide 'Caring at its best'.

We last published our Strategic Direction in November 2012, since then much has changed not least the publication of the 'NHS 5 Year Forward View' nationally; and locally, the far greater emphasis on working in partnership with other health and social care colleagues through the 'Better Care Together' programme*. Indeed, what is more apparent now than ever before is that we cannot be a strong, sustainable, high quality acute Trust without there being equally strong and sustainable local primary care and social care… in that sense our future and our ability to provide high quality care for the 1.1m people living in the richly diverse communities across the City and Counties is interwoven with that of our partners.

As we start to gain momentum with our plans, we want to share with staff, stakeholders, patients and the public how our vision and strategy is developing. This is an important time in the history of our hospitals; for the first time in over a decade we are having serious conversations about bringing significant and much needed investment to the Trust.

In the rest of this document you will read about our key strategic objectives; the short term priorities for this year (2015-16) and the longer term ambitions for our services, our hospital sites and our partnerships with other organisations in the NHS and social care.

*BCT the comprehensive 5 year plan for health and social care across Leicester, Leicestershire and Rutland will be the subject of public consultation in autumn of this year and Leicester's Hospitals will be at the heart of that plan.

Our vision: "To Deliver *Caring at its Best*"

Our commitment to quality is unwavering: that means we aim to provide *effective care* with ever improving outcomes; *safe care* where the risks of errors is reduced to an absolute minimum and last but by no means least, *compassionate care* where patients and their families are always treated with respect and tenderness. This is the core of our vision and everything else that we do should be in support of that.

In five years' time we will be smaller, more specialised, and financially sustainable. We will make our specialist expertise available to primary and social care and by exporting more of our non-specialist services to the community and we will play a much bigger role in preventing illness and supporting patients before they reach a point of crisis. This will reduce the need for people to come into hospital, reduce the number of beds we need and ultimately enable us to run our specialist services from two, rather than three big hospitals.

For those patients who do need hospital treatment they will find that our services are quicker, easier to navigate and higher quality, largely as a result of being able to focus on our specialisms, our slicker processes, our better use of technology and because we will no longer expect our staff to spread themselves across three main sites.

We will invest in our buildings so that patients and staff feel a sense of pride in their local NHS. We will build a new A&E; a new day case centre, a new children's hospital, there will be new investment in our maternity services and a new multi storey car park. At the same time we plan, with our health and social care partners to transform the General Hospital from an acute inpatient hospital into a broader health campus.

Our specialist services will grow as we create partnerships and networks with other regional hospitals; we will support district hospitals to maintain their services locally and in doing so increase referrals into our tertiary services and expand the potential for population based research.

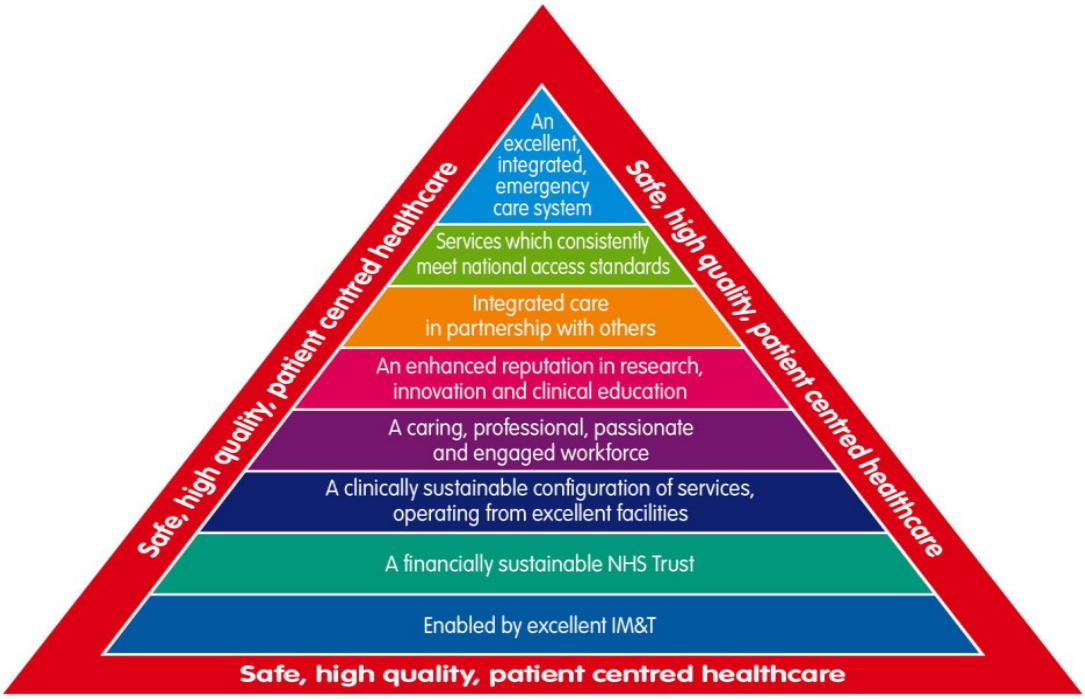
As a consequence of shifting our focus to specialist work and using our expertise outside hospital we expect to attract increased research funding and clinical talent to our hospitals, making Leicester the regional Trust of choice for people wanting a career in the NHS.

Finally, recognising that quality, safety and compassion are almost entirely reliant on the expertise, behaviour and values of all who work in Leicester's hospitals, we will continue to invest time and resource into building a culture of engagement where people are listened to, problems are confronted and staff feel valued for the tremendous work they do.

This is what we call Caring at its Best.

Underpinning the vision are our Strategic Objectives. These encompass all the things we need to do in order to deliver the vision and ultimately our desire to provide Caring at its Best. Our Strategic Objectives are represented in the strategy triangle below; the fact that 'safe , high quality, patient centred health care' wraps around every objective is not an accident of design but a reflection that safe, high quality care is an essential prerequisite for all our endeavours.

Over the next few pages we will explore each of these long term objectives in more detail, with a particular focus on the work we will be doing during 2015/16.



Safe, high quality, patient centred healthcare

In 2012 we launched our 'Quality Commitment' which set out our desire to improve safety and quality across all our clinical services. Since then we have seen steady improvements in mortality, falls, pressure sores, patient experience and hospital acquired infections. There is always more to do. The quality commitment has three main aims; Better clinical outcomes, safer, harm free care and improved patient experience.

Improving patient outcomes

We will further reduce mortality in our hospitals.

Mortality is measured for all NHS hospitals using the Summary Hospital-level Mortality Indicator (SHMI). Whilst UHL's SHMI is currently in the 'as expected' range, it is our aim to have an overall SHMI of 100 or less by March 2016 and to reduce it further in future years.

By reviewing all in-hospital deaths and through use of clinical bench marking tools that help us to identify where there is room for improvement or lessons to learn, we will focus on those pathways of care that are likely to have greatest clinical impact for patients. This year we will also be piloting use of the Copeland Risk Adjusted Barometer (CRAB) which will help us triangulate information and detect potential problems or trends at an earlier stage.

Specifically, but not exclusively, we will be working hard on the following areas:

- Acute Kidney Injury – with the aim to further embed the AKI alert tool and review process.
- Acute Myocardial Infarction (heart attack) - developing consistent pathways of care (prompt ECG investigation, interpretation and training of staff)
- Continued work to embed respiratory and pneumonia care pathways and a specific focus on acute bronchitis
- 7 Day Services – we will continue work to improve the consistency of services and level of senior medical supervision and decision-making 7 days a week

Reducing patient harm

We will reduce avoidable harm by earlier recognition and intervention for patients who are deteriorating. We will do this by:

- Earlier recognition and treatment of patients with serious infection (sepsis) using sepsis screening tools, and rapid initiation of intravenous antibiotics within 1 hour of presentation for those patients who have suspected severe sepsis.
- Implementing a standardised electronic handover system for use by all doctors and nurses to improve communication between teams and departments
- Implementing an electronic observations system for inpatient areas to improve the early escalation of patients who are becoming unwell
- Roll out of a single order communications system for all inpatient areas and selected outpatient departments to improve results management.
- Reducing medication errors by use of a Medication Safety Thermometer.
- Implementing safety briefings into selected clinical settings to support a culture of continual learning and improvement.

Improving patient experience:

We will continue to listen to views from patients, their family and carers to ensure feedback shapes our service design and delivery.

Many methods are used to find out 'what matters most' to patients and the Friends and Family Test is one of the measures. It is used nationally to measure patient's levels of satisfaction and our aim

is to achieve a consistent score of over 97% recommendation for the Friends and Family Test across all services.

Improving patient experience is about taking every opportunity to listen and work with the people who use our services, this needs to occur every day, across all services, using the skills and expertise of both the patients and the clinician.

One of our key priorities for the next year is to expand the excellent work to improve the experiences of care for patients that are approaching the end of life. This will include:

- Introducing guidance to assist in the early identification of patients at risk of deteriorating and potentially dying who have one or more advanced long term conditions.
- Ensuring well-co-ordinated, supportive palliative care that allows patients and their families more time for decisions about treatment and care options
- Strengthening bereavement services and support

And In line with our 'Frail Older Peoples Strategy', the experience of care for older people will improve as we 'Fix the Fundamentals' identified by patients that can make a huge difference to an older persons stay in hospital. This will include:

- Improving environmental factors such as signage, hearing loops, retreat rooms and dining facilities including improving snack choices and flexibility around meal times
- Improving the amount and type of information provided about a person's time in hospital and in preparation for going home

Our specific priorities for 2015/16:

- Continue to reduce the mortality rate, (measured by SHMI) to under 100 i.e. better than average.
- Reduce patient harm (falls, pressure sores, infections etc) by 5%
- Achieve a 97% friend and family test score for patients and staff recommending the Trust as a place to be treated
- Achieve an overall 'Good' rating from the next Care Quality Commission inspection
- Develop the 'UHL Way' for all improvement programmes
- Improve the quality and timeliness of our patient letters
- Listen and respond to feedback better by implementing our new Patient and Public Involvement strategy, working with stakeholders and our Patient Partners.

An excellent, integrated emergency care system

Whilst there have been significant improvements in the performance of the emergency care system locally, there are still days when Leicester's Emergency Department is overflowing with patients. This results in long delays, ambulances queuing to unload their patients and ultimately poor patient experience.

At times of high demand this situation is made worse by the fact that the current A&E was built for 100,000 patients a year and yet is now coping with 180,000.

There are three factors which contribute to this situation. First, there are too many people in our local communities who reach a crisis point in their health which then makes a trip to hospital unavoidable; second there are delays in hospital as a result of poor processes and pathways; and third, when patients reach the end of their stay in hospital and are ready to go home their discharge is delayed by the amount of time it takes to establish support packages in the community; transport to take them home and making sure they leave hospital with the right medicines.

To address these three factors we will…

<u>Work with partners to help predict a person's health crisis and make services which avoid hospital admission available, closer to home</u>

Often a crisis like a fall for an older person or the worsening of an existing illness is predictable, yet for too many people the result is a hospital visit. In future our primary care colleagues are going to work with carers and their patients who are known to be at risk to make sure they have personal care plans completely focused on them and their needs. At the same time we will make more services which have traditionally been based in the hospitals, and more of our specialist clinical knowledge, available in the community. This will mean that a spell in hospital becomes the exception in all but the most complex situations.

In 2015-16 we are aiming to reduce admissions by 10%, after allowing for growth caused by the rising population.

<u>Improve our internal processes so that delays are 'designed out' and patients get to the right place quickly</u>

It is too often the case that our emergency department comes to a standstill as a result of patients still flowing into the department but not moving out onto our wards because beds are fully occupied. This is called 'exit block'. As with most things in emergency care there are a number of factors which contribute to this and many of them require a response from all parts of the local emergency care system. BUT there are factors which are our responsibility and ours alone. The timeliness of clinical decision making and discharges are the single most important factors. So, when ward rounds start early, prescriptions are written up quickly and discharge co-ordinators are briefed we know that we can create sufficient capacity to see the hospitals through even those days of very high demand.

In 2015-16 we are aiming for a 10% reduction in the average length of stay of our patients in emergency and specialist medicine, our busiest service, and a 10% improvement in timely discharges supported by our colleagues in Leicester Partnership Trust.

Working with other parts of health and social care to make sure that when patients are ready to leave us, they are ready to look after them.

'Delayed transfers of care' (DTOCs) occur when a patient reaches the end of their stay in hospital, have been assessed as fit to go home but for reasons outside of the hospitals' control, they cannot. This is sometimes because it takes too long to find the patient a care home place or too long to create a package of home care to support them in their own community. These kinds of delays are more than inconvenient. For many patients, and especially the very old or very frail, an over long stay in hospital can mean that their chances for a full recovery diminish with every extra day they spend in bed.

Our specific priorities for 2015/16:

- To reduce emergency admissions by better use of ambulatory care i.e. care which does not require an overnight stay in hospital
- Improve our ability to cope with pressure on the Clinical Decisions Unit at the Glenfield Hospital
- Improve our ability to cope with pressure on the Emergency Department especially in the evening and overnight
- Reduce the average length of stay in emergency medicine
- Reduce the time it takes for ambulances to handover their patients at A&E and get back out on the road.

Services which consistently meet national access standards

Most of us are of a generation that can remember when patients lived for too long with pain as a result of the long waiting list for things like hip replacements and other types of non-emergency surgery. Sadly, we can also recall those days when patients would die whilst still on the waiting list for surgery. Those days are behind us and now anybody waiting for more than 18 weeks for their procedure is the exception, in fact most patients have their procedure well within the 18 week maximum waiting time and Leicester's Hospitals have the second smallest waiting list for elective treatment compared to the other top 12 big acute teaching trusts in the country.

That said, our job is to end the exceptions, convert 'most' into 'all' and ensure that we provide fast access to high quality care in *all services at all times*.

The reasons for delays and cancellations fall broadly into two categories. The first is that in some of our services the demand is rising inexorably every year, faster than our ability to deal with it, recruit more staff or change the models of care so that we are more efficient

and more productive. The second category is the impact that emergency pressures have on our non-emergency care services. There are times when the level of admissions from emergency patients overflows our emergency beds and into those beds set aside for non-emergencies; the result is that patients are cancelled, often at short notice. Similarly there are times when our operating theatres or Intensive Care Units are full of emergency patients and again we have to cancel non-emergencies until such a time as we can guarantee that there will be theatre and intensive care space.

To avoid this happening in future and as part of Better Care Together we are redesigning those services where the demand is greatest and growing, for example ophthalmology, to make sure that the clinical pathway through the service is as streamlined and rapid as possible. In some circumstances this means we will seek to shift parts of the service out of our hospitals so that they can be more effectively delivered locally in community hospitals. These proposals will form part of the public debate in the Autumn.

At the same time, as we consolidate emergency and specialist care into the Royal and the Glenfield Hospitals we will start to move some of our non-emergency services to the General Hospital so that they are protected from emergency pressures. Ultimately, we aim to have a dedicated facility specialising in elective care like hip and knee replacements, cataract operations and breast surgery at one of our hospital sites. We call this a Planned Treatment Centre.

The combined effect of these measures means that we will first during 2015-16 ensure that we hit all referral to treatment time targets and then further reduce patient waits to the point at which we are the recognised as the lowest wait teaching trust in the NHS from 2016-17.

Our specific priorities for 2015/16:

- Deliver all referral to treatment time targets
- Deliver all cancer diagnosis and treatment targets
- Deliver all diagnostic test targets
- Design and implement tools and processes that allow us to plan activity and to cope with spikes in activity more effectively.

Integrated care in partnership with others

When patients think about the NHS they see one service, which includes GPs, ambulances, community services and hospitals. Unfortunately and until very recently the NHS has been

anything but one service. Now with the added realisation of social care's importance in the mix, integration is at the top of the health and social care agenda.

Patients often feedback that their experience of individual parts of the NHS was exceptional but that they were left confused or, worse still, feeling uncared for in the many hand offs between the different parts of health and social care. This causes anxiety, delay and waste.

GPs have been described as 'expert generalists'; their unique skill is to recognise illness in their patients and where necessary refer onwards to hospital specialists for confirmation and treatment. However, the boundaries between specialists in hospital and generalists in the community are becoming blurred. There are many patients with more than one illness or condition who would benefit from care which was provided by a combination of specialist and generalist knowledge; these are often the patients who are admitted as emergency cases through A&E when they reach a crisis in their health.

Rather than perpetuate the boundaries between the different parts of the NHS and social care, we want to do away with them. At one level this simply requires some of the services which have traditionally been provided in hospital to move into the community and be provided closer to home. But at a more interesting level this could mean teams of GPs working alongside, ambulance staff, community nurses, physiotherapists, consultant geriatricians, dementia specialists and social care to look after some of our 'oldest old' people in such a way that they are supported to live independently for longer and where likely problems are spotted and dealt with well before the need for a stay in hospital becomes the only option.

<u>Partnerships with other hospitals:</u>

As well as working more closely with primary and social care, we are also forming formal and informal partnerships with other local hospitals. These relationships work in two ways and benefit all involved. First, for some smaller local hospitals like neighbouring District Generals, they are finding it increasingly hard to attract specialist staff to work in their services. This is largely down to the fact that many new clinicians would prefer to work in bigger centres like Leicester, where there is an opportunity to conduct research and access to a more varied mix of patients. To address this issue we are working with colleagues in places like Northampton and Kettering to create strategic alliances where they are able to successfully recruit clinical staff by offering posts which are hosted by our Trust and which enable recruits to spend time in Leicester as well as at the local hospitals. These kind of alliances not only ensure that people have access to important services in the wider East Midlands, they also increase the potential 'critical mass' of patients who can be referred to Leicester's Hospitals for specialist treatments, meaning that we are guaranteeing the long term future of our services.

Better Care Together:

The Better Care Together partnership between local NHS providers, the Clinical Commissioning Groups, Social Care and the third sector was established in June 2013 with the aim of creating a single, integrated, 5 year strategy for health and social care which would deliver better care *and* cost savings to the local health economy.

The vision for BCT is to create a system which "Supports you through every stage of life". Meaning that services will…

- Support children and parents so they have the very best start in life
- Help people stay well in mind and body throughout their life
- Know your history to help anticipate and plan for your health needs
- Care for the most vulnerable and frail of our citizens
- Be there when it matters most and especially in a crisis
- Help support people and their loved ones when life comes to an end.

The vision is simple but the enactment of the vision will be complex because it involves, for the first time, the harmonisation of the individual 5 year strategies of six different local partner organisations. And because Better Care Together is all about pulling off the difficult task of improving care and saving money, there will inevitably be some difficult decisions made along the way. To make sure that these decisions are influenced not only by what makes most sense clinically or operationally but also by the hopes and aspirations of local people, the partnership also includes local stakeholder organisations like Healthwatch who help to bring the patient and public voice into shaping the future of our services.

By autumn 2015 we expect that most of the planning will be complete for the major components of Better Care Together meaning that the partnership will be able to set out for all to see, the long term future of health and social care services, and thus a period of formal consultation and reflection will follow to allow the public, staff and other stakeholders to comment and test the plans.

Our specific priorities for 2015/16:

- Deliver the Better Care Together Year 2 programme, including new care pathways and more care delivered in community hospitals and people's own homes
- Participate in BCT formal consultation
- Develop and formalise partnerships with other local providers
- Explore new partnerships to deliver better joined up care

An enhanced reputation in research, innovation and clinical education

The strength and breadth of our clinical research and education sets Leicester's Hospitals apart from most smaller hospitals. We are one of the major research institutions outside what is known as the 'golden triangle' formed by Oxford, Cambridge and London.

We are already a leading centre in cardiovascular research through the work of our Cardiovascular Biomedical Research Unit at the Glenfield. Similarly, in the field of respiratory illness we have the Institute for Lung Health also at the Glenfield. Meanwhile the General Hospital is home to the Diabetes Centre of Excellence and the Royal hosts the Cancer Research UK Centre.

Research not only brings income and prestige to the Trust; it also makes Leicester an attractive place to work for established clinical innovators or those on the way up. As a consequence local people will often benefit from being able to participate in clinical trials which give them access to new and novel techniques which patients in other parts of the country do not have access to.

Our forthcoming research projects include…

The 100,000 Genome Project, where UHL has recently been awarded 'Genomic Medicine Centre' status meaning that our researchers will be part of an international collaborative exploring the genetic causes of diseases.

The Life Study, an ambitious programme which will collect information about babies and their families over the course of their lifetime to investigate the influences that economics, education, health and wellbeing have on their development. Leicester will be the largest recruiter of families to this study in the country.

The East Midlands Breathomics Research Facility, in partnership with the University of Leicester, this is a £3.2m investment to establish a national centre capable of improving the diagnosis of patients using new, non-invasive diagnostic tools.

The Institute for Older People's Health, a new collaboration between the Trust, DeMontfort University, Age UK and Leicestershire Partnership Trust to create a research institute focusing on addressing the challenges we face in health and social care when it comes to looking after our growing older population.

We also have a major role as an educator of the health professionals of tomorrow, working in conjunction with our university partners. Whilst we deliver much excellent teaching and

training, we need to ensure that we do this consistently. We will also continue to develop new roles for staff such as nurses and therapists so they can take on some of the duties that have traditionally been the province solely of our doctors.

Our specific priorities for 2015/16:

- To develop a quality assurance process for medical education
- Strengthen our relationships with university partners
- Deliver the Genome project
- Prepare for Biomedical Research Unit re-bidding
- Develop a commercial innovation strategy

A caring, professional, passionate and engaged workforce

One in every hundred people who live in Leicester, Leicestershire or Rutland work for Leicester's Hospitals. As such our staff are not only the providers of care to 1 million people locally they are also the custodians of our reputation. Our hospitals are only as good as the people who work in them. Thankfully our people are very good. However, our NHS staff survey results indicate that there is more work to do, particularly in terms of staff recommending the Trust as a place to work or receive treatment

Two years ago we launched 'Listening into Action', (LiA), a whole hospital programme which enables teams to come together with their leaders to solve issues that get in the way of our ability to provide excellent care. The teams which have been through the LiA programme show greater levels of engagement, better team working and problem solving and overall increased satisfaction with both the care they give to patients and their satisfaction with the Trust as a place to work. We will continue to roll out Listening into Action so that it spreads throughout our hospitals.

Complementing Listening into Action, we will develop a culture of leadership at all levels which really values everyone's contribution, which gives clear direction, which demonstrates exemplary standards of communication and which responds appropriately when concerns are raised by staff.

Our specific priorities for 2015/16:

- Accelerate the roll out of Listening into Action
- Remove the things that get in the way of our staff being able to do the best job
- A stronger, more engaged leadership culture
- Develop and implement the medical workforce strategy, with a particular focus on attracting medical staff to the hard to recruit to areas.
- New actions to respond to the equality and diversity agenda including the new Race Equality Standard
- Ensuring that we comply with the new national 'whistleblowing' standards.

A clinically sustainable configuration of services, operating from excellent facilities

Leicester is very unusual in having three big acute hospitals, the General, the Glenfield and the Royal Infirmary, for the modest population they serve. This creates problems; first it means that we spread some of our specialist staff too thinly across the three hospitals; second it means that we duplicate and even triplicate services at two / three sites; third it means that some of our services are in the wrong place and last but not least it is very expensive to run. For example the Trust runs three Intensive Care Units, one at each site. However, whilst demand for ITU grows at the Royal and the Glenfield, it has diminished at the General. Over the last few years this has meant that recruiting clinical staff to the ITU at the General has been difficult because new intensivists want to practice in big, busy units.

So, we are going to commit significant investment in intensive care services, which will ultimately see intensive care for the sickest patients consolidated at the Royal Infirmary and Glenfield hospitals. The programme will involve the creation of two 'super' Intensive Therapy Units, (ITUs), a significant increase in level 3 capacity, (level 3 is where we care for the 'sickest of the sick') and the development of the largest ITU transport service outside of London.

Moving ITU from the General to create more capacity at the Royal and the Glenfield will mean that other services will also be required to move. This is because some operations can only be safely carried out when there is an Intensive Care bed available close by. These are some of the associated moves we are discussing with our clinical services:

- Major complex elective Hepatobiliary and emergency service could move to the Glenfield. All day case activity will remain at the General.
- Renal transplant and acute nephrology service to the Glenfield.

- Complex elective and emergency general surgery could move to the Royal. All day case activity will remain at the General.
- Gynaecology/Gynae-Oncology which requires General Surgical joint operating will move to the Royal. All other elective activity will remain at the General.
- The majority of the Urology service to remain at the General.

From three acute sites to two:

In 2012 we said that it was our intention to further focus emergency and specialist care at the Royal and the Glenfield. This will enable us to reduce the duplication of services, provide better 24/7 and seven day a week clinical cover and reduce costs.

This then means that the General Hospital would have a different future. Currently our thinking is that the General is the best location to explore models of integrated care across primary, secondary and social care. We also want to look at how we might separate emergency and non-emergency, elective care. The main driver for this is the fact that currently our emergency and elective services largely sit side by side and as a result when emergency demand is too high our elective patients experience delays and cancellations to their planned surgery. Ultimately we want to build a dedicated facility, known as a Planned Treatment Centre for this non-emergency work which will protect the services from emergency pressures and offer a better all-round patient experience. In the meantime we are looking at the possibility of creating an interim planned care service at the General Hospital so that we can start to make improvements to waiting times, patient experience and operational efficiency more quickly.

A new integrated children's hospital:

We already have a dedicated children's emergency department and we are home to most of the services that would normally be found in a specialist children's hospital Trust. The majority of our children's services are at the Royal Infirmary with the notable exception of children's heart services, which are based at the Glenfield in the East Midlands Congenital Heart Centre. Recently NHS England published standards which said that all Trusts that currently provide children's heart surgery must in future make sure that the service is 'co-located' with other children's services.

We are clear that we want to retain children's heart surgery and as such we will be relocating this service to the Royal Infirmary. At the same time we want to use this opportunity to create a more integrated children's hospital at the Royal Infirmary meaning that specialisms, wards, clinics and outpatient departments are together in the same distinct footprint with their own dedicated entrance and facilities designed around the needs of our younger patients. It is unlikely that we will construct a completely new building for this purpose, as the cost would be excessive. Instead our solution will create a genuinely

integrated children's service which feels like a dedicated children's hospital but at a fraction of the cost.

The new Emergency Floor (Accident and Emergency Department)

The existing A&E was built to cope with 100,000 attendances a year and is currently seeing 180,000 and whilst the avoidance schemes discussed elsewhere in this document will serve to reduce or at the very least cap the levels of attendance, we know that we need more space to deal with emergencies.

By winter 2016 the new £43m A&E will be built. This is Phase 1 of the Emergency Floor development. A year later, Phase 2 will be in operation, providing a suite of assessment units located right next to the A&E instead of four floors apart as they are currently. It will be the UK's first frailty friendly A&E meaning that it is designed with the needs of our oldest and most vulnerable patients in mind and in doing so will benefit not just this group but everyone who uses it.

A new multi storey car park at the Royal Infirmary

We do not need to explain why this is important, anybody who uses the Royal, and nearly a million people a year do, will know that parking and the queues for parking are horrendous. So, we will be increasing our car parking capacity by nearly 350 spaces by building a new multi storey car park at the Royal.

In total and with the right backing from our national colleagues, we expect to spend £320m over the next 5 years on improvements to our hospitals. This will be the first time that Leicester's Hospitals have seen major investment in nearly two a decades. The Emergency Floor has already been approved and funded nationally. In addition, what is known as the Strategic Outline Case for Better Care Together has also been approved. This will be the 'wrapper' within which the rest of our investment programme will be taken forward.

Our specific priorities for 2015/16 are:

- To create detailed 'development plans' for each of our hospital sites
- Improve ITU capacity by creating two super ITUs at the Glenfield and the Royal
- Start building phase 1 of the new Emergency Department
- Complete the vascular business case and the outline business cases for; The Planned care Treatment Centre, Maternity, Children's Hospital, Operating theatres, and bed reconfiguration.
- Develop a major charitable appeal for our investment programme
- Build a new multi-storey car park at the Royal Infirmary

A financially sustainable NHS Trust

Looking after the money means we are better able to look after our patients. This has never been more important than in these times of austerity when every penny counts.

Last year the Trust operated with an agreed £40m deficit, essentially meaning that there was a significant and continuing gap between what it cost to run our hospitals every year and what we receive by way of payment for the services we provide. For as long as this is the case we will struggle to invest in the development of our services and our staff.

There are a number of reasons why we cannot balance our books at the moment but they broadly fall into two categories. The first is that at a service by service level more of our services operate at a loss than a profit and when the losses are added up and set against those services that make a profit, one does not cover the other. There are some services which we provide and always will provide which will never cover their costs here or at any of the other hospitals up and down the country; A&E is the classic example. But these services are in the minority. More important are the services which ought to be profitable but are not currently. Again there are various reasons why this is the case but our focus is on two elements; making sure that we are paid the right 'tariff' (or price) for the work we do and most importantly making sure that our clinical models and the clinical pathways are as effective and efficient as they can be. We have a programme of work in place to ensure that this happens for all our services.

The second key reason for the deficit has already been discussed albeit in a different context and that is the current configuration of our hospitals and the fact that we have three acute sites, without the size of population that would necessitate this. Whether it's the fact that we have to run three Intensive Care Units or three staff canteens, it is a fact that three is substantially more expensive than two.

In this context the Trust's Financial Strategy will deliver a recovery from a 2014/15 planned deficit of £40.7m to a reduced deficit of £36.1m in 2015/16, to eventually delivering a small surplus in 2019/20.

The recovery plan shows an improvement in the Trust's financial position in each year through productivity and efficiency gains but the most significant element (the final £30m) would be delivered in 2019/10 as a result of moving from three acute hospital sites to two, thereby reducing the expensive clinical duplication of staff and equipment.

Alongside the strategic reconfiguration part of the recovery plan, the other key component of financial improvement will be the delivery of the Trust's ambitious savings programme. In 2014/15, we saved £48m on the cost of running the hospitals against a target of £45m.

This was the largest in year savings total the Trust has ever achieved and one of the largest in the NHS.

This work will continue in 2015/16 as we target savings through better performance in the average length of time patients stay in hospital, better use of our operating theatres and more efficient bookings of outpatient appointments. This will contribute to 2015/16 savings requirement of £41m. In future years we will be focussing more and more on improving the quality of our care at the same time as saving money. There are many examples of how this can be done, for instance cancelling patients for surgery wastes precious operating theatre time and is very distressing for those patients. Another example is hospital acquired infections, and though we already have very low rates, if we can reduce them further we keep patients safe and save money on the drugs that would be used to fight infections.

Our specific priorities for 2015/16 are:

- Deliver our agreed £36m deficit
- Achieve the savings target of £41m
- Revise and agree the 5 year financial strategy with the Board and the Trust Development Authority.
- Continue the programme of detailed clinical service reviews.

Enabled by excellent IM&T

There is a strange contradiction in the NHS. Big research led teaching hospitals like ours harness some of the most advanced technology on the planet in diagnosing and treating patients. We routinely use robotics in surgery or for dispensing drugs whilst our imaging equipment is state of the art and represents millions of pounds worth of investment. And yet paper patient notes are routinely trafficked around the Trust in shopping trolleys at the start and end of clinics, filed in warehouses the size of football pitches; and patients often report their frustration at being asked the same questions over and over again as they travel through the NHS system.

It is not just that this is old fashioned; it actually gets in the way of providing really good patient care. To counter this one of the key schemes which will underpin some of the other improvements described elsewhere in this document is the creation of an 'Electronic Patient Record'… in other words a full and comprehensive computerised account of a patient's history, illness, progress, complications, drug treatments and imaging that is available to our doctors and nurses at the touch of a button. This will mean that clinical decisions are taken with a full history at hand and in some cases so much more rapidly than has traditionally been the case, that lives will be saved.

Our specific priorities for 2015/16 are:

- Prepare the ground for the delivery of the Electronic Patient Record in 2016/17
- Ensure that we have the right basic IM&T infrastructure to deliver our plan
- Review IBM support to make sure that we have the right resources in the right places.

Our values:

We know that our ultimate purpose as a Trust and as individuals who work for the NHS is to seek at all times to provide 'Caring at its Best' to our patients and their families. And equally when this is not the case, to question why and work out how things could be made better.

There is no single rule book in Leicester's Hospitals. We are such a massive and complex organisation that even if there was one it would require a forklift to carry it. Instead we are governed by our values. These were created by staff, for staff and they describe the behaviours we should display at all times to our patients and to one another. Living our values every day and refusing to tolerate those who do not wish to, is the most important single action we can take to create a Hospital Trust which is loved by its patients and staff and respected by peers and stakeholders. This is why we constantly reinforce our values, when new colleagues join us, when staff have their annual performance review, and through our Caring at its Best Awards, which run throughout the year.

Summary:

Developing and delivering a 5 year strategy in the NHS is rarely straightforward, just when the landscape seems fixed, everything changes. But in Leicester we have sufficient clarity about our plans, and sufficient understanding of national policy and support to be able to take them forward with confidence. This is not least because the ideas, plans and aspirations contained in this strategy start from the basic and thankfully fixed point of what is best for patients.

Although the direction of travel is clear, there are still big decisions to be made both within the UHL strategy and the wider Better Care Together partnership. There will be a continuous process of engagement and consultation with patients, the public and staff as we work towards those decision points. We also need to remember that for this strategy to be realistic and achievable, it has to be flexible, which means it must be able to take account of changes to the local landscape, policy and public / patient opinion. What will not change is

the overall purpose of this Trust. To deliver ‘Caring at its Best’ for the million people who use us every year.

Different language / accessibility options here.

ENDS
MW 27/5/2015