University Hospitals of Leicester

NHS Trust

UPDATE June 2016

Delivering Caring at its best

Our 5-Year Plan and 2016/17 Priorities

Introduction

As we continue to enact our vision to 'Deliver Caring at its Best' our plans become more detailed and refined.
At the same time, as we draw closer together as a local health economy through the work of 'Better Care Together' the relationships, inter-reliances and opportunities for the Trust and our partners become more obvious.

Now feels like the right time to explain in more detail the latest thinking around our clinical services strategy and the future of each of our hospitals. It is really important to understand that this document does not replace our 5-Year Plan "Delivering Caring at its Best", which we published last year, rather it updates it to take account of the progress we have made in the last 12 months and to reflect some of the changes to the local and national NHS landscape.

But before we get into some of that detail let's first reflect on what went well and not so well last year.

One year on:

In July 2015 we published 'Delivering Caring at its Best' our 5-Year Plan, which set out in detail our long term strategic objectives and our in-year priorities.
Less than a year on it is worth reflecting on what we have achieved in a relatively short space of time.

We said...

We would begin the work to build a new Emergency Department…

… and that work is happening on budget with a scheduled opening in spring 2017.

We would reduce our mortality rate…

… and we have; our mortality rate is now routinely below the national average and better than many of those Trusts we consider as peers.

We would reduce patient harms that occur as a result of falls, infections, pressure sores or medication errors…

… and we have; infection rates have never been lower, our cases of clostridium difficile are lower than any other similarly sized hospital and despite massive demand, falls and pressure sores have reduced.

We would improve our staff survey results and levels of staff engagement…

… and we have; with the latest results showing significant increases in the numbers of staff who think that quality is our main priority and also in the numbers of staff who recommend our hospitals as a place to work or be treated.

We would deliver our agreed financial deficit…

… and we have; in fact as many other Trusts saw their finances worsen during the year, our numbers improved and we reduced our deficit by £2m more than was originally planned.

Lastly, we said we would sort out once and for all car parking at the Royal Infirmary and end the misery of those patients and relatives who queue for parking spaces…

… and we have; with the opening of our new multi storey car park.

Overall, we have a lot to be proud of...

Not all good news:

Whilst we have made really good progress in many areas, there are still some big issues we have struggled with.

We said we would, working with partners in other parts of the NHS, reduce emergency admissions…

… we haven't; in fact admissions through our Emergency Department and Clinical Decisions Unit have increased and for much of the year we have struggled to balance capacity and demand.

We said we would deliver all cancer diagnosis and treatment targets…

… and though we are much improved we are still not achieving against all of the national standards.

We said we would improve the diagnosis and timely treatment of sepsis…

… and though this is moving in the right direction, it has taken too long to do what is so obviously right.

We said we would take part in the Better Care Together consultation so that the public could have their say on our reconfiguration proposals…

… and though a lot of good work has taken place to improve models of care across the whole health system, we have more to do before we are ready to consult formally on the major changes to our hospital configuration.

So, overall we have a lot to be proud of, especially in terms of improvements to quality and safety. These are the two things we think are most important, so, as one team we should be proud of the effort, passion and commitment which has enabled us to make these improvements.

2016/17 Quality Commitment

Since 2012 we have refreshed our Quality Commitment every year, and every year we have seen good progress on those things we set out to fix. The fact that mortality is reducing and that our staff think quality is top of the agenda would indicate that the approach is working.

Let's now turn to the future and begin with a look at our updated Quality Commitment.

We first launched our Quality Commitment in 2012, partly in response to feedback from staff who thought that there had been too much talk about targets and money.

Here is the thinking behind some of the priorities for this year:

Sepsis:

We know that sepsis is a killer and that once we suspect that a patient has sepsis the time to treatment is critical. Sadly, there have been occasions in our past when a diagnosis has been missed despite there being clear clinical evidence… the consequences are devastating for the patient, their family and the staff involved. The memory of young Jack Adcock should continue to trouble us all.

So, this year, bearing in mind that nationally 12,000-15,000 deaths are preventable with timely recognition and management of sepsis, we will be focusing on simple, evidence-based interventions that will save lives.

End of Life Care:

Despite what we see in hospital dramas on TV, death is rarely a sudden event and more often than not the fact that a patient is unlikely to recover is known well in advance of their death. In that sense death can be a *planned* but unscheduled event. If we always took this approach of planning for death we would improve the experience for patients and their families in the last few days of life. This year we want to focus on End of Life Care plans so that where possible patients and their loved ones can exercise some choice about how and where they spend their last days and hours.

Safe use of insulin:

This year we will focus on implementing our strategy which centres around minimising harm, educating staff and empowering patients.

We will ensure our staff are trained in our new e-learning module - Six Steps to Insulin Safety - so that those who prescribe or administer insulin do so safely. We will create a network of champions and develop ethos of leadership and good practice and empower staff to identify good as well as poor practice, and we will use patient feedback to improve their experience.

Reducing 'in clinic' waiting times:

By far the greatest number of complaints we receive are about the delays experienced by patients attending outpatient appointments. Half of our outpatients are seen on time or within 15 minutes of their designated appointment, with the other half waiting over half an hour. Two hour delays are sadly not uncommon. Given that we see over 800,000 outpatients a year, it is unsurprising that this equals a lot of complaints.
There are many factors which contribute; not least that we sometimes overbook clinics to make sure that we see as many patients as possible in a session. We are determined to do something about this and have started work with one of our busiest outpatient areas.

This year our Quality Commitment is broken down into the three areas of quality; *improving outcomes, reducing harm and delivering care with compassion.*

2016/17 QUALITY COMMITMENT

AIM	Clinical Effectiveness Improve Patient Outcomes	Patient Safety Reduce Harm	Patient Experience Care and Compassion
KPI	What are we trying to accomplish?		
	To reduce avoidable deaths To reduce avoidable re-admissions	To reduce harm caused by unwarranted clinical variation	To use patient feedback to drive improvements to services and care
2016/17 PRIORITIES	What will we do to achieve this?		
	Reduce avoidable mortality: • Screen all in-hospital deaths • Participate in national retrospective case record review • Improve compliance with Sepsis 6 interventions in all clinical areas Reduce avoidable readmissions: • Implement Readmission Risk tool	Reduce variation over the week: • Meet Core 7 day services standards Improve recognition and escalation of the deteriorating patient: • Implement UHL Early Warning Score and E-Obs: Reduce the number of insulin-related medication errors: • Implement 'Safe use of Insulin'	Ensure patients are informed and involved in their care • Keep patients informed & involved in decisions around their care & treatment Care of patients in the last days of life • Improve the use of end of life care plans Improve the experience of outpatients • Reduce 'in clinic' waiting times in Ophthalmology • Improve clinical correspondence times
	How will we know if we have done it?		
	SHMI ≤99 Readmission Rate <8.5%	Reduce incidents that result in severe/moderate harm by further 5%	6% improvement - patient involvement scores 10% improvement - care plan use and outpatient experience scores Achieve 14 day correspondence standard

Underpinned by the UHL Way to improve change, culture and leadership and embed Quality Improvement

We will be focusing on simple, evidence-based interventions that will save lives

QUALITY commitment

Reconfiguration Plan and Clinical Services Strategy

As you will see from the Quality Commitment table overleaf, there are far more improvements to quality, safety and experience which we want to make this year, but in the interest of brevity we will move on to look at our reconfiguration plan and our clinical services strategy.

From three acute sites to two:

We know that Leicester is unusual in having three big acute hospitals for the size of population we serve and that this creates problems.
Our specialist staff are spread too thinly; we duplicate and triplicate services across sites and it is expensive to run. This is why a key building block of our strategy is to focus all emergency and specialist care at the Royal and the Glenfield, with a different future for the General.

It is worth noting that many, perhaps even the majority, of our services are only located where they are now because that is where they were before the Trust was formed in 2000, in other words it is an accident of history not best clinical practice that gives us our current configuration.

Three distinct models of care:

At the same time we recognise that as we develop our plans it becomes increasingly apparent that we are essentially made up of three different types of clinical service and that each of these will have a different approach to providing their services in future. Given that we provide more than 60 different clinical services it is not desirable nor possible to describe the vision for each of them in this short booklet. Instead, the description of the types of clinical service over the next few pages are designed to provide a high level view, which should help Clinical Management Groups, service leaders and staff to consider the future shape of their services in an overall context endorsed by our Trust Board.

A key building block of our strategy is to focus all emergency and specialist care at the Royal and the Glenfield, with a different future for the General

Reconfiguration Plan and Clinical Services Strategy

Our ultimate aim is to separate most of the emergency and planned work to prevent patients being cancelled

1. Specialist and tertiary services:

These are the services which we, as a consequence of our size, expertise, research and outcomes are best placed to provide locally and regionally. For some services we might be the only provider in the region, for example paediatric cardiac surgery. In others our critical mass and expertise means that we support smaller local hospitals in neighbouring counties to maintain their services and they refer the more complex and challenging patients to us. The developing partnership with Kettering and Northampton hospitals for cancer patients is a good example.

The future of these services is to grow through partnerships and clinical networks.

Creating a Planned Care Hub

2. Planned elective and outpatient services:

These are the pre-booked, non-emergency services often seen as the bread and butter of acute hospitals like ours. Currently many of these services run alongside our emergency services and as a result when emergency pressures increase it is the elective patients who suffer delays and last minute cancellations. To prevent this happening our ultimate aim is to separate most of the emergency and elective work by doing two things. We will create a new Planned Care and Outpatient Hub at the Glenfield Hospital where we will see most patients, especially those from the City, requiring planned procedures and outpatient appointments. At the same time we will redistribute some of our services into certain of the counties' community hospitals so that patients living in Leicestershire or Rutland can see a clinician and have their elective procedure without travelling into the City.

The future of these services is that some will ultimately centralise at the Glenfield and others will localise into the community.

3. Urgent and emergency care:

Everyone recognises that urgent and emergency demand is increasing largely, but not entirely, as a result of two factors. First, there are more people living longer, often with underlying health issues. Second, that this same group of patients frequently have complex health needs which are not best addressed by our own 'single organ specialists' in hospital or by the more generalist doctors in primary care. Ideally this group of patients should be looked after by a multi-disciplinary team of clinicians who *together* have the right amount of specialist and generalist expertise to manage the patient's health and wellbeing without the need for an emergency admission to hospital.

Currently the local NHS is not designed to work like that and so these patients are looked after in primary care until they reach a point where their condition becomes too complex or severe and they need to be brought into hospital for specialist treatment.

In future we want to work across these traditional boundaries so that either our specialist teams export their knowledge to supplement primary care, or we import primary care experts to help us and in doing so prevent unnecessary admissions.

The future of these services is to share specialist knowledge across organisational silos, have the right number of beds and sufficient capacity in our intensive care units, and thus reduce both demand and the pressure felt in our hospitals.

Summary

So here is a brief description of what we expect each hospital to look like in a few years' time. (Remember that many of the changes we have been talking about over the last year since the publication of our 5-Year Plan will still need to be consulted upon with stakeholders and members of the public before we start to enact them).

Our stated aim remains the same, to provide 'Caring at its best' for all our patients in whatever setting we operate from. To do this we need to forego the largely historical happenstance that is our current configuration of services and instead build our future based on an understanding that our expertise should not be confined within the walls of our hospitals. At the same time we recognise that people often default to buildings and locations when thinking about the future shape of services…

The General Hospital

Subject to the forthcoming public consultation, the plan remains for acute services to be moved to the Royal Infirmary and Glenfield. Included in these moves is the maternity service; one of the key elements of Better Care Together is the consolidation of all maternity and women's services at the Royal Infirmary. However, depending on the results of the BCT consultation this could mean that whilst most of maternity is situated at the Royal we may continue to provide a midwife led birthing unit at the General to offer mums a choice of birth settings.

The Leicester Diabetes Centre will remain at the General and will continue to expand to become the preeminent diabetes research institute in the UK.

Alongside our services we should remember that the General is also home to other health and social care services. The Evington Centre will remain as the community style hospital for Leicester, incorporating a stroke rehabilitation ward. Whilst the joint Intensive Community Response Service made up of teams of nurses and social care specialists from Leicestershire Partnership Trust and the City Council will remain on site.

Finally and in addition, it is likely that the City CCG will base one of two major primary care 'hubs' serving the City population at the General Hospital which will enable clinicians from primary and secondary care to work more closely together on innovative integrated care pathways for certain cohorts of patients.

The Royal Infirmary

The Royal will continue to be the epicentre of our emergency care, not least because this is where the new Emergency Floor is being built. As described previously, the Royal will also see maternity and gynaecology services consolidated in a refurbished and greatly extended Kensington building.

Phase 2 of the Emergency Floor will see the creation of new assessment units co-located next to the new ED and as a result the space occupied by the current assessment units will be freed up to bring acute services over from the General.

A key component of our overall reconfiguration is the creation of two 'super ICUs' one each at the Royal and the Glenfield; however, the pressure currently experienced at the Royal is such that we will need to find a way to support our intensivists whilst we secure the funding for what will be major investments.

The Royal is of course home to most of our Children's Hospital services, including Children's ED. The exception is the children's heart service which is currently based in the East Midlands Congenital Heart Centre at the Glenfield. To protect the service for the longer term we will move children's hearts services to the Royal as part of the investment to create a properly integrated children's hospital within the existing footprint of the Balmoral building. The new children's hospital will have its own entrance and distinct sense of place.

The Glenfield

The Glenfield will grow as services move from both the General and the Royal. The first of those moves will be the vascular service so that we can create a properly co-located cardiovascular centre. This will require investment in a hybrid theatre and additional ICU beds and this work has already begun. Renal services, including transplant, will also move to the Glenfield. Ultimately, we think that the Glenfield is the best site to locate our elective and planned care hub, however as already mentioned, that development is towards the end of our 5-Year Plan, not least because it will require a significant amount of money to build it. To protect some of these services from emergency pressures in the shorter term we will ring-fence bed and operating theatre capacity at the Royal Infirmary.

Making all this happen

when our beds are full and money is scarce:

Imagine that we ran a hotel rather than a group of hospitals and that we wanted to fit new bathrooms in every guest room…

We could either, close for a few months during the off peak season and do it all at once or we could remain open and do the work a room or floor at a time.

We cannot close our hospitals and because our beds are always full and we cannot close wards whilst we make changes to others. Originally, we anticipated that as a result of some of the demand management and hospital at home schemes in the community, we would have enough spare capacity to be able to close wards, clinics and treatment areas whilst we made the necessary improvements. However demand has increased rather than declined and we need to adjust our plans so we can still make improvements.

There are three things we need; first, create more ward capacity at Glenfield, so that services moving from the General can be accommodated. At the same time we need to address the internal process issues which create built in delays and waste our current bed availability; and we need to address capacity issues within intensive care.

We are working on plans to do all of these. Once those solutions are in place we will be able to move forward and updates will be provided throughout the year.

As well as knowing how we are going to phase the changes, we also need a plan for how we are going to pay for them! Capital, (the money which the NHS sets aside nationally to invest in major building projects) is in short supply and there are plenty of other Trusts who think they have as good a case as we do for receiving investment.

Moving our services around so that we can make sure that the right services are next to one another for reasons of safety, quality and efficiency sounds easy but it is not.

Creating more ward capacity at Glenfield

We think that there are two key elements that ought to put us at the front of the queue. The first is that compared to much of the rest of the NHS, Leicester's Hospitals have seen very little investment over the last two decades, (the new ED floor is the first significant building project for years); the second and most important, is that we have been consistent over a number of years in setting out that the only way for the Trust to become financially and clinically sustainable is for us to reduce from three to two acute sites… put simply the cost of running three hospitals with the duplication and triplication that involves, is the main reason for our remaining deficit.

Demand has increased rather than declined and we need to adjust our plans so we can still make them happen

The way we approach change

From the point at which we first launched our 5-Year Plan we had plenty of feedback from staff saying they welcomed the clarity of purpose and the strong sense of knowing where we wanted to take our organisation. But we also understand that the level of change needed to make our vision a reality is quite daunting. It is important that our people not only know where we are heading but also how we are going to enact those changes in ways that reflect our strongly held values.

The UHL Way, developed out of the Listening into Action programme, will be our way of delivering improvements across the Trust. In management speak, it is our improvement methodology, in reality it will simply become 'the way we change things around here'.

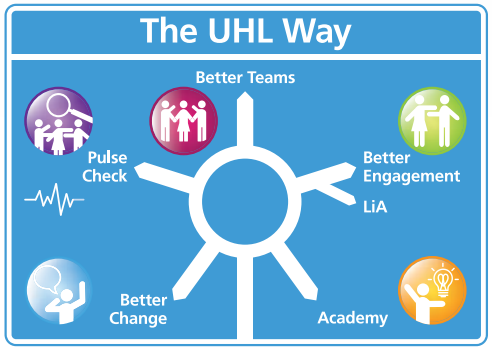
The UHL Way has three core components all of which are designed to make improvement easier for our teams. Those components are:

1. Better Engagement

Is a continuation of our already established Listening into Action programme. Better Engagement is about involving staff and patients in exploring the issues which affect us all and co-creating ideas and solutions which address them.

2. Better Teams

Is about how we support and enhance the development of individuals and their teams to agree and achieve common goals together.



Listening into Action

3. Better Change

Is how we develop our people so that they have the skills and techniques for running large and small change projects with skill and confidence.

The UHL Way is underpinned by the UHL Academy which will be the central source of hands on support, training and development for anyone involved in managing change and quality improvement.

Our 2016/17 Annual Priorities:

Continuing to deliver safe, high quality, patient centred care

Caring at its best

In putting together this document we wanted to focus on the most important subjects, namely our continuing drive to deliver high quality patient centred care, the future shape of our clinical services and vision for our three hospitals.

These are the elements of the overall plan which staff most often refer to.

Of course there are other standards, priorities and aspirations which collectively make up our annual plan and for completeness these are shown over the page.

Remember the strategic objectives shown in the triangle are our long term goals, whilst the annual priorities are those things which we want to do this year which make those long term goals achievable.

Safe, high quality patient centred care

- Reduce avoidable mortality and re-admissions through screening of deaths and use of re-admissions toolkit
- Reduce harm through core 7 day standards, new early warning system and observation processes and safer use of insulin
- Improve patient experience through involving them in their care, better end of life planning and improvements in outpatients
- Prepare effectively for the 2016 Care Quality Commission (CQC) inspection
- Develop a high quality in-house Estates and Facilities Service

The first three priorities above are a summary of our new Quality Commitment

An excellent, integrated, emergency care system

- Reduce ambulance handover delays in order to improve patient experience, care and safety
- Fully utilise ambulatory care to reduce emergency admissions and to reduce length of stay (including Intensive Community Support)
- Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps
- Diagnose and reduce delays in the inpatient process to increase effective capacity

Services which consistently meet national access standards

- Maintain 18 weeks Referral to Treatment (RTT) and diagnostic access standard compliance
- Deliver all cancer access standards sustainably

Integrated care in partnership with others

- Work with partners to deliver year 3 of the Better Care Together (BCT) programme to ensure we continue to make progress towards the Leicester, Leicestershire and Rutland vision (including formal consultation)
- Develop new and existing partnerships with a range of partners including tertiary and local service providers to deliver a sustainable network of providers across the region
- Progress the implementation of the East Midlands Pathology (EMPATH) Strategic Outline Case

An enhanced reputation in research, innovation and clinical education

- Deliver a successful bid for a Biomedical Research Centre
- Support the development of the Genomic Medical Centre and Precision Medicine Institute
- Develop and exploit the OptiMeD project, scaling this up across the Trust
- Improve the experience of our medical students to enhance their training and improve retention, and help to introduce the new University of Leicester Medical Curriculum
- Develop and implement our Commercial Strategy to deliver innovation and growth across both clinical and non-clinical opportunities
- Launch the Leicester Academy for the Study of Ageing (LASA)

Our 2016/17 Annual Priorities in full

A caring, professional, passionate and engaged workforce

- Develop an integrated workforce strategy to deliver a flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability
- Deliver the Year 1 Implementation Plan for UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and improvement
- Develop training for new and enhanced roles i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders
- Deliver the recommendations of "Freedom to Speak Up" Review to further promote a more open and honest reporting culture
- Developing a more inclusive and diverse workforce to better represent the communities we serve and to provide services that meet the needs of all patients

A clinically sustainable configuration of services, operating from excellent facilities

- Complete and open Phase 1 of the new Emergency Floor
- Deliver our reconfiguration business cases for vascular and level 3 Intensive Care Unit (and dependent services)
- Develop new models of care that will support the development of our services and our reconfiguration plans
- Develop outline business cases for our integrated children's hospital, women's services, and planned ambulatory care hub

A financially sustainable NHS Trust

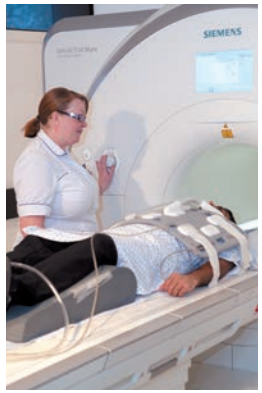
- Deliver our cost improvement programme target in full
- Reduce our deficit in line with our 5-Year plan
- Reduce our agency spend to the national cash target
- Implement service line reporting through the programme of service reviews to ensure the ongoing viability of our clinical services
- Deliver operational productivity and efficiency improvements in line with the Carter Report

Enabled by excellent IM&T

- Improve access to and integration of our Information Technology (IT) systems
- Conclude the Electronic Patient Record (EPR) business case and start implementation

UPDATE
June 2016

Delivering Caring at its best



Our 5-Year Plan and 2016/17 Priorities

If you would like this information in another language or format, please contact the Service Equality Manager on 0116 250 2959

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ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਲੀਫਲਿਟ ਦਾ ਲਿਖਤੀ ਜਾਂ ਟੇਪ ਕੀਤਾ ਅਨੁਵਾਦ ਚਾਹੀਦਾ ਹੋਵੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਡੈਬ ਬੇਕਰ, ਸਰਵਿਸ ਇਕੁਆਲਿਟੀ ਮੈਨੇਜਰ ਨਾਲ 0116 250 2959 'ਤੇ ਸੰਪਰਕ ਕਰੋ।

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Haddaad rabto warqadan oo turjuman oo ku duuban cajalad ama qoraal ah fadlan la xiriir, Maamulaha Adeegga Sinaanta 0116 250 2959.

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