CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – MAY 2019

Authors: John Adler and Stephen Ward Sponsor: John Adler **Trust Board paper E (revised)**

Executive Summary

Context

The Chief Executive's monthly update report to the Trust Board for May 2019 is attached. It includes:-

(a) the Quality and Performance Dashboard for March 2019 attached at appendix 1 (the full month 12 quality and performance report is available on the Trust's public website and is hyperlinked within this report);

(b) key issues relating to our Strategic Objectives and Annual Priorities.

Questions

1. Does the Trust Board have any questions or comments about our performance and plans on the matters set out in the report?

Conclusion

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

Input Sought

We would welcome the Board's input regarding the content of this month's report to the Board.

For Reference

Edit as appropriate:

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

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

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

a. Organisational Risk Register [Not applicable]

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
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

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

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

5. Scheduled date for the **next paper** on this topic: [June 2019 Trust Board]

6. Executive Summaries should not exceed **1 page**. [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**

DATE: **2 MAY 2019**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – MAY 2019**

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1. Introduction

1.1 My monthly update report this month focuses on:-

(a) the Board Quality and Performance Dashboard attached at **appendix 1**;

(b) the Board Assurance Framework (BAF) and Organisational Risk Register;

(c) key issues relating to our Annual Priorities, and

(d) a range of other issues which I think it is important to highlight to the Trust Board.

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

2 Quality and Performance Dashboard – March 2019

2.1 The Quality and Performance Dashboard for March 2019 is appended to this report **at appendix 1**.

2.2 The Dashboard aims to ensure that Board members are able to see at a glance how we are performing against a range of key measures.

2.3 The more comprehensive monthly Quality and Performance report continues to be reviewed in depth at a joint meeting of the People, Process and Performance Committee and Quality and Outcomes Committee. The month 12 quality and performance report is published on the Trust's website.

Good News:

2.4 **Mortality** – the latest published SHMI (period October 2017 to September 2018) is 99, slightly higher than previous SHMI but within the expected range. **Diagnostic 6 week wait –** standard achieved for 7 consecutive months. **52+ weeks wait –** has been compliant for 9 consecutive months. **Referral to Treatment –** our performance was below national standard however we achieved the NHS Improvement waiting list size trajectory (which is the key performance measure for 2018/19). **Delayed transfers of care** - remain within the tolerance. However, there are a range of other

delays that do not appear in the count. **12 hour trolley wait** was 0 in March. **C DIFF** – was below threshold this month and the annual target was achieved. **Pressure Ulcers** - 0 **Grade 4,** 0 **Grade 3,** 5 **Grade 2** reported during March. **CAS alerts** – was compliant in March. **Moderate harms and above** – February (reported 1 month in arrears) was within threshold. **Inpatient and Day Case Patient Satisfaction (FFT)** achieved the Quality Commitment of 97%. **Cancer Two Week Wait** was 95.5% in February. **Fractured NOF** – remains compliant for the 8th consecutive month. **Cancelled operations** and **Patients rebooked within 28 days** – we continue to show improvement with our elective cancellations. **90% of Stay on a Stroke Unit** – 86.5% reported in February. **Annual Appraisal** is at 92.6%.

Bad News:

2.5 **UHL ED 4 hour performance** – was 75.1% for March, system performance (including LLR UCCs) was 82.0%.. **Ambulance Handover 60+ minutes (CAD)** – performance at 5%. **MRSA –** 1 case reported in March. **Single Sex Accommodation Breaches** – 2 reported in February. **Cancer 31 day treatment** was 94.8% in February. **2 Week Wait Cancer Symptomatic Breast** was 90.4% in February. **Cancer 62 day treatment** was not achieved in February – further detail of recovery actions in is the cancer recovery report. **Statutory and Mandatory Training** reported from HELM is at 90% (rising trend).**TIA (high risk patients) –** 29.9% reported in March.

3. Board Assurance Framework (BAF) and Organisational Risk Register

3.1 The Board Assurance Framework (BAF) and organisational risk register have been kept under review and a detailed BAF and an extract from the risk register are included in the integrated risk and assurance paper featuring elsewhere on today's Board agenda.

Board Assurance Framework

3.2 The BAF remains a dynamic document and all principal risks have been updated by their lead Director (to report the position for March) and have been reviewed by their relevant Executive Boards during April 2019, where they have been scrutinised ahead of the final version to Board today.

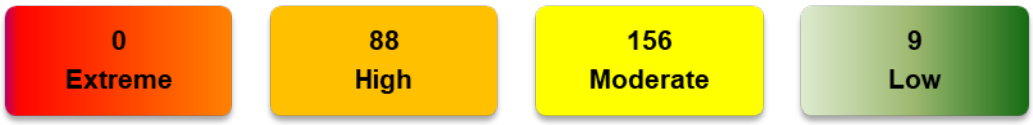
3.3 The highest rated principal risks on the 2018/19 BAF are described in the table below:

Principal Risk Description 2018/19	**Risk Rating (I x L)**	**Objective & Lead Director**
PR2: If the Trust is unable to achieve and maintain the required ***workforce capacity and capability*** standards, then it may result in widespread instances of poor clinical outcomes for patients.	5 x 4 = 20	Our People DPOP
PR3: If the Trust is unable to achieve and maintain ***financial sustainability***, then it will result in a failure to deliver the financial plan.	4 x 5 = 20	Financial Stability CFO

PR4: If the Trust is unable to effectively manage the ***emergency care pathway***, then it may result in widespread instances of poor clinical outcomes for patients and sustained failure to achieve constitutional standards.	5 x 4 = 20	Organisation of Care COO
PR6: If the Trust does not adequately develop and maintain its ***estate***, then it may result in an increased risk of failure of critical plant, equipment and core critical services.	5 x 4 = 20	Key Strategic Enabler DEF

Organisational Risk Register

3.4 The UHL risk register has been kept under review by the Executive Performance Board and across all CMGs during the reporting period and displays 253 risk entries:



3.5 Thematic analysis across the organisational risk register shows the common risk causation theme is workforce shortages (including nursing and medical) across all CMGs. Thematic findings from the risk register are reflective of the highest rated themes captured on the BAF.

4. Emergency Care

4.1 Our performance against the 4 hour standard for March 2019 was 75.1% and 82% for Leicester, Leicestershire and Rutland as a whole.

4.2 We saw a total of 22,999 patients in the Emergency Department and Eye Casualty in March 2019: an increase of 3,333 patients (16.9%) on March 2018. For the 2018/19 financial year, we experienced a 6.2% increase in attendances, compared with the previous year.

4.3 There has been an emerging trend (upward) in attendances since September 2018. Despite a slight drop in December 2018, we have had an unusually high level of attendances in injuries and resuscitation. In March 2019, we had the highest ever number of ED attendances.

4.4 A good deal of focus is being applied with partners to reduce ambulance handover delays, Performance remains variable at present, but nevertheless overall delays in March 2019 were some 40% less than in March 2018.

4.5 Working as a member of the Leicester, Leicestershire and Rutland A&E Delivery Board, attention continues to be focused on:

- reducing demand;
- improving ambulance handover performance;

- improving flow through ED;
- improving flow in and out of hospital.

4.6 Details of the Trust's emergency care performance continue to be the subject of report by the Chief Operating Officer monthly to the People, Process and Performance Committee. Details of the Committee's most recent consideration of the position are set out in the summary of that meeting which features elsewhere on this Board agenda.

5. Quality Strategy – Becoming the Best

5.1 Considerable activity continues to take place as we begin implementation of our new Quality Strategy. In the last month, this has focussed primarily on our quality and supporting priorities, reporting structures, culture and leadership, our quality improvement methodology and patient and public involvement.

5.2 We have now developed the reporting templates required to manage our 12 quality and supporting priorities for 2019/20. These are now being populated by the Executive leads and their project teams. We have also undertaken a comprehensive resource-mapping exercise. This has indicated a requirement for more resources than are available. Potential solutions to this will be discussed at the Executive Team time-out on 30th April and I will update the Board verbally on the outcome of those discussions.

5.3 We have considered the reporting arrangements for the priorities and have concluded that whilst we should continue to operate with "thematic" Executive Boards, these need to be restructured to reflect our more integrated approach. Thus we are proposing to have the following Executive Boards from June:

- Quality and Performance
- Strategy and Finance
- People and Culture
- Information Management and Technology

A paper setting out the rationale for this structure and practical arrangements will be considered by the Executive Quality Board on 7th May. There will also be a need to review the structure of the Board Committees, noting that ultimately it will be for the Trust Board itself to determine if any changes should be made to the structure of its sub-committees

5.4 The culture and leadership aspects of the strategy continue to be taken forward in conjunction with NHS Improvement and the East Midlands Leadership Academy. The culture and leadership survey continues to be promoted and a series of focus groups which I will host have been arranged in June. In addition we have begun recruitment of our Improvement Agents and have attracted over 40 volunteers so far.

5.5 The Expert Reference Group has considered a further level of detail on our chosen quality improvement methodology. The group has also agreed that we should engage the Advancing Quality Alliance (AQuA) to help us with the implementation of

the methodology and wider aspects of the Quality Strategy. AQuA is well-established NHS quality improvement organisation which works primarily in the North West and is hosted by Salford Royal Foundation Trust. The cost of this engagement will be met from within the £1m Quality Strategy budget allocation.

5.6 Following the further discussions with our Patient Partners which I referenced in my previous report, a new Patient and Public Involvement (PPI) Strategy has been produced. This features elsewhere on the agenda of today's meeting. Board members will note that it fully reflects the approach to PPI described in the Quality Strategy; I am confident that over time this will bring us much closer to the "co-production" model to which we aspire.

5.7 The Executive Time-Out on 7th May will also consider how best to now promote the Quality Strategy, particularly internally. This is likely to involve a large scale communications and engagement exercise over the early summer. I will report back further on this at the meeting.

6. Better Care Together Partnership – Update

6.1 I attach at **appendix 2** a copy of the first Better Care Together business update for partner Boards, Governing Bodies and councillors.

6.2 On 16th May, an extended workshop-style meeting of the System Leadership Team will be held to which a subset of non-executive directors and lay and elected members will also be invited. The purpose of this workshop is to finalise plans to form a Partnership Group and appoint an Independent Chair as well as take forward our thinking on developing an integrated care system as envisaged in the NHS Long Term Plan.

7. East Midlands Congenital Heart Centre (EMCHC)

7.1 I am pleased to report that we met our surgical activity target for EMCHC for 2018/19 treating 384 patients against a lower threshold target of 382. This means that the service will continue to be commissioned without any requirement for regional or national action.

7.2 This is a significant achievement, especially as it required a recovery from an earlier period in the year where we had lagged quite a way behind the target. This is a testament to the hard work and commitment of the whole clinical and support team encompassing our Surgical, Theatres, Anaesthetic, Perfusion, PICU and Ward teams who have exemplified the Trust value, 'We are one team and we are best when we work together'.

7.3 Led by Rebecca Brown, Chief Operating Officer, work continues to ensure that a sustainable plan is in place to achieve the EMCHC surgical activity target for 2019/20 and beyond, given that the target increases each year.

7.4 NHS England has also recently agreed to an extension of the deadline for the relocation of the service to the Royal Infirmary. This will now take place in

December 2020 rather than the previously agreed date of June 2020. The delay is to facilitate the financial management of the Trust's capital programme.

8. Maternity and Midwifery Festival Awards 2019

8.1 The Maternity and Midwifery Festival Awards 2019 were held in Leicester for the first time on Tuesday, 9th April at the King Power Stadium. This is one of three national events.

8.2 I am pleased to report the success of the Trust, as follows:

- the UHL Maternity Team won the overall Maternity and Midwifery Festival Team award;
- newly qualified Midwife, Rebecca Telling, won the Student Midwife Award. Rebecca qualified in January 2019 and now works in the maternity unit at the Leicester General Hospital. Rebecca was recognised for her valuable contribution to a recent breast-feeding project and exhibition, and support of the local campaign, 'Don't Fear the Smear';
- Annabelle Barker, Midwife, was highly commended for Best Manager, in recognition of the work of the Trust's dedicated Home Birth Team;
- The Home Birth Team was highly commended in the Innovation category: the Team has a base at Glenfield Hospital and provides a 24 hour service for women who live in Leicester, Leicestershire and Rutland.
- Barbara McDonald, who is a midwife and practice learning facilitator, was highly commended in the Education category

8.3 I am sure the Trust Board will join me in congratulating all involved for this remarkable scale of recognition.

9. Conclusion

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

John Adler
Chief Executive

26th April 2019

Quality & Performance

		YTD Plan	YTD Actual	Mar-19 Plan	Mar-19 Actual	Trend*	Trend Line	Compliant by?
Safe	S1: Reduction for moderate harm and above (1 month in arrears)	142	228	<=12	12	●		Compliant
	S2: Serious Incidents	<37	29	3	1	●		Compliant
	S10: Never events	0	8	0	2	●		Apr-19
	S11: Clostridium Difficile	61	57	5	5	●		Compliant
	S12 MRSA - Unavoidable or Assigned to 3rd party	0	3	0	1	●		Apr-19
	S13: MRSA (Avoidable)	0	0	0	0	●		Compliant
	S14: MRSA (All)	0	3	0	1	●		Apr-19
	S23: Falls per 1,000 bed days for patients > 65 years (1 month in arrears)	<5.6	6.4	<5.6	6.6	●		Apr-19
	S24: Avoidable Pressure Ulcers Grade 4	0	0	0	0	●		Compliant
	S25: Avoidable Pressure Ulcers Grade 3	<27	7	<=3	0	●		Compliant
	S26: Avoidable Pressure Ulcers Grade 2	<84	62	<=7	5	●		Compliant
Caring	C3: Inpatient and Day Case friends & family - % positive	97%	97%	97%	97%	●		Compliant
	C6: A&E friends and family - % positive	97%	95%	97%	92%	●		See Note 1
	C10: Single Sex Accommodation Breaches (patients affected)	0	58	0	2	●		See Note 1
Well Led	W13: % of Staff with Annual Appraisal	95%	92.6%	95%	92.6%	●		Apr-19
	W14: Statutory and Mandatory Training	95%	89%	95%	90%	●		Apr-19
	W16 BME % - Leadership (8A – Including Medical Consultants) - Qtr 3	28%	29.0%	28%	29.0%	●		Compliant
	W17: BME % - Leadership (8A – Excluding Medical Consultants) - Qtr 3	28%	16%	28%	16%	●		Dec-23
Effective	E1: 30 day readmissions (1 month in arrears)	<8.5%	9.0%	<8.5%	9.1%	●		See Note 1
	E2: Mortality Published SHMI (Oct 17 - Sep 18)	99	99	99	99	●		Compliant
	E6: # Neck Femurs operated on 0-35hrs	72%	74.6%	72%	75.3%	●		Compliant
	E7: Stroke - 90% of Stay on a Stroke Unit (1 month in arrears)	80%	84.7%	80%	86.5%	●		Compliant
Responsive	**R1: ED 4hr Waits UHL**	95%	77.0%	95%	75.1%	●		See Note 1
	R2: ED 4 Hour Waits UHL + LLR UCC (Type 3)	95%	83.2%	95%	82.0%	●		See Note 1
	R4: RTT waiting Times - Incompletes (UHL+Alliance)	92%	84.7%	92%	84.7%	●		See Note 1
	R6: 6 week – Diagnostics Test Waiting Times (UHL+Alliance)	<1%	0.9%	<1%	0.9%	●		Compliant
	R12: Operations cancelled (UHL + Alliance)	1.0%	1.1%	1.0%	1.2%	●		Jun-19
	R14: Delayed transfers of care	3.5%	1.5%	3.5%	1.7%	●		Compliant
	R15: % Ambulance Handover >60 Mins (CAD)	TBC	4%	TBC	5%	●		See Note 1
	R16: % Ambulance handover >30mins & <60mins (CAD)	TBC	8%	TBC	13%	●		See Note 1
	RC9: Cancer waiting 104+ days	0	27	0	27	●		See Note 1

		YTD Plan	YTD Actual	Feb-19 Plan	Feb-19 Actual	Trend*	Trend Line	Compliant by?
Responsive Cancer	RC1: 2 week wait - All Suspected Cancer	93%	91.9%	93%	95.5%	●		Compliant
	RC3: 31 day target - All Cancers	96%	95.2%	96%	94.8%	●		Jul-19
	RC7: 62 day target - All Cancers	85%	75.3%	85%	69.9%	●		Sep-19

Enablers

		YTD Plan	YTD Actual	Qtr4 18/19 Plan	Qtr4 18/19 Actual			
People	W7: Staff recommend as a place to work (from Pulse Check)		59.8%		57.0%			Not Applicable
	C9: Staff recommend as a place for treatment (from Pulse Check)		71.2%		74.0%			Not Applicable

		YTD Plan	YTD Actual	Mar-19 Plan	Mar-19 Actual	Trend*	Trend Line	Compliant by?
Finance	Surplus/(deficit) £m	(21.2)	(51.8)	6.4	9.3	●		Compliant
	Cashflow balance (as a measure of liquidity) £m	1.0	4.0	1.0	4.0	●		Compliant
	CIP £m	51.5	51.6	12.3	12.5	●		Compliant
	Capex £m	26.7	26.7	(4.5)	4.7	●		Compliant

		YTD Plan	YTD Actual	Mar-19 Plan	Mar-19 Actual	Trend*	Trend Line	Compliant by?
Estates & facility mgt.	Average cleanliness audit score - very high risk areas	98%	96%	98%	95%	●		See Note 3
	Average cleanliness audit score -high risk areas	95%	94%	95%	93%	●		See Note 3
	Average cleanliness audit score - significant risk areas	85%	94%	85%	93%	●		Compliant

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

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

Note 1 - **'Compliant by?'** for these metrics a are dependent on the Trust rebalancing demand and capacity.

Note 2 - Unable to determine compliance dates for these metrics. We have control measures in place to mitigate risks however we have no direct control due over HCAIs.

Note 3 - Compliance is dependent on investment

Better care together
Leicester, Leicestershire & Rutland health and social care

Better Care Together Partnership Update

A business update for partner boards, governing bodies and members

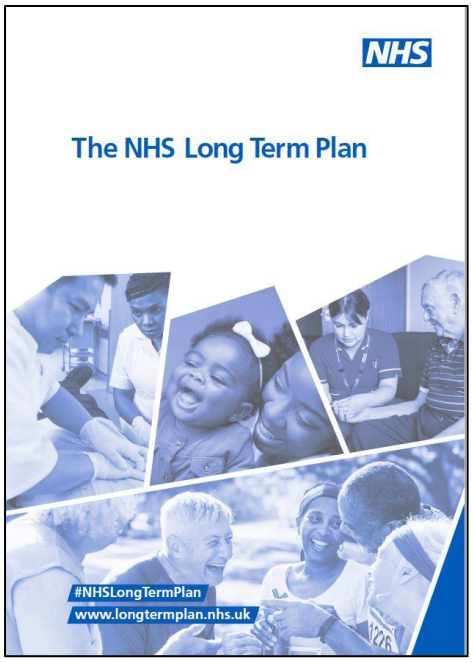
March 2019

Welcome to the first of a regular business update from the System Leadership Team (SLT) of Better Care Together. The purpose of this update is to inform governing bodies, boards and members on the key business and strategic programmes of work being discussed and taken forward SLT.

Responding to the NHS Long Term Plan

In January NHS England published the NHS Long Term Plan. This has been developed nationally – in partnership with frontline health and care staff, patients and their families – in response to the Government's commitment to provide an extra £20.5 billion annual funding for the NHS in England by 2023/24.

The Long Term Plan sets out a strategy to make sure the NHS is fit for the future, providing high-quality care and better health outcomes through every stage of life. It also describes the actions that will be needed at local, regional and national levels to make this ambitious vision a reality.



To respond to the NHS Long Term Plan, Better Care Together partners will produce a refreshed version of our own local plan in the coming months.

This will build on the work we have already done together as a partnership and focus on the priority areas we have already identified for transforming our health and care services.

Indeed, it's encouraging to see that a lot of the detail in the NHS Long Term Plan is very much aligned with our own priorities for Leicester, Leicestershire and Rutland – including our focus on creating integrated local health and care services closer to people's homes, giving people more control of their own health and care, our efforts to improve prevention of ill-health and tackle health inequalities, and working to prevent unnecessary hospital admissions and speed up discharges home.

Between now and late 2019 we will be working with our BCT partners and wider stakeholders, including the public, to produce our refreshed five-year plan. Governing bodies, boards and members will also of course be involved in those discussions, and we will also keep you informed through future editions of this update and via our website. In the meantime you can read more about the NHS Long Term Plan at www.longtermplan.nhs.uk.

SLT reviews BCT governance

SLT is currently undertaking a review of its governance arrangements. This work is being undertaken in order to future proof the local health system, while also supporting its response to delivering the requirements of the NHS Long Term Plan.

It is anticipated that the outcomes of the review will strengthen overall governance of the programme and support delivery of the system's strategic priorities through robust management and oversight.

As part of the review SLT is to propose updated Terms of Reference, which will be shared within health and care organisations for discussion and agreement as appropriate.

Under the proposals SLT will continue to be constituted as a formal joint committee of the three CCGs – allowing the commissioners to make collective decisions. Other partners continue to make decisions in line with any authority delegated to its individual representatives.

It is also recommended that Derbyshire Health United be invited to join the group as members, reflecting the organisation's position as a key provider of services in LLR.

Meanwhile, a new BCT Partnership Group is proposed to be established in line with guidance contained within the Long Term Plan.

The group, led through the appointment of an independent chair, would bring together non-executive, lay and political representation to scrutinise and challenge the operation of SLT as well as the delivery of the wider programme. It will also take a key role in ensuring adequate and effective patient and public engagement.

In doing so it would provide an oversight function for statutory partners in particular, ensuring they receive common and shared assurance in relation to BCT.

Draft Terms of Reference for the Partnership Group have been developed and circulated to partner organisations for discussion and feedback.

Finally, to support the development of the refreshed five-year plan it is proposed that the BCT Interdependencies Group be re-established and tasked with its delivery, reporting into the System Leadership Team.

To support the proposed refreshed governance arrangements a comprehensive governance handbook is also being developed. This user-led document will include Terms of Reference for the Partnership Group and SLT as well as all sub-groups, a comprehensive guide to the overarching governance hierarchy and assurance flows, and an agreed set of system-wide leadership behaviours and standards of business conduct.

The role of SLT

The System Leadership Team is the senior management group which oversees all aspects of the development and delivery of the BCT plan for the Leicester, Leicestershire and Rutland (LLR).

It brings together clinical and executive leadership of health and local authority partners to serve three core purposes:

- Set the direction and oversee delivery of the BCT programme for LLR, including the development of an Integrated Care System (ICS) and five-year BCT plan;
- Support collective problem solving and decision-making for system-wide issues; and
- Provide oversight and monitoring of performance against planned outcomes, agreeing actions to address any variances from the plan – e.g., system finance position – with appropriate reference to the governance arrangements of each organisation.

System Leadership Team work programme

The SLT has agreed that the future schedule of its meetings would be a mix of more formal business-focused meetings interspersed with workshop-type development sessions. It is anticipated that these development sessions would happen quarterly.

Agendas for SLT meetings will have an emphasis on more system-level conversation and a focus on understanding and unblocking issues that prevent system priorities from being delivered.

This will include a rolling programme of work stream deep dives, with an indicative schedule set out below.

Prevention and Inequalities	April 2019
Mental Health	April 2019
Learning Disabilities	April 2019
Planned Care	June 2019
Cancer	June 2019
Integrated Community Services	July 2019
Primary Care	July 2019
Urgent Care	August 2019
Workforce	October 2019
IM&T	October 2019
Note updates will include: What the key priorities are and how they link to the Long Term Plan; What has been achieved; Priorities for the next 12 months; and risks and issues	

Outside of the above deep dive schedule any other work stream issues will be escalated to SLT by exception for consideration and recommendations for resolution as appropriate.

In addition to the above there are a number of known business items that will need to be dealt with throughout the year, and these are set out below.

Systems Finance and Activity	Monthly
Estates Update	Quarterly
STP Risk Register	Quarterly
Outcomes Framework	Quarterly
Communications and Engagement Update	Quarterly
Response to Long Term Plan (Draft)	August 2019
Memorandum of Understanding (Draft)	August 2019
Response to Long Term Plan (Final)	October 2019
Memorandum of Understanding (Final)	October 2019

Working towards becoming an Integrated Care System

One of the key requirements of the NHS Long Term Plan is for all STP footprints to have evolved into an Integrated Care System by April 2021.

Integrated Care Systems – or ICSs – are a way of working, collaboratively, between a range of health and social care organisations, to help proactively manage and improve people's health. What it is not is a creation of a new organisation.

Instead, they bring together local organisations to redesign care and improve population health, creating shared leadership and common action. The Long Term Plan describes them as *"…a pragmatic and practical way of delivering the 'triple integration' of primary care and specialist care, physical and mental health services, and health with social care."*

An ICS will have a key role in working with local authorities at 'place' level and, through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health.

Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single strategic commissioner for each ICS area.

As a result Clinical Commissioning Groups (CCGs) will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.

Locally, the CCGs have already agreed to appoint one Chief Executive Officer and senior management team across the three organisations. The second phase of the work will be to consider whether a merger of the three Clinical Commissioning Groups should happen. This work will take place during 2019.

In the meantime, SLT came together during January for a facilitated development session to discuss the local journey towards creating an ICS and set out a roadmap for delivery.

The outcome was agreement in principle that it intends to develop a delivery plan by September 2019 and be ready to work in shadow form as an Integrated Care System from April 2020.

The Good Governance Institute Maturity Matrix has been used to assess where we currently are as a system and what actions we need to take next. This has identified the following key areas of focus for the year ahead:

- Purpose and clarity of remit - rearticulate vision, purpose and principles
- System Infrastructure, leadership, financial framework
- Governance and decision making, including establishing transparent oversight arrangements and putting in place a Memorandum of Understanding
- Internal and external stakeholder engagement, including joint approaches to communications and engagement activities with staff and stakeholders
- Priorities and outcomes, including tangible programmes of joint work.

Boards and governing bodies will be fully involved in discussions about delivery of the above priority areas over the course of the coming months.

Leicester's Hospitals' investment and reconfiguration plans

Final approval and funding for the £31m interim Intensive Care Unit (ICU) consolidation and associated services scheme has now been received. This scheme transfers Level 3 intensive care beds from the Leicester General Hospital to Glenfield Hospital. It also moves dependent specialist surgical services to Glenfield, and consolidates general surgery at the Royal Infirmary site.

The key building components and dates when the construction completes within this scheme are:

- Expansion of Glenfield ICU – Dec 2019
- New wards at Glenfield for HPB and renal transplant – Feb 2020
- New Interventional Radiology Department at Glenfield – March 2020
- Refurbished wards at the Royal for emergency general surgery and colorectal surgery (wards 15,16 and 21) – October 2019.

Part of this scheme will include moving some day case surgery from the Royal Infirmary and Glenfield to the General.

In addition to this scheme, UHL is also relocating the children's element of the East Midlands Congenital Heart Centre (EMCHC) from Glenfield to the Royal Infirmary. This £14m scheme will see a number of moves within the Kensington Building, supported by the development of a new build Cardiac theatre and catheter lab.

Enabling works include the move of Gynaecology outpatients into the Jarvis building and the gynaecology assessment unit and early pregnancy assessment unit into ward 8 in the Balmoral building. The EMCHC service is scheduled to move in June 2020 as the first phase of the new standalone children's hospital project.

All of these investments will provide great new facilities. At the same time as progressing these schemes, we have been pursuing a larger bid as part of the national capital process. This bid is designed to provide enough funding for us to complete our reconfiguration over a number of years.

National NHS colleagues have been very clear that our bid has made good progress and that they wish it to continue to do so, so that it is in the best position it can be to get further funding when new money becomes available. This is likely to be later this year or early in 2020. The UHL Trust Board has also recently reviewed the position and confirmed that the plan remains the best one available to ensure that patients and staff have access to high quality, sustainable facilities and clinical services.

Our plan remains that, once capital funding is secured in principle, we will move to full consultation on our acute reconfiguration plans.

Reconfiguration plans shared with patients and the public

Although we are not in a position to formally consult on our plans until capital support is obtained in principle the partnership has been engaging extensively over the course of recent months. Nine public engagement events were held in the city and two counties in the lead up to Christmas, while this year plans have been shared through more than 30 outreach meetings with seldom heard and hard to reach communities.

A video and information booklet demonstrating the case for change and our outline plans has been produced and will shortly be shared publicly. These can be accessed by visiting the BCT website: www.bettercareleicester.nhs.uk.

A new approach to communications and involvement

A refreshed approach to engagement, involvement and communication for the BCT programme has recently been discussed and supported by SLT.

The approach sets out when and how the partnership will communicate with and involve patients and the public, staff and other stakeholders in the work of Better Care Together.

Agreement has been given to driving the involvement of patients and stakeholders through and by work streams and work stream senior responsible officers in partnership with communications and engagement leads.

At its heart is a culture and mind set where engagement is seen as 'an always event' when services are redesigned or modified. To support this work stream leads will be provided with a better understanding of the legal and statutory duties of engagement – as well as the many practical and real benefits of involving patients in the process through the sharing of experience and expertise.

In addition a commitment has been given to the use of the BCT brand consistently across all work streams and BCT partners to increase awareness of the overall programme and the many positive improvements it is already making.

This emphasis in approach will be discussed with work streams through the BCT Interdependencies Group, as well as through communications and engagement leads. A copy of the document setting out the approach to communications and engagement can be accessed here.

Proposed new structure for Patient and Public Involvement

A comprehensive review of the existing Patient and Public Involvement Group (PPIG), which provides support and advice for engagement activities across the BCT programme, has been undertaken in partnership with group members.

The review concluded that there is a broad level of support within the group to refresh arrangements and create a new two-step approach - with complementary parts concentrating on assurance and networking.

A new Patient and Public Involvement Assurance Group (PPIAG), consisting of 10 to 12 people with significant experience of patient engagement, will be established. This group will replace the existing PPIG and will work within an agreed assurance framework to review, comment on and recommend actions in respect of patient involvement and engagement across BCT projects.

It will also liaise with work streams to ensure that insights and business intelligence gained through involvement and engagement influences decision making. PPIAG will be represented on, and report findings to, the new BCT Partnership Group once established. It is envisaged that the Partnership Group will agree a programme of review with input from the Senior Leadership Team, work stream SROs, PPIAG and the Communications and Engagement Group.

Creating a Citizens' Panel

In order to further support a consistent approach to engagement, and to connect with local networks, we have secured £40k from NHS England to develop a Citizens' Panel.

The Panel, which will be largely online, will provide BCT with an additional systematic approach to gathering insights and feedback on a range of health and care issues from a representative sample of our circa 1.1 million population.

We wish to co-create the panel with support from BCT partners, the newly created PPIAG and our upper and second tier local authorities and parish councils.

Community Services Redesign work continues

Work has continued at pace on the Community Services Redesign (CSR) in recent months. The project, initiated by the CCGs in April 2018 to address identified issues within existing community services provision, aims to ensure services are configured appropriately to deliver the best possible care for patients in community settings.

The scope of the redesign work includes the following services provided by Leicestershire Partnership NHS Trust:

- District nursing services – which provide home-based patients with ongoing nursing care for long-term conditions or end-of-life care, with treatments such as wound care and continence care
- Integrated Community Support service – a 'virtual ward' providing healthcare services in a patient's own home
- Community hospital beds (including stroke beds)
- Community physiotherapy services (not including MSK physiotherapy) and community stroke rehabilitation service
- Primary care co-ordinators – who work in hospitals to support staff to help get patients home as quickly as possible once they are ready to leave hospital
- Single Point of Access.

Due to the complexity of the work, achieving significant change is being seen as a two to three year transformation programme which follows a systematic process. The emerging proposed new model is based around the following main services:

Neighbourhood community nursing – teams would manage the majority of care of complex patients in the community (for example those who are frail, have multiple conditions or other complex/costly health and care needs), working closely with social care and primary care networks (groups of GP practices with 30,000– 50,000 patients). Neighbourhood teams would provide both planned and same day urgent care, providing improved continuity of care.

Home First services – these are integrated health and social care crisis response rehabilitation and reablement services, which would deliver intensive short-term care for up to six weeks. Home First services will be accessed via Locality Decision Units, with health and social care services working on the basis of trusted assessment and delivering co-ordinated packages of care.

Community bed based care - delivered either in community hospitals for patients requiring medical rehabilitation needing significant 24/7 nursing care and on-site therapies, and in reablement beds for patients with lower medical needs requiring reablement and a degree of 24/7 support.

Initial changes to the staffing in current ICS teams will be made, redesigning them into neighbourhood nursing teams and Home First services. A second phase of work will then be undertaken to engage on and generate options for longer term changes to community health services which would deliver a greater shift towards supporting more people to be cared for at home (where that is appropriate for their needs). This work will include setting out options for the range of services delivered from community hospital sites, and the future community bed model. Whilst CCG governing bodies have agreed the model in principle specific options will require further discussion and approval.

Meanwhile, the CSR team has undertaken extensive engagement with patients, carers, staff, as well as the public, local authority elected members and executive teams on the work done to date. This has played back the results of the engagement work so far, describing the vision for integrated community health and care services and seeking support for the direction of travel. Feedback from these discussions will be used to inform and shape next steps.

Frailty work programme comes to a close

The Frailty programme, commissioned by SLT in May 2018, has come to the end of its initial phase.

The original aims of the programme were to design and implement 16 high-impact drivers which the system agreed could influence the delivery of an integrated system of care for our functionally frail cohort of patients in LLR.

By their nature, most of these 16 drivers were not straightforward to design or deliver. This is because all 16 projects spanned multiple organisations, multiple IMT systems and, most importantly, multiple differing organisational cultures.

However, although originally daunting, in reality it was this complexity that led to success of the work stream – giving a group of motivated and likeminded staff the mandate to 'fix' an issue in a patient-focussed and collegiate manner.

This has led to a range of solutions to long-standing issues faced by our patients and staff across LLR.

Ten of the original sixteen drivers have been fully delivered, with a further four partially completed.

The final two actions were deferred as they fell into the scope of the Community Services Redesign programme – principally to ensure alignment with the emerging model. As a result, no further work was completed in relation to this through the frailty programme. Other outstanding actions have been agreed with the relevant STP work stream.

Within the LLR frailty programme there were a number of actions specifically for UHL. Whilst these have been delivered embedding the processes will take time and further engagement within the Trust.

As a result the Trust, supported by SLT, has agreed that the UHL element of the frailty programme remains active. This will enable Leicester's hospitals to embed frailty scoring across the wider Trust, as well as ensuring that the outputs of related work streams - such as the CSR - are fully aligned with long-term requirements.

Appendix 2a

Better Care Together Partnership update

A business update for partner boards, governing bodies and members

April 2019

Welcome to the second of a regular business update from the System Leadership Team (SLT) of Better Care Together. The purpose of this update is to inform governing bodies, boards and members on the key business and strategic work programmes being discussed and taken forward by SLT.

Digital strategy

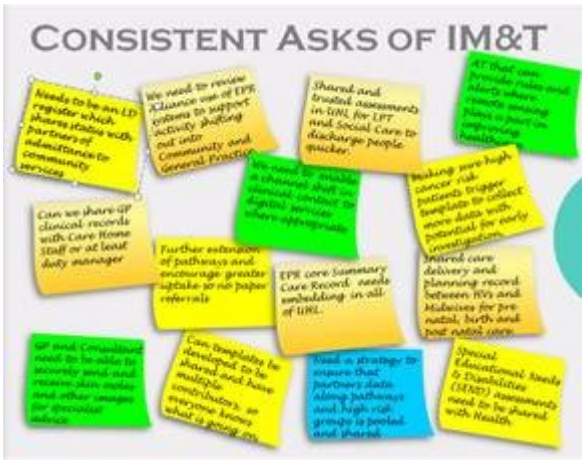
System Leadership Team (SLT) members discussed how the Digital Strategy for Leicester, Leicestershire and Rutland (LLR) should be best progressed over the next few years.

There are a number of information management and technology (IM&T) projects already being progressed across the system, a number of new demands arising from partner organisations and calls for further adoption of IM&T schemes set out in the NHS Long Term Plan.

The Digital Strategy sets out a number of strategic actions focused on system-wide transformation and improving digital capability. The strategy has considered the common asks of IM&T and reviewed them in relation to the priorities of Better Care Together (BCT). It has set out to prioritise and fund the schemes based on strategic fit, levels of complexity, and patient and broader benefits.

Four strategic priorities have emerged:

- Record sharing - real-time access to LLR clinical records for all professionals
- Digital self-care - enabling patients to self-manage and navigate the health and care system for themselves using digital means
- Supporting pathways - ensuring the patient journey is captured electronically and information is transferred with professionals and patients involved in the next step in care
- Business intelligence and research - integrated health and social care data analysis and business intelligence to support both direct care, research studies and population health management.



In one case study, the Rutland Integrated Discharge project has utilised the health and social care module of TPP SystmOne, with a joint electronic shared assessment form, enabling health and social care colleagues in the Rutland Hospital Discharge Team to work together on a single assessment of hospital patients as part of supporting their transfer of care. Staff are able to co-ordinate care more effectively around the patient. They have reported the system to be faster to complete assessments with joint involvement. Patients answer fewer duplicated questions, are more assured that staff are co-ordinating effectively, and are more likely to have a timely discharge with appropriate support in the community.

Clinician views:

Dr Steve Jackson, University Hospitals Leicester: *"I have seen two patients recently who have been presenting to hospital with various pains and being treated with opiates and cyclizine intravenously. They have been in various hospital departments and sent home without diagnoses. One of the patients has been to several different acute trusts in the area in the recent past. One of the patients was even, according to the S1 record, causing the GP some concerns about the stockpiling of such medication. In both records, there was a clear plan from the primary care team that the patients needed support to present less frequently to secondary care and to work on the weaning off of medication. Being aware of this when I saw the patients I was able to support this plan rather than treat as 'abdo pain requiring opiates'."*

Measuring outcomes

The SLT has reviewed the Better Care Together (BCT) Outcomes Framework which has 16 of 33 measures rated as 'green', four as 'amber' and nine as 'red'. The remaining four measures do not have agreed targets. An estimated 80 per cent of the measures in the framework have been updated since they were previously reported to the SLT. The table below shows the RAG (red, amber, green) ratings for key themes.

Better Care Together (BCT) Goals	Red	Amber	Green	not-RAG rated
A. Keep more people well and out of hospital	1	1	5	0
B. More care closer to home	1	2	3	0
C. Responsive care in a crisis	2	0	2	2
D. High quality specialised care	3	0	5	2
E. Health & social care system fit for the future	2	1	1	0
All Outcome Measures	**9**	**4**	**16**	**4**

The measures currently rated red as not achieving their target are:

- Patient waiting 18 weeks or less from referral to hospital treatment
- Patient experience of GP services
- Percentage of patients admitted, transferred or discharged from A&E within four hours
- Type one A&E attendances
- Improving access to psychological therapies – recovery
- Access to children and adolescent mental health services
- Reduce inappropriate out-of-area placements for mental health
- Primary care workforce – number of GPs
- Effectiveness of working relationships in the local system.

The Outcomes Framework is continually reviewed to ensure the measures included are relevant and useful. The latest update presented to SLT included several changes with some measures being dropped and some being replaced.

The next update of the Outcomes Framework will incorporate the latest planning round for 2019-20 across the STP footprint. It is planned that future revisions of the Outcomes Framework will integrate metrics for Integrated Community Health Services and early implementers of Integrated Locality Teams.

Terms of reference for new Partnership Group

Terms of reference have been discussed for a new Partnership Group to support the scrutiny of proposals being advanced by BCT.

It is proposed, the Partnership Group, comprised of non-executive and lay members, will provide oversight and challenge to our plans. It will help ensure early engagement and involvement of senior health, care and political leaders in the development of LLR plans and will provide advice and challenge on specific development proposals in advance of formal consultation.

The Partnership Group will not replace the role that Health Overview and Scrutiny Committees have in terms of providing oversight and challenge but it will ensure that the Joint Health Overview and Scrutiny Committee is regularly updated and consulted as appropriate. The Partnership Group will ensure that non-executive directors and elected members have input into discussions that affect the strategic direction of BCT.

It will be led by an independent chair who will be appointed for an initial two-year period with the option of a further year's extension. Membership of the group will be drawn from organisations within the LLR area. In addition there will be representation on the group by the BCT lead and SLT chair. The group will meet at least four times per year with meetings in public, ensuring openness and transparency.

In March, the SLT agreed to replace the existing Patient and Public Involvement Group (PPIG) with a new Patient and Public Involvement Assurance Group (PPIAG), consisting of 10 to 12 people with significant experience of patient engagement. The PPIAG will work within an agreed assurance framework to review, comment on and recommend actions in respect of patient involvement and engagement across BCT projects.

Revised dates for workstream updates

The SLT meetings are due to receive regular reports from the workstreams. This timetable has now been reviewed and revised accordingly:

- Prevention and inequalities - June 2019
- Planned care - June 2019
- Cancer - June 2019
- Integrated community services - July 2019
- Primary care - July 2019
- Mental health and learning disabilities - August 2019
- Urgent care - August 2019
- Workforce - October 2019
- Information management and technology (IM&T) - October 2019

This business update will include monthly features based on the work stream reports.

Communications and engagement

BCT partners are committed to greater involvement of patients, the public and stakeholders in the proposed improvements to services – particularly those that are likely to result in significant changes to the way in which services are delivered.

Communications and engagement activities for BCT that have taken place in 2019 include a series of briefings with MPs. These briefings have been updating MPs on all BCT work, with a particular focus on the acute and maternity reconfiguration and the community services re-design. These briefings are supported by all NHS BCT partners.

We have continued our programme of outreach, working with different communities including 'seldom heard' groups and those people who are vulnerable and often extensively impacted on changes to NHS services. We are particularly working through voluntary and community sector agencies and local support networks to involve these communities. We have continued with 'drop-in' public events with sessions in libraries proving the most successful.

We completed the schedule of public workshops in March to discuss the community services re-design with public, patients, carers, staff and stakeholders. The additional business intelligence gained from these workshops is being analysed and will be reported on in due course.

Public activities have reduced in recent weeks due to the local elections set to take place on 2 May 2019. The pre-election period is a 'period of sensitivity', which requires NHS and other public bodies to adhere to guidance requiring them to avoid actions which distract from or could influence the election outcome.

This period has allowed for a review of the outcomes of activities undertaken and to plan the next schedule of activities. This is set to include ensuring that workstreams have a greater level of understanding of the importance of public, patient and staff engagement, co-design and co-production and are provided guidance of what 'good' communication looks like.

We will continue building on-going and long-lasting relationships with communities across Leicester, Leicestershire and Rutland including the voluntary and community sector. We are preparing 'all-member briefings' for new councillors (post-election) to establish informal and formal two-way communication channels. We are also sourcing new sources of support to help us develop the online citizens' panel and the Public and Patient Assurance Group, complete the evaluation of insights gathered from the community services review, complete the acute and reconfiguration video and brochure, ensure more timely distribution of the BCT newsletter and enhance our web content.

Healthwatch campaign to inform BCT re-fresh of plans

Healthwatch Leicester and Leicestershire and Healthwatch Rutland recently launched a 'What would you do?' campaign to encourage people across LLR to share their views about what local NHS services should look like.

Their campaign aims to encourage people to say how extra money from the Government should be spent on local NHS services as part of the NHS Long Term Plan.

The findings will be combined with insights gathered from the public through on-going BCT partner engagement activities and will be presented to BCT partners to inform the local re-fresh of the BCT plan.

There are two public surveys to capture views and people can fill in one or both:

Survey 1. What would you do to give people more control over their care?
Survey 2. What would you do to give people better support?

Visit the Healthwatch website for more details on What Would You Do?