Update on implementation of the PPI Strategy

Author: K. Mayes Sponsor: M. Wightman **Trust Board paper J**

Executive Summary

Context

In June 2017 the Trust Board approved a refreshed Patient and Public Involvement (PPI) Strategy and implementation plan. This paper provides an overview of activity since the last quarterly update in September 2017. Four appendices accompany this paper:

Appendix 1: summary of recent Patient Partner activity from Martin Caple, Chair of the Patient Partner group.
Appendix 2: summary of recent activity in the Joint Patient Reference group, also chaired by Martin Caple.
Appendix 3: notes from a recent "Community Conversations event in Oakham Rutland.
Appendix 4: minutes of a planning engagement meeting held on October 26th 2017.

Conclusion

Since the last update in September 2017, local "Patient Voice" groups have been consulted on our planning priorities for 2018/19. Separately, their participation in the recently formed Joint Patient Reference Group has resulted in a draft terms of reference which has been considered by members of the Trust Board. The group seeks to act as a forum to share and consolidate issues and concerns as they relate to UHL services.

A second "Community Conversations" event was held in Oakham, Rutland in November 2017. This new programme of events invites members of the Trust Board to engage with communities in a variety of settings across LLR. A further event is planned for January 16th 2018 at the Leicestershire Centre for Integrated Living. The focus of this event will be on the experience of people with disabilities accessing UHL services. The PPI Team are also planning a fourth event in April 2018 which will be held at the Shama Women's Centre in the Highfields area of the city (date TBC). Board members are encouraged to attend.

A recruitment campaign has begun to recruit a further four Patient Partners to the Trust. This will cover existing vacancies and those left by two Patient Partners who are stepping down form their roles at the end of 2017.

This report also includes a brief summary of the Trust's Annual Public Meeting 2017 which was held in September at the Peepul Centre.

Input Sought

The Trust Board is asked to note this paper and the updates on engagement with patient groups and summaries of Patient Partner and Joint Patient Reference Group activity.

For Reference

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

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

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Yes]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
2154	There is a risk that a lack of engagement with PPI processes by CMGs and Directorates could affect legal obligations	12	8	

b. Board Assurance Framework [No]

3. Related **Patient and Public Involvement** actions taken, or to be taken:

This report provides an overview of recent PPI activity and outlines how engagement with patients and the wider public is being encouraged within the Trust. The patient voice is represented in two update papers attached as appendices and submitted by the Chair of our Patient Partner group.

4. Results of any **Equality Impact Assessment**, relating to this matter:

The PPI strategy actively promotes inclusive patient and public involvement which is mindful of the diverse population that we serve. This paper provides assurance that a programme of community engagement is actively seeking the input of our diverse local communities.

5. Scheduled date for the **next paper** on this topic: [01/03/18]
6. Executive Summaries should not exceed **2 pages**. [My paper does comply]
7. Papers should not exceed **7 pages.** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT BY: Mark Wightman, Director of Strategy & Communications

AUTHOR: Karl Mayes, PPI and Membership Manager

DATE: 07/12/17

SUBJECT: Update on implementation of the PPI Strategy

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1. Introduction

1.1 In June 2017 the Trust Board approved a refreshed Patient and Public Involvement (PPI) Strategy. The strategy;

- Outlined the mechanisms by which the Trust communicates and engages with its stakeholders.
- Outlined the ways in which the Trust involves its patients and the wider community in its service development
- Set out the Trust's plans to achieve high quality stakeholder, patient and public involvement over the next 3 years.

1.2 An implementation plan was approved alongside the strategy. Updates on this plan are brought to Trust Board quarterly. This is the update for Q3.

1.3 Appendix 1 of this document comprises a summary of recent Patient Partner activity from Martin Caple, Chair of the Patient Partner group.

1.4 Appendix 2 of this document comprises a summary of recent activity in the Joint Patient Reference group, also chaired by Martin Caple.

1.5 Appendix 3 of this document comprises the notes from a recent "Community Conversations event in Oakham Rutland.

1.6 Appendix 4 of this document comprises the minutes of a planning engagement meeting held on October 26th 2017.

Key activity since the last update in September 2017

2. Annual Public Meeting 2017

2.1 On September 20th 2017 the Trust held its Annual Public Meeting. For the first time, the event was held at the Peepul Centre, in the Belgrave Road area of the city. Approximately 200 people attended over the course of the event, which managed to attract a number of people from the local area.

2.2 The first half of the event was dedicated to a Health and Information fair in which UHL staff and partner organisations showcased their services and engaged with members of the public. There were over 40 stalls, which ranged from the promotion of career opportunities at UHL to information about research and specific patient services.

2.3 During The second part of the meeting, our Chief Executive, John Adler, and Chairman, Karamjit Singh reflected on the previous year and on some of the challenges facing the Trust in the future. The floor was then opened for questions from the public.

3. Community Conversations: Rutland

3.1 In July 2017 the Trust launched its programme of "Community Conversations" events. The aim of these events is to enable Board members to be more visible in local communities, to listen to a diverse range of views on our services and promote and publicise the work of the Trust. The events run quarterly and will be held in a variety of different community venues across Leicester, Leicestershire and Rutland.

3.2 The second of our Community Conversations events was held on November 1st in Oakham, Rutland, at the Community Hub; base of Healthwatch Rutland. The event was attended by Non-Executive Directors Ballu Patel, Ian Crowe and Andrew Johnson. Mark Wightman represented the Executive team and was supported by Karl Mayes and Hannah Rooney from the PPI Team. 31 members of the pubic participated in the discussions.

3.3 Jennifer Fenelon, Chair of Healthwatch Rutland, delivered a presentation highlighting the key issues experienced by the people of Rutland in relation to hospital services. The Three key issues highlighted were;

a) Signage and way finding
b) Enabling people to 'step down' from acute care en route home
c) Non-urgent transport issues

3.4 Mark Wightman delivered a presentation outlining the direction of travel in the local health economy under the plans set out in the STP. The group were invited to ask questions and discuss any concerns. Full notes from this meeting may be found in appendix 3 of this document.

3.5 Two further Community Conversation events are now being planned for January 16th 2018 (focusing on the experience of people with disabilities) and in April 2018 at the Sharma Women's Centre in the Highfields district of the city. Trust Board members are encouraged to attend.

4. Patient Partner recruitment

4.1 Two of our Patient Partners are stepping down at the end of 2017. Geoffrey Smith has been a Patient Partner (formerly Patient Advisor) for 14 years. During this time he has consistently championed patient and public involvement across the Trust and constructively challenged senior managers and clinicians to improve the patient experience. Mary Gordon has been a Patient Partner for just four years, but during this time has earned the respect of many of our staff, not only for her focus on

patients, but also for her professional expertise and advice. We wish them well in their future endeavours.

4.2 To fill the vacancies left by Geoff and Mary, and two other existing vacancies, the PPI team have begun a process to recruit new Patient Partners. An advertisement has gone out to the Trust's public Membership and will be sent out to other engagement networks. The closing date for applications is January 19th 2018. The LLR Alliance recently took the decision to move to a Patient Partner model for their organisation. They wish to recruit five new Patient Partners and details of these opportunities are included in the UHL advertisement.

4.3 A further update on Patient Partner activity is provided in Martin Caple's Patient Partner Summary Report (appendix 1 of this document).

5. Engagement on UHL Planning Priorities 2018/19

5.1 On October 26th 2017, representatives from local "Patient Voice" groups were invited to contribute to the Trust's thinking on its priorities and planning for 2018/19. Mark Wightman chaired the meeting which was also attended by Karl Mayes, Patient & Public Involvement Manager and Rachna Vyas, Head of Strategic Development. Representatives from the following patient groups attended:

- Healthwatch Leicestershire
- Healthwatch Rutland
- Healthwatch Leicester
- UHL Patient Partners
- Leicester City PPG Network

5.2 Participants were invited to review the Trust's current strategic priorities and comment on whether they felt they reflected the concerns and aspirations of their respective memberships. The group were also invited to make suggestions for inclusion in the Trust's planning review for 2018/19.

5.3 They key issues raised during the meeting were as follows:

- Improve Medical staff retention by developing medical students in the earlier stage of their careers.
- The focus on frail older people was supported but be mindful that a focus on older frail people may deflect attention from younger, more complex / frail patients.
- There is still work to be done to improve the Trust's "Cultural Competence"
- Patient & Public Involvement (PPI) ought to be more prominent in the Trust's strategic aspirations.
- The Trust should reflect the data it already collects (i.e. the FFT survey responses) in its strategic planning.
- Outpatient Improvement needs to feature in the Trust's priorities.
- The Trust should recognise the need to improve staff morale.
- Could we see a greater focus on discharge and Step Down?
- Signage, particularly at the LRI remains an issue for patients.
- Improve communication with patients, particularly patient letters
- Explore how patients can better access advice and support "upstream" to help prevent unnecessary admissions

5.4 The minutes of this meeting may be found in appendix 4 of this document.

6. Joint Patient Reference Group

6.1 At a recent Trust Board Thinking Day dedicated to PPI (August 2017), it was agreed that the Joint Patient Reference Group would develop a terms of reference which would include a description of its relationship with the Trust. The group comprises representatives from key local “Patient Voice” groups, including our three Healthwatch organisations, Patient Partners and the LLR Alliance patient group. At the last meeting of the group a draft terms of reference were agreed for consideration by the Trust.

6.2 The group’s draft terms of reference were discussed at a meeting between the Trust’s Chairman, Director of Strategy and Communications, Director of Corporate and Legal Affairs and PPI & Membership Manager. Although the group have suggested that a Trust Board member Chair the group, it was strongly felt that the group’s key strength lay in its independence. As such, the recommendation was for the Chair of the group to be appointed from the group’s membership, perhaps on a rotational basis. However, it was agreed that a member of the Trust Board would attend meetings to promote dialogue between the group and the Trust Board. The Trust will continue to support the group through the provision of meeting venues. It was also suggested that future Trust Board Thinking Day sessions on PPI would focus on the priorities and concerns identified through the Joint Patient Reference Group.

6.3 A more detailed summary of the recent activity of the Joint Patient Reference Group by Martin Caple, Chair of the group, may be found in appendix 2 of this document.

Karl Mayes
PPI & Membership Manager
December 2017

Appendix 1: Patient Partner Summary Report by Martin Caple, Chair UHL Patient Partner Group

Patient Partner Summary Report

1st August to 30th November, 2017

Report by Martin Caple, Chair, Patient Partner Group

Introduction

1. The purpose of this report is to outline the key activities and progress achieved by Patient Partners in the past 4 months.

Patient Partner activities in the 4 month period

2 Listed below is a brief summary of the main activities of Patient Partners (PPs) both within Clinical Management Groups (CMGs) and on corporate cross cutting UHL issues in the last quarter:-

- Members of key strategic UHL committees.
- Attendance at CMG Board and Quality and Safety Committee meetings
- Involvement in serious incident investigations
- Safety Walkabouts
- Facilitate patient focus events
- Surveys of patients
- Clinical audits
- Patient Partner now on UHL Mental Health Board
- Attend Quality Improvement event for medical and nursing students
- Attend 2018 Planning Priorities meeting
- Involvement in all the current reconfiguration projects
- Involvement in Safer Surgery policy relaunch
- Sit on TTO Project Board
- Review patient information leaflets

- Involved in Optimed project
- Involved in Orthopaedic Surgery Preparation Board
- Participate in ITU "Day to Remember" events for relatives former patents who passed away.
- Attendance at national health conference
- Attend Complaints Review Panel
- Sit on recruitment panels
- Attend Caring at its Best Awards.
- Participate in numerous LIA events, notably the Outpatient project.

3. Just selecting some issues from the above I would highlight the introduction of Patient Partners being involved in serious incident/root cause analysis investigations. To date different PPs have been involved in 5 cases where they have provided a patient/public perspective on the issues. Two PPs attended the initial Planning Priorities meeting with other patient groups and hopefully we will be involved in further stages of the process at a CMG level. A PP attended a national Expo Health Innovation Event at Manchester which focussed on key national issues affecting the NHS, including patient involvement and co-production. Also, an internal initiative recently has seen PPs receive training to be involved within CMGs in clinical audits.

4. Another significant long-term project where Patient Partners are heavily involved is the review of all patient information leaflets. This project led by the newly appointed Patient Information Librarian, Hannah Beckett, involves a review of all UHL leaflets to assess whether they need updating and/or are still relevant.

Board Thinking Day on Patient and Public Involvement

5. Seven Patient Partners attended the Board thinking Day on PPI on 10th August when the topics of discussion focused on 5 specific issues:-

- PPI inconsistencies across the Trust.
- Making co-production between patient representatives and UHL a reality.
- Having a more pro-active two way process of exchanging information.
- Involving patient representatives at the outset of projects.
- Ensuring the communication between UHL and patient groups is clearer avoiding jargon and technical language.

6. The key action points from this session are outlined in the main body of the report

being presented by Mark Wightman and has been circulated to all participants. One of those actions is to pursue co-production between patient representatives and UHL staff. A recently appointed Patient Partner, Anna Severwright, has experience in this area having been involved with NHS England as a patient representative and she is assisting with Karl Mayes and other Patient Partners to take matters forward.

Top Issues of Patient Partners

7. Recently each Patient Partner was asked to highlight their "top issues of concern" within UHL to assist our work programme in 2018. Those matters have been collated in a paper that will be considered at our meeting on 4th December. I will give a verbal update on the outcome at the Board meeting on 7th December.

Overall number of Patient Partners

8. Following the recruiting campaign earlier this year the number of Patient Partners increased to 21 although that will reduce to 19 shortly as Geoff Smith and Mary Gordon, both highly respected by staff and other Patient Partners alike, are leaving the role. Geoff is leaving after 14 years in the position and throughout this time he has been a committed and knowledgeable patient advocate giving sound sensible views on a variety of issues at all levels of the organisation. Mary has been in the role for 5 years and, similarly, her contribution has been immense giving a viewpoint not only from a patient perspective but also from her background and experience in the commercial world. Having worked with them closely I know how much we will miss their experience, knowledge and contributions and I wish them both well in the future.

9. A new recruiting campaign for additional Patient Partners has commenced with a view to appointing at least another 4 people to the role ensuring there are 3 PPs on each CMG and enough to cover cross CMG corporate issues.

C**onclusion**

10. In summary the key points in this report are:-

a) The profile and engagement of Patient Partners has been raised by increasing the numbers and by our services being called upon far more across the Trust, although there are still inconsistencies across CMGs, as I have reported previously.

b) By identifying what we see as our top patient concerns hopefully we will be able to liaise with senior staff about those issues and work together to improve matters.

c) We are keen to assist progressing the action points from the PPI Thinking Day and to be more involved in the planning process for 2018.

d) We welcome the interest and engagement by the Board in PPI generally and the role of Patient Partners. The attendance of Ballu Patel, Non-Executive Director, at our bi-monthly meetings is particularly welcomed and provides a valuable link to the Board.

Recommendation

11. This report is submitted for the information of the Board and further regular reports will be submitted every 3 months.

Martin Caple

29th November, 2017

Appendix 2: Joint Patient Reference Group Summary Report by Martin Caple, Chair, Joint Patient Reference

Joint Patient Reference Group
Report by Martin Caple

Introduction

1. The purpose of this report is to update the Board on the current position and issues raised by the Joint Patient Reference Group.

Background

2. The Joint Patient Reference Group was established in late 2016 following a UHL Board Thinking Day on patient and public involvement. It comprises representatives from Healthwatch, the Leicester Mercury Patients Panel, the Alliance Patient and Public Partnership Group, the Leicester City Patient Participation Group Forum, the Better Care Together Group, the UHL Equality Advisory Group and the UHL Patient Partner Group.

3. Since its inception I have been chairing this forum and Trust support has been provided by Karl Mayes.

4. After a slow start the Group has gained some momentum and it has been agreed that its prime objective is to present to the Board an agreed summary of priority issues and concerns raised by patients and the public.

Meeting - 31st October, 2017

5. At the last meeting on 31st October, 2017, we discussed the terms of reference of the Group.
This is an issue identified as necessary following the Board PPI Thinking Day last August.
In doing this we discussed a proposal that this Group could report to a wider health body comprising the Chairs of the Clinical Commissioning Groups, the Leicestershire Partnership Trust the Alliance and UHL. After discussion it was agreed that it was preferable to report to UHL through the Board. We also discussed the chairing of the group and the suggestion was made that this should be rotated on a 6 monthly basis together with the administrative support. This was rejected and the majority view was that it would be advantageous for a member of the UHL Board to be the Chair and a Non-Executive member was suggested.

6. This latter point about the chairing of the Group has been considered internally in UHL and the outcome is reported in the main body of this report by Karl Mayes.

7. At the meeting on 31st October the current main concern for the majority of patient groups related to signage and way finding at all 3 sites, but particularly at the Leicester Royal Infirmary. The concerns included the need to correlate information in patient letters with navigation of hospital sites. It was also suggested that patient letters should include information on which car park to use for the visit. Also it was

mentioned that that there are signs that point to places that do not now exist and other signs that point to the same place but in different directions.

8. Another concern raised related to the step down facility in UHL and the need to transfer patients to community hospitals nearer to their homes at the earliest opportunity rather than them remaining unnecessarily in an acute hospital.

Conclusion

9. The next meeting of the Group is on 8th February, 2018 and Karamjit Singh has indicated he will attend. In the meantime, after the Board meeting, I will notify members of the Group of the position.

10. At the meeting on 8th February there will be a discussion about the outcome and action points from the PPI Thinking Day.

Recommendation

11. The report is submitted for the information of the Board but also for comment on the issues raised in this report, particularly the key concerns raised in paragraphs 7 and 8.

Martin Caple

29th November, 2017

Appendix 3: Notes from the "Community Conversations" event in Oakham Rutland, November 1st 2017.

Wednesday 1st November 2017, 1pm -3.30pm,

Gover Centre, Oakham, Rutland

Summary of Discussion

Present

Mark Wightman, **Director of Strategy and Communications**

Andrew Johnson, **Non-Executive Director** Ian Crowe, **Non-Executive Director**

Ballu Patel, **Non-Executive Director**

Sarah Iverson, **Chief Executive, Healthwatch Rutland**

Jennifer Fenelon, **Chair, Healthwatch Rutland**

Karl Mayes, **Patient and Public Involvement/Membership Manager**

Hannah Rooney**, Patient and Public Involvement/Membership Officer**

31 Members of the public

Summary

1. Introduction

1.1 Ballu Patel introduced the session and highlighted staff commitment to good quality care. Ballu shared that he is the Chair of the Charity Commission at UHL and has a special interest in public engagement.

1.2 Ian Crowe introduced himself as a Non-Executive Director at UHL, Chair of the Quality and Outcomes Committee and Armed Forces Champion for the Trust.

1.3 Andrew Johnson introduced himself as a Non-Executive Director and Chair of People, Process and Performance Committee, Outpatients

Committee and Pharmacy. Also lead on Freedom to Speak Up (Whistleblowing).

2. Presentation by Jenifer Fenelon

2.1 Jennifer Fenelon, Chair of Healthwatch Rutland introduced herself and welcomed members of the UHL Trust Board.

2.2 Jenifer delivered a presentation highlighting the key issues experienced by the people of Rutland in relation to hospital services.

2.3 Three key issues highlighted by Healthwatch Rutland are:

1) Signage and way finding
2) Enabling people to 'step down' from acute care en route home
3) Non-urgent transport problems

2016 CQC survey highlighted the following issues:

2.4 Emergency experience

- Breaches of the 4 hour wait in A&E
- Long handover periods from ambulance to A&E and knock on effect in Rutland
- Long trolley waits

2.5 Experience of Clinical Care

- Waits for treatment /chopping and changing admissions dates
- Involvement in own treatment/getting questions answered
- Facilities for the Young Disabled Unit
- Issues around dementia diagnosis scans
- People taking medicines into hospital and not able to take out
- Short notice discharge and delays

2.6 Cleanliness

- Getting better but could be better still
- Food getting better
- Parking – better with multi-storey but there are still black spots (i.e. dropping off points at LRI)

3. Presentation by Sarah Iverson

3.1 Sarah Iverson, Chief Executive of Healthwatch Rutland delivered a presentation on the specific issues experienced by the Rutland Community.

- EMAS – slow response times. Longest wait in East Midlands
- TASL (non-emergency transport) Complicated in terms of who can use this and when. There are concerns about the new provider which started on 1st

October 2017. Many people live outside of the market towns and do not have access to public transport.

- Voluntary Action Rutland – Volunteer driver services are operating in Rutland to take people to hospital though some journeys to LRI are being refused as it is so complicated on arrival. The driver service requires planning in advance to enable the service to ensure a driver is in place.
- Why UHL rather than Peterborough? More people are going to Peterborough due to emergency access issues. There is not enough emphasis on transport problems when decisions are made. People in Rutland are required to use Maternity Services at the LRI, what is being put into plans to ensure people of

4. Presentation by Mark Wightman

4.1 Mark Wightman delivered a presentation outlining the direction of travel in the local health economy. He made the following points;

4.2 Although Next year is the 70th birthday of the NHS and this is the first time health and social care are planning together.

4.3 The current system is in crisis – 7.5% of income is spent on health services that's 2/3% behind other economies.

4.4 In the last 20 years the world has changed significantly, NHS is not keeping up/in sync.

4.5 Population is increasing, there are more older people with multiple health problems.

4.6 Under the Blair government spending on NHS tripled. Since 2008, spending in real terms has gone, not keeping up with inflation.

4.7 What is going to be done about it?

- £400 million is being invested in new facilities and community hospitals
- 3 sites to be reduced to 2 sites – currently acute medicine is practised at all three sites. This will save £25 million

4.8 Patients are telling us:

- They want to stay at home
- They want more information and support to look after themselves
- It is difficult to get an appointment at GP surgeries
- They need to be looked after beyond hospital

Therefore, it makes sense to export care into the community. Three main issues are:

- Lifestyle and prevention
- GPs need to be spending more time with people who need it

- There is a funding gap between the money available and the cost of services in four years' time

In the spring, there will be a consultation on:

1) The option of moving from 3 to 2 sites
2) New Women's Hospital
3) New plan for community hospitals

5. Questions from the Public/Issues Highlighted:

Q1) Was the option of closing the LRI considered?

A1) No, this would be too costly

Q2) I understand the CCG is trying to close down community hospitals, how does this fit in with your plans?

A2) This is being re-looked at by East Leicestershire CCG and West Leicestershire CCG

Q3) Will the Leicester General Hospital effectively become a community hospital for the city?

A3) Yes, a community style hospital. We own a lot of estate that is currently underutilised. We are looking at potentially selling some off to provide land for community housing.

Q4) Which parts of the General will be sold?

A4) Areas on the periphery

Q5) The CQC declared the Young Disabled Unit YDU not fit for purpose in terms of environment. What is being done about this?

A5) Patients are currently supported in Ward 2 but £2 million will be invested to move this service to the Evington Centre.

Q6) Having seen the original plans, what are the new plans looking like now? Are they soundly-based?

A6) Yes the new plan is better than previous and shows number of beds increasing. Plans for the Rutland Memorial Hospital are being re-looked at.

Q7) You mentioned keeping theatres at the General. Don't you need intensive care to accompany theatres?

This depends on the theatre work, simple work/minor injuries would not require intensive care

Q8) The sequence of events is important, how will opening and closing of services be coordinated?

A8) We won't close something until something else is available. Therefore for a period, we will have to run the old and new service at the same time.

Q9) What is happening to Hospice Care?

A9) This isn't managed by UHL.

Sarah Iverson explained that there is not a lot of confidence that care in the community is being built up to provide the support in the absence of community hospitals. Senior nurses are leaving so less support on wards also. The tight criteria community hospitals have for taking in patients' needs to change to reflect the need for more community support.

Volunteer drivers spoke about their experiences at UHL:

- There is still a large build-up of traffic on Havelock Street at times
- There is a large volume of people needing to go through Windsor and Balmoral to get to where they need to do – difficult for the less mobile.
- Tannoy for lift is loud and unclear
- Glenfield Hospital has designated spaces for volunteer drivers – we need this at the LRI
- If people are required to take taxis to hospital from Rutland as no alternative it can cost £80-£90. People cannot afford this especially older people – people need assurances that something will be done about transport. Uppingham bus service has recently been reduced. Has there been any liaison around people going to Peterborough?

A: Unfortunately we don't have an easy solution at present. It is not within the hospital's gift to support public transport.

Q10) Could the finely tuned criteria for who can access TASL be expanded in the circumstances?

A10) The CCG commission this service though the STP has a section to say 'Are plans equitable?' do the plans discriminate against different people therefore a proper impact assessment will be required.

Jenifer mentioned that TASL will be attending next Healthwatch Board meeting.

Q11) Parents of children including those with disabilities need consideration. Multiple appointments/trips to hospital are often required

from Rutland and this means a lot of planning for parents in terms of taking other children with them. Flexibility in terms of appointments would help.

6. Presentation by Karl Mayes

6.1 Karl Mayes gave an overview of the various ways the public can get involved with the Trust:

- Membership
- Volunteering
- E-Partners
- Patient Partners
- Marvellous Medicine

There are currently 495 public members of UHL Trust from Rutland. Karl introduced David Allen who is a Patient Partner with the Trust and resident of Oakham.

7. Additional comments/questions for UHL Board:

- There is a problem with sending patients home too early when community support is not there.
- UHL needs to develop a relationship with other hospitals within the region. Needs to be interconnectivity between hospitals.
- Importance of a partnership with the Rutland Community
- 'Step Down' suite is needed. Rutland County Council Social Workers liaise with care homes with empty beds to support 'stepping down' from hospital process. Another participant queried the practicalities of this in terms of the medical intervention a patient may need/appropriateness of support – care homes may not always be able to provide this.
- There are issues with communication – delays in getting test results, results getting lost in system for 6 months. UHL needs to sort its 'in house' processes out as well as cross-organisational joint working. Mark Wightman explained that UHL are hampered by NHS England's decision to reject bid for £22 million to fund electronic record system. This means that much patient information is still on paper. Electronic records are being created by scanning results and moving information on to current electronic system called ICE – building on what UHL already have.
- Operations are routinely being cancelled due to absence of patient records – 5,000 Outpatients per week.
- What is happening about funding? A: Chancellor's budget out in next few weeks.
- Why is Leicester losing out? A: In the era of PFI investment, Leicester was the last area to be considered and PFI collapsed just when Leicester was

intended to benefit. The £48 million we were granted for the new emergency floor was the first injection of cash Leicester has had since then.

- Andrew Johnson said that A&E admissions have risen from 450 2 years ago to 650-700 currently. This is due to people living longer and increasing expectations.

- How much does is cost per bed per day at UHL?
  Medical Bed = £350 - £400
  Intensive Care Bed = £2,500
  Total Life Support = £5,000

Appendix 4: Minutes from the planning engagement meeting on October 26th 2017

Planning Priorities: Engagement Meeting

Meeting held on Thursday October 26th 2017 at 14:00 in the Odames Meeting Room, LRI.

MEETING NOTES

Present:

From UHL
Mark Wightman – Director of Strategy & Communications
Karl Mayes - PPI & Membership Manager
Rachna Vyas - Head of Strategic Development

External
Omita Gaikwad (Healthwatch Leicester)
Claire Knowles (Healthwatch Leicester)
Geoffrey Smith (Patient Partner)
Anna Severwright (Patient Partner)
Jennifer Fenelon (Healthwatch Rutland)
Harsha Kotecha (Leicester City PPPG)
Evan Rees (Healthwatch Leicestershire)

1. Apologies

Apologies were noted from Zubeda Gangat (UHL Equality Advisory Group) and Hannah Rooney (UHL PPI Officer)

2. Presentation: UHL Priorities, Mark Wightman, Director of Strategy & Communications

2.1 Mark Wightman gave a presentation outlining the Trust's current thinking on its priorities. He noted that the priorities identified aimed to move the Trust towards its aspiration of delivering "Caring at its Best". He said that the Trust Board had agreed that last year's 47 priorities was too many and didn't allow us to focus on what really matters. He added that a review of high performing Trusts revealed that they tended to set fewer key priorities.

2.2 Mark spoke about the Trust's Primary Objective which is to deliver safe, high quality, patient-centred, efficient healthcare. This is enshrined in what the Trust refers to as its "Quality Commitment". The Commitment covers Clinical Effectiveness, Patient Safety, Patient Experience and the organisation of care.

2.3 Mark Then gave an overview of the priorities which support the delivery of the Quality Commitment.

2.4 Integration - Mark said that this was very much where the Trust's Strategic thinking was heading. Indeed, there is more focus through the STP on how we integrate care. He gave the example of improving pathways for frail older people where we are working more closely with other health partners.

2.5 Strategic enablers - Among the enablers we are focusing on is an improvement to our IT systems. Current systems are poor and as such conducive to human error. The financial situation will not allow a complete revamp of our IT systems. As such, we are taking a staged approach. We are also looking at how we can be more effective and collaborative corporately.

3. Discussion

Following Mark's presentation the floor was opened for discussion.

3.1 Harsha Kotecha asked how the discussions held at the recent Thinking Day would be fed in to the planning process. She also asked how the Joint Patient Reference Group (JPRG) would be engaged in this process. Karl Mayes noted that the Thinking Day specifically focused on the Trust's performance around Patient & Public Involvement, although relevant issues that were captured relating to strategy would be considered as part of the planning process. Regarding the JPRG he said that each of the participating groups on the JPRG had been invited to this planning meeting. As such, this meeting represented a key opportunity for that group to be involved in priority setting.

3.2 Jennifer Fenelon asked for more clarity regarding the Trust's intention to "form new relationships with Primary Care". Mark said there were two key components of this; In part it is about improving our current service to Primary Care (Letters, communication etc…) It was also about "fixing the basics", for example, helping GPs to manage referrals better. More generally it is about improving how Primary Care works across LLR with a focus on greater integration. A further element of this relates to the Primary Care workforce. For example, Leicester City has an increasingly older GP workforce. The Trust would like to explore with the City CCG how we can make the GP role more atttractiv3e and fulfilling (i.e. by exploring placements in the acute sector for GPs).

3.3 Omita Gaikwad noted that new GPs were being sought from other parts of the world. She asked, if we seek to incentivize GP recruitment, how this might go down with other staff. In particular she asked if there might be a perception of inequality through such a practice. Omita suggested that developing medical students in the earlier part of their career may represent a good longer term strategy. She also asked how the Trust would define "Patient Experience".

3.4 Mark referred the group to the Trust's core values. He said the Trust's approach to Patient Experience was captured in the Trust's value: We Treat People How We Would Like to be Treated. Mark spoke of the range of measures we use to look at Patient Experience, using, for example, the Friends and Family Test as well as a range of other measures generated by the Patient Experience team. Karl Mayes noted that the more qualitative side of Patient Experience was captured thorough engagement. In specific projects, for example, engagement with patients would inform the approach. He gave the example of a new programme to improve our Outpatient facilities which was using patient engagement to explore patient experience.

3.5 Geoff Smith asked about the focus on Frail older people. Mark noted that we have seen a significant increase in the numbers of frail older people coming through our Emergency Department (ED) and these patients are more likely to have a poorer experience. He added that frailty is often associated with complexity. Mark mentioned the recent review undertaken by Ian Sturgess in which the frail older people's pathway was seen as most needing of attention. We have made a number of improvements but still have some way to go.

3.6 Anna Severwright said that it was not just the older person who presented with multiple co morbidities. She said we should be mindful that a focus on frail older people might end up missing younger, more complex patients.

3.7 Rachna Vyas said that it was not simply age but co-morbidity that draws people in to the system. In the city patients are assessed in terms of their frailty markers, not their age.

3.8 Harsha Kotecha raised the issue of cultural competence, noting her personal experience in which her father's wish to wash, dress and pray before breakfast was not respected when he was an inpatient. She suggested that the system and nursing processes were not mindful of the patient's cultural needs. Karl Mayes noted that, in principle, all nurses were trained to recognize and respond to what are referred to as the "12 activities of daily living", one of which is religious and cultural needs. This is a tool to ensure that patients are treated in a holistic way and that their unique needs are cared for. As such, it is less the "system" that fails patients but rather a lack of awareness among some staff. Nonetheless such instances do still occur, do need addressing and the remit for training would lie with the Trust's equality team.

3.9 Anna Severwright asked what the next steps would be for this planning process. She added that Patient Partners felt that Patient and Public Involvement ought to be more prominent in the strategic "jigsaw" diagram.

3.10 Jennifer Fenelon noted that the majority of the strategic priorities seemed to focus more on process rather than patients. She acknowledged that they would lead to an improvement in patient care but they remain "process measures".

3.11 Mark drew the group's attention to the central strand of the Trust's strategic objectives; our Quality Commitment. He noted that we could have the very best

clinicians, patient pathways etc. However, without sufficient beds we would not be able to deliver quality care. As such, the processes outlined in the document are essential to our patient centred objectives.

3.12 Evan Rees reiterated Anna Severwright's point that he would like to see a greater emphasis on patient involvement in the Trust's strategic aspirations. In particular he was keen to see more reference to co-design and how we intend to involve patients at the earliest stages. Mark Wightman acknowledged that, thus far, the involvement / engagement element was not sufficiently prioritized.

3.13 Harsha Kotecha said that GP surgeries were not using the Friends and Family test (FFT) and had instead replaced it with three simple questions which, she said, provided a more useful set of data. The questions are:

- What do we do well?
- What should we stop doing?
- What should we start doing?

Anna Severwright noted that the FFT did also provide an opportunity to give free text comments which allowed for richer data. Harsha Kotecha suggested looking at these responses to inform the planning process.

3.14 Jennifer Fenelon asked whether shared decision making was a feature of the quality measures. Mark Wightman noted that whether it specifically appears in the document or not, it is a component of how the Trust operates. Clinicians are increasingly talking to the patients asking "what do *you* want out of this"?

3.15 Anna Severwright said that looking at the planning priorities, Outpatient improvement needs to be in there. There are also still big issues with theatres, waiting times and delays. She added that improving staff morale ought to be reflected in the final document.

3.16 Evan Rees asked whether staff turnover was on a par with other Trusts. Mark said that we were above average compared to local partners. He added that staff morale could be affected by a range of issues, notably poor staffing and poor IT. He acknowledged that IT within the Trust was poor and we have recognised the difficulties with medical and nurse staffing.

3.17 Anna Severwright said that we should be making staff feel more valued and appreciated. Geoffrey Smith added that we should work on how we empower our staff.

3.18 Geoffrey Smith said that we should have a greater focus on discharge and step down in the next round of planning priorities. Mark noted that step down care is part of our Quality Commitment. He told the group that the Trust has recently created its

own step down facility which will provide a bridge between hospital and home. Jennifer Fenelon said that while she supported such a facility, she did not feel that it should be located in an acute hospital site but rather in community hospital settings. Evan Rees suggested that the three Healthwatch organisations ought to be discussing this issue with the CCGs.

3.19 Omita Gaikwad asked whether the Trust reported on progress on its current priorities. Mark said that there were a number of ways in which the Trust did this; for example, through the Annual Report, Chief Executive's Bulletin and at the APM.

3.20 Harsha noted that signage, particularly at the LRI remined a priority for a number pof the patient groups.

3.21 Geoffrey Smith raised the issue of communication with patients, saying this still requires improvement. He particularly mentioned patient letters, adding that this was an issue which would benefit from co-production.

3.22 Harsha asked if the Trust routinely captures patient emails. She added that her preference as a patient would be to receive communication via email. Mark said that this was an important component of our recent work to improve the outpatient experience, including a focus on how we use IT.

3.23 Evan Rees stated that emergency admissions straight to ward (i.e. not through the ED) can be difficult, with long waits to be seen.

3.24 Jennifer Fenelon asked whether patient transport was to be a feature of the work on Outpatients.

Action – Karl Mayes to ask Jane Edyvean about this.

3.25 Harsha asked when the new priorities would be set. Mark said that the Trust was aiming for December / January. Harsha asked if the group would see a draft for comment. Omita said that if the timing worked the draft could come to the Joint Patient Reference Group.

3.26 Anna Severwright said that it would be useful if patients had access to advice and support upstream to help prevent unnecessary admissions. Mark said that this would be captured in the integrated care section of the current priorities.

4. Summary of Key Issues

Issue
1. Improve Medical staff retention by developing medical students in the earlier stage of their careers.
2. The focus on frail older people was supported but be mindful that a focus on older frail people may deflect attention from younger, more complex / frail patients.

3. There is still work to be done to improve the Trust's "Cultural Competence"
4. Patient & Public Involvement (PPI) ought to be more prominent in the Trust's strategic aspirations.
5. The Trust should reflect the data it already collects (i.e. the FFT survey responses) in its strategic planning.
6. Outpatient Improvement needs to feature in the Trust's priorities.
7. The Trust should recognise the need to improve staff morale.
8. Could we see a greater focus on discharge and Step Down?
9. Signage, particularly at the LRI remains an issue for patients.
10. Improve communication with patients, particularly patient letters
11. Explore how patients can better access advice and support "upstream" to help prevent unnecessary admissions