Report by Chief Executive – Monthly Update: September 2019

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

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)	N/A	
Executive Board	N/A	
Trust Board Committee	N/A	
Trust Board	N/A	

Executive Summary

Context

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

(a) the Quality and Performance Dashboard for July 2019 attached at appendix 1 (the full month 4 quality and performance report is available on the Trust's public website and is hyperlinked within this report);

(b) key issues relating to the Trust Priorities.

Questions

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

Conclusion

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:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[No]
Safely and timely discharge	[Yes]
Improved Cancer pathways	[No]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[No]

2. Supporting priorities:

People strategy implementation	[No]
Estate investment and reconfiguration	[No]
e-Hospital	[No]
More embedded research	[No]
Better corporate services	[No]
Quality strategy development	[No]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required – None Required.

- How did the outcome of the EIA influence your Patient and Public Involvement ? N/A

- If an EIA was not carried out, what was the rationale for this decision? On the basis that this is a monthly update report.

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	**X**	ALL
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	**X**	N/A
New Risk identified in paper: What ***type*** and ***description***?	N/A	N/A
None		

5. Scheduled date for the **next paper** on this topic: October 2019 Trust Board
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5th SEPTEMBER 2019**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – SEPTEMBER 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 Trust 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 – July 2019

2.1 The Quality and Performance Dashboard for July 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 4 quality and performance report is published on the Trust's website.

2.4 ***Good News:***

- **Mortality** – the latest published SHMI (period March 2018 to February 2019) has decreased to 99, this remains within the expected range.
- **Diagnostic 6 week wait –** standard achieved for 11 consecutive months.
- **52+ weeks wait –** has been compliant for 13 consecutive months.
- **Delayed transfers of care** - remain within the tolerance.
- **12 hour trolley wait -** 0 breaches reported.

- **Moderate harms and above** – June (reported 1 month in arrears) was within threshold.
- **CAS alerts** - compliant.
- **MRSA –** 0 cases reported.
- **Pressure Ulcers** - 0 **Grade 4,** 1 **Grade 3** and 4 **Grade 2** reported during July.
- **Inpatient and Day Case Patient Satisfaction (FFT)** achieved 97% which is above the national average.
- **2 Week Wait Cancer Symptomatic Breast** was 94.5% in June.
- **90% of Stay on a Stroke Unit** – threshold achieved with 86.0% reported in June.
- **TIA (high risk patients) –** threshold achieved with 78.9% reported in July.
- **Annual Appraisal** is at 91.8%.
- **Statutory and Mandatory Training** compliance has increased to 93%. A specific focus is being applied to Bank and Estates & Facilities staff with a compliance deadline of 31/10.

2.5 ***Bad News***

- **UHL ED 4 hour performance** – 72.0% for July, system performance (including LLR UCCs) was 80.6%.
- **Ambulance Handover 60+ minutes (CAD)** – performance at 10.2%.
- **Referral to treatment** – numbers on the waiting list (now the primary performance measure) were above the NHSE/I trajectory and 18 week performance was below the NHS Constitution standard at 83.3%.
- **Single Sex Accommodation Breaches** – 7 reported in July.
- **C DIFF** – 12 cases reported this month against a monthly trajectory of 9. YTD is within trajectory.
- **Cancer Two Week Wait** was 91.0% in June against a target of 93%.
- **Cancer 31 day treatment** was 93.9% in June against a target of 96%.
- **Cancer 62 day treatment** was 74.4% in June against a target of 85%.
- **Fractured NOF** decreased to 58.3% in July, YTD remains above target which is 72%.
- **Cancelled operations OTD** - 1.2% reported in July.
- **Patients not rebooked within 28 days following late cancellation of surgery -** 16.

3. <u>Board Assurance Framework (BAF) and organisational Risk Register</u>

3.1 The Trust Board approved the 2019/20 BAF for quarter one at its meeting in August 2019. Since that meeting, in line with our BAF governance arrangements, all Executive leads have now reviewed and updated their principal risks for the period ending 31st July 2019.

3.2 The highest rated principal risks on the BAF for the reporting period are:

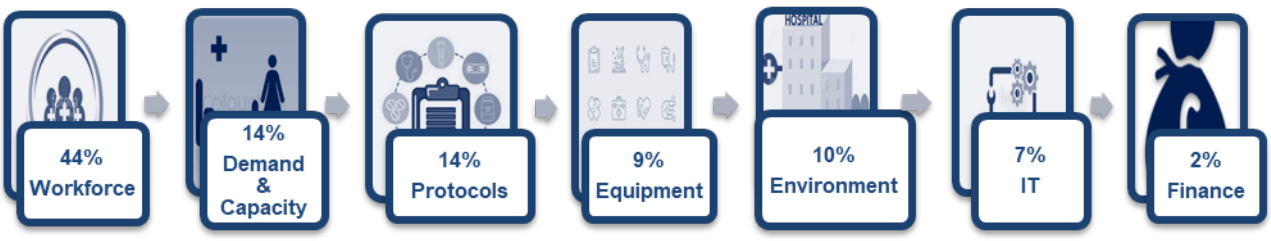
PR No.	Principal Risk Event *If we don't put in place effective systems and processes to deal with the threats described in each principal risk… then it may result in…*	Executive Lead Owner	Current Rating: July (L x I)
1	Failure to deliver key performance standards for emergency, planned and cancer care	COO	5 x 4 = 20
5	Failure to recruit, develop and retain a workforce of sufficient quantity and skills	DPOD	5 x 4 = 20
6a	Serious disruption to the Trust's critical estates infrastructure	DEF	4 x 5 = 20
6b	Serious disruption to the Trust's critical IT infrastructure	CIO	4 x 5 = 20

3.3 One principal risk rating has changed during the reporting period (ending 31st July 2019), namely, principal risk 4 - failure to deliver the Quality Strategy to plan – reducing from a 12 (L3 x I4) to 8 (L2 x I4) based on effectiveness of the current preventive control measures.

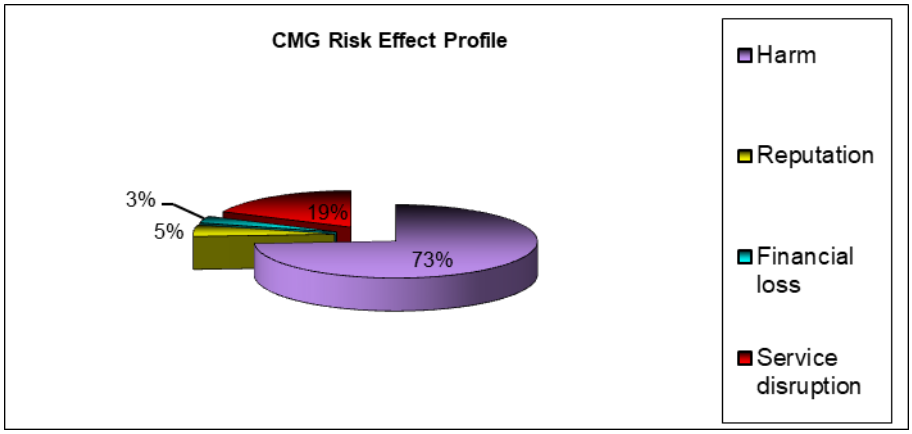
Organisational Risk Register

3.4 The UHL risk register has been kept under review by the Executive Quality and Performance Board and across all CMGs during the reporting period and displays 240 risk entries:

3.5 Thematic analysis across the organisational risk register shows the most common risk causation theme across all CMGs to be workforce capacity and capability. Other causation themes reported on the CMG risk registers are illustrated in the graphic below:



3.6 Thematic analysis across all CMGs risk registers shows the common risk effects are potential for harm. Other themes are illustrated in the graphic below:



3.7 During the reporting period there have been three new risks rated 15 and above entered on the risk register and endorsed by the Executive Team:

ID	CMG	Risk Description – New Risks	Current Rating	Target Rating
3474	CMG 4 - ITAPS	If the Endoscopy washer machines based within all 3 theatre departments have a catastrophic failure, caused due to aged and obsolete equipment, then it may result in a prolonged disruption to the continuity of patient care because theatres will be unable to provide cleaned and safe flexible lumened scopes to their patients.	20	4
3475	CMG 4 - ITAPS	If there is no effective maintenance programme in place to improve the operating theatres at the LGH, LRI & GGH sites, including ventilation, and fire safety, then it may result in failure to achieve compliance with required regulations & standards, leading to reputational impact, potential harm and service disruption.	20	12
3483	CMG 7 - W&C	If the Viewpoint Maternity Scan system is not upgraded to the supported 6.0 version and the archiving solution is not addressed, then it may result in a detrimental impact on quality of delivered care and patient safety with missed fetal anomalies, leading to potential harm.	20	5

4. Emergency Care

4.1 Our performance against the 4 hour standard for July 2019 was 72% and 80.6% for Leicester, Leicestershire and Rutland as a whole.

4.2 Overall, we are seeing an increase in the numbers of patients coming to us and an increase in patient acuity. July 2019 saw a 5.5% increase in Emergency Department attendances, and a 5% increase in emergency admissions compared to July 2018.

4.3 Ambulance attendances increased by 13.1% between April and July 2019 as compared to the same period last year, and our ambulance handover performance remains unsatisfactory.

4.4 The increased activity has caused severe operational pressures, particularly over the last 7-10 days, causing significant delays in ED, delays in accessing beds for patients and unacceptable ambulance handover performance. In essence we are experiencing winter levels of activity without having winter capacity available. This has been exacerbated by the recent heatwave.

4.5 In response to these pressures, and the difficult outlook for winter, we have taken four principal actions:

- Together with our system partners, we are ramping up the actions in the new Demand Management Plan, which is designed to reduce the number of patients presenting to our acute services.
- We are accelerating our Safe and Timely Discharge priority workstream, focussing on the medical wards at the LRI (where we have the main shortfall in bed capacity). The aim of this is to safely reduce length of stay and thus the number of beds required.
- We are looking again at whether and how we can create additional medical bed capacity or some alternative provision, over and above the two additional wards in our existing winter capacity plan. Our options here are severely constrained by nurse staffing issues in particular.
- In the immediate term, we have been enacting the actions in our Full Hospital Policy. This includes outlying substantial numbers of medical patients into surgical wards, which has in turn caused some cancellations of operations. We have of course tried to minimise these.

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, notably at the most recent meeting. Details of this discussion are set out in the summary of that meeting which features elsewhere on this Board agenda.

5. <u>Care Quality Commission (CQC) – Well Led Inspection</u>

5.1 On 21st August 2019, we were in formed by the CQC that they will carry out a Well Led inspection at UHL between 4th and 6th November 2019.

5.2 As part of the inspection, the CQC will, as a minimum, interview the following:

- Trust Chairman
- Chief Executive
- Medical Director
- Chief Nurse
- Chief Operating Officer
- Chief Financial Officer
- Director of People and OD
- A sample of Non-Executive Directors (the Non-Executive Director for Safety and Risk is a priority – the Chair of the Quality and Outcomes Committee),
- Freedom To Speak Up Guardian
- Chair of the Audit Committee
- Chair of the Finance and Investment Committee
- Guardian of Safe Working Hours.

5.3 Prior to the Well Led inspection, the CQC will also carry out an unannounced inspection of at least one core service: the Trust will be contacted by the CQC approximately 30 minutes before the CQC team arrives on site to carry out the inspection.

6. Potential No Deal EU Exit Preparations

6.1 The Department of Health and Social Care (DHSC) is leading the response to EU Exit across the health and care sector. DHSC is also the key contact for the sector with the Department for Exiting the EU (DExEU) and the Cabinet Office. NHS England and NHS Improvement are working closely with DHSC to best prepare the NHS.

6.2 DHSC has produced EU exit operational guidance which outlines the actions that Providers and Commissioners of health and social care services should take to prepare for, and manage, the risks of a no-deal exit scenario.

6.3 The Director of Corporate and Legal Affairs is the Trust's EU exit SRO, and is supported in this task by the Director of Safety and Risk and Emergency Planning Team in overseeing the development of business continuity plans in line with existing Emergency Preparedness, Resilience and Response (EPRR) arrangements. A report features elsewhere on today's Board agenda on our EPRR position.

6.4 The UHL EU Exit Group has been reconvened and comprises subject matter experts from each of the key areas identified in the national guidance as areas for particular focus, namely:

- supply of medicines and vaccines;
- supply of medical devices and clinical consumables;
- supply of non-clinical consumables, goods and services;
- workforce;
- reciprocal healthcare;
- research and clinical trials;
- data sharing, processing and access.

6.5 The Group is:

(a) reviewing our preparedness and making sure our planning assumptions and risk assessments remain fit for purpose and up to date,
(b) revisiting the Trust's contract and supplier assurance processes, including smaller and/or niche local suppliers not covered by national assurance exercises,
(c) working through various exercise scenarios with the relevant teams, with the aim of providing further assurance.

6.6 UHL is also fully engaged with local system preparations around EU Exit through the Local Resilience Forum, linking with partner agencies including local authorities and Clinical Commissioning Groups to collaboratively manage and address issues.

6.7 NHS England is to assure local preparations from the end of August 2019. This assurance process will cover similar ground as previous exercises, including plans,

systems and contingency arrangements for key areas such as operational readiness, communication, continuity of supply, workforce, clinical trials, data, finance and health demand.

6.8 Further information is expected to be available at the NHS England EU Exit regional workshops taking place in September, with updates on the operational guidance and planning context, including the key changes since April 2019.

6.9 A further update report will be submitted to the Trust Board at its next meeting on 3rd October 2019.

7. NHS Operating Framework 2019/20

7.1 On 28th August 2019, NHS England and NHS Improvement (NHSE and I) published the NHS Operating Framework for 2019/20. This outlines the approach NHSE and I will take to oversee organisational performance and identify where Providers and Commissioners may need support.

7.2 The NHS Operating Framework has replaced the NHS Single Operating Framework for Providers and Improvement and Assessment Framework (IAF) for Clinical Commissioning Groups.

7.3 Alongside the new Framework, NHSE/I have published a document outlining the Provider oversight approach in detail, and a document setting out the metrics used to monitor and assess Provider performance.

7.4 The specific dataset for 2019/20 set out in the Oversight Framework (see **Appendix 2**) broadly reflects existing Provider and Commissioner oversight and assessment priorities. They are split by their alignment to priority areas in the NHS Long Term Plan. Where appropriate, these will be aggregated across system-level and are likely to be complemented by purpose-built system metrics.

7.5 Regional Directors and their teams will lead on system oversight, working closely with organisations and systems and drawing on the expertise and advice of national colleagues.

7.6 Four metrics have been added to the 2019/20 set to identify issues at Providers, based on the annual NHS staff survey and covering bullying and harassment, teamwork and inclusivity.

7.7 The relationship between a Provider's/Clinical Commissioning Group's identified support needs, and the type of support made available, is summarised in the Oversight Framework document. For Providers, the categories reflect the existing categories:

1. maximum autonomy (no actual support needs)
2. targeted support (support needed in one or more of the five themes, but not in breach of licence)
3. mandated support (significant support needs and actual or suspected breach of

licence but not in special measures)

4. special measures (in actual or suspected breach of licence with very serious/complex issues).

7.8 NHSE/I intend to use 2019/20 to develop proposals for a new framework. The specific metrics that will be used for oversight and assessment will include the measures identified in the NHS Long Term Plan Implementation Framework. NHSE/I say they will involve partners at key stages of the design work, to consider the purpose of the framework, its scope and the methodologies for monitoring, escalation and taking formal or informal action with organisations.

7.9 Further updates will be submitted to the Trust Board as the new framework is developed.

8. Better Care Together Partnership

8.1 I have attached at **appendix 3**, for information, a copy of the July/August 2019 Better Care Together Partnership update for Boards which comments upon the integrated community programme, primary care (including the GP strategy), the elective care transformation plan and progress being made through the end of life programme. For completeness, I have also attached, at **appendix 4**, a copy of the Better Care Together Partnership Stakeholder Bulletin for July/August 2019.

9. Conclusion

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

John Adler
Chief Executive

29th August 2019

Quality & Performance

		YTD		Jul-19				
		Plan	Actual	Plan	Actual	Trend*	Trend Line	Compliant by?
Safe	S1: Serious Incidents	<29	9	2	0	●		Compliant
	S11: Never events	0	1	0	0	●		Compliant
	S12: Clostridium Difficile	<108	34	5	14	●		Sep-19
	S13 MRSA - Unavoidable or Assigned to 3rd party	0	0	0	0	●		Compliant
	S14: MRSA (Avoidable)	0	0	0	0	●		Compliant
	S15: MRSA (All)	0	0	0	0	●		Compliant
	S24: Falls per 1,000 bed days for all patients (1 month in arrears)	<=6.02	4.9	<=6.02	4.4	●		Compliant
	S26: Avoidable Pressure Ulcers Grade 4	0	0	0	0	●		Compliant
	S27: Avoidable Pressure Ulcers Grade 3	<27	1	<=3	1	●		Compliant
	S28: Avoidable Pressure Ulcers Grade 2	<84	21	<=7	4	●		Compliant
Caring	C3: Inpatient and Day Case friends & family - % positive	96%	97%	96%	97%	●		Compliant
	C6: A&E friends and family - % positive	94%	95%	96%	94%	●		Compliant
	C10: Single Sex Accommodation Breaches (patients affected)	0	7	0	7	●		Oct-19
Well Led	W13: % of Staff with Annual Appraisal	95%	91.8%	95%	91.8%	●		Oct-19
	W14: Statutory and Mandatory Training	95%	93%	95%	93%	●		Oct-19
	W16 BME % - Leadership (8A – Including Medical Consultants) - Qtr 1	28%	29%	28%	29%	●		Compliant
	W17: BME % - Leadership (8A – Excluding Medical Consultants) - Qtr 1	28%	16%	28%	16%	●		Dec-23
Effective	E1: 30 day readmissions (1 month in arrears)	<8.5%	9.0%	<8.5%	8.9%	●		See Note 1
	E2: Mortality Published SHMI (Jan 18 to Dec 18)	99	99	99	99	●		Compliant
	E6: # Neck Femurs operated on 0-35hrs	72%	72.9%	72%	58.3%	●		See Note 2
	E7: Stroke - 90% of Stay on a Stroke Unit (1 month in arrears)	80%	86.5%	80%	86.0%	●		Compliant
Responsive	R1: ED 4hr Waits UHL	95%	73.8%	95%	72.0%	●		See Note 1
	R2: ED 4 Hour Waits UHL Acute Footprint	95%	81.5%	95%	80.6%	●		See Note 1
	R4: RTT waiting Times - Incompletes (UHL+Alliance)	92%	83.3%	92%	83.3%	●		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%	1.1%	1.0%	1.2%	●		See Note 1
	R14: Delayed transfers of care	3.5%	1.6%	3.5%	1.8%	●		Compliant
	R15: % Ambulance Handover >60 Mins (CAD)		6.0%	0.8%	10.2%	●		See Note 1
	R16: % Ambulance handover >30mins & <60mins (CAD)		14.2%	7.2%	18.4%	●		See Note 1
	RC9: Cancer waiting 104+ days	0	24	0	24	●		See Note 1

		YTD		Jun-19				
		Plan	Actual	Plan	Actual	Trend*	Trend Line	Compliant by?
Responsive Cancer	RC1: 2 week wait - All Suspected Cancer	93%	93.4%	93%	91.0%	●		Compliant
	RC3: 31 day target - All Cancers	96%	94.1%	96%	93.9%	●		Jul-19
	RC7: 62 day target - All Cancers	85%	75.1%	85%	74.4%	●		Sep-19

Enablers

		YTD		Qtr1 19/20	
		Plan	Actual	Plan	Actual
People	W7: Staff recommend as a place to work (from Pulse Check)		59.0%		59.0%
	C9: Staff recommend as a place for treatment (from Pulse Check)		74.0%		74.0%

		YTD		Jul-19				
		Plan	Actual	Plan	Actual	Trend*	Trend Line	Compliant by?
Finance	Surplus/(deficit) £m	(13.4)	(13.4)	0.1	0.1	●		Compliant
	Cashflow balance (as a measure of liquidity) £m	1.0	4.5	1.0	4.5	●		Compliant
	CIP £m	6.9	7.1	2.2	2.1	●		Compliant
	Capex £m	(19.5)	6.8	(4.7)	2.3	●		Jul-19

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

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 - Compliance is dependent on investment

Appendix 1: Oversight metrics

New metrics for 2019/20 are highlighted in bold.

1. New service models		
	Integrated primary care and community health services	
1	Patient experience of GP services	CCGs
2	Patient experience of booking a GP appointment	CCGs
3	Emergency admissions for urgent care sensitive conditions	CCGs
	Acute emergency care and transfers of care	
4	Percentage of patients admitted, transferred or discharged from A&E within four hours	CCGs and providers
5	Achievement of clinical standards in the delivery of 7-day services	CCGs and providers
6	Delayed transfers of care per 100,000 population	CCGs
7	Population use of hospital beds following emergency admission	CCGs
8	Percentage of NHS continuing healthcare full assessments taking place in an acute hospital setting	CCGs
	Personalisation and patient choice	
9	Personal health budgets	CCGs
10	Use of the NHS e-referral service to enable choice at first routine elective referral	CCGs
2. Preventing ill health and reducing inequalities		
	Smoking	
11	Maternal smoking at delivery	CCGs
	Obesity	
12	Percentage of children aged 10-11 classified as overweight or obese	CCGs
	Falls	
13	Injuries from falls in people aged 65 and over	CCGs and providers
	Antimicrobial resistance	
14	Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	CCGs
15	Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	CCGs
	Health inequalities	
16	Proportion of people on GP severe mental illness register receiving physical health checks in primary care	CCGs
17	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions	CCGs
3. Quality of care and outcomes		
	General	
18	Provision of high-quality care: hospitals	CCGs and providers
19	Quality of Care metrics: a set of 30 quality proxies to identify any emerging	Providers

	quality concerns at acute, mental health, ambulance and community trusts – see Provider annex for more details	
20	Provision of high-quality care: primary medical services	CCGs
21	Evidence that sepsis awareness raising among healthcare professionals has been prioritised by CCGs	CCGs
22	**Evidence-based interventions**	**CCGs**
	Maternity services	
23	Neonatal mortality and stillbirths	CCGs
24	Women's experience of maternity services	CCGs
25	Choices in maternity services	CCGs
	Cancer services	
26	Cancers diagnosed at an early stage	CCGs
27	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	CCGs and providers
28	One-year survival from all cancers	CCGs
29	Cancer patient experience	CCGs
	Mental health	
30	Improving Access to Psychological Therapies – recovery	CCGs and providers
31	Improving Access to Psychological Therapies – access	CCGs and providers
32	People with first episode of psychosis starting treatment with a National Institute for Health and Care Excellence (NICE) – recommended package of care treated within two weeks of referral	CCGs and providers
33	Mental health out-of-area placements	CCGs and providers
34	Quality of mental health data submitted to NHS Digital (DQMI)	CCGs and providers
	Learning disability and autism	
35	Reliance on specialist inpatient care for people with a learning disability and/or autism	CCGs
36	Proportion of people with a learning disability on the GP register receiving an annual health check	CCGs
37	Completeness of the GP learning disability register	CCGs
38	**Learning disabilities mortality review: the percentage of reviews completed within 6 months of notification**	
	Diabetes	
39	Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	CCGs
40	People with diabetes diagnosed less than a year who attend a structured education course	CCGs
41	Estimated diagnosis rate for people with dementia	Providers
42	Dementia care planning and post-diagnostic support	CCGs
43	The proportion of carers with a long-term condition who feel supported to	CCGs

	manage their condition	
44	Percentage of deaths with three or more emergency admissions in last three months of life	CCGs
	Planned care	
45	Patients waiting 18 weeks or less from referral to hospital treatment	CCGs and providers
46	**Overall size of the waiting list**	**CCGs**
47	**Patients waiting over 52 weeks for treatment**	**CCGs**
48	Patients waiting six weeks or more for a diagnostic test	CCGs and providers
4. Leadership and workforce		
49	Quality of leadership	CCGs and providers
50	Probity and corporate governance	CCGs and providers
51	Effectiveness of working relationships in the local system	CCGs and providers
52	Compliance with statutory guidance on patient and public participation in commissioning health and care	CCGs
53	Primary care workforce	CCGs
54	Staff engagement index	CCGs
55	Progress against the Workforce Race Equality Standard	CCGs and providers
56	Effectiveness of shared objective-setting and teamworking	Providers
57	Providing equal opportunities and eliminating discrimination	Providers
58	Black and minority ethnic (BME) leadership ambition for executive appointments	Providers
59	Reducing/eliminating bullying and harassment from managers and other staff	Providers
5 Finance and use of resources		
60	In-year financial performance	CCGs and providers
61	Delivery of the mental health investment standard	CCGs
62	**Children and Young People and Eating Disorders investment as a percentage of total mental health spend**	**CCGs**
63	Expenditure in areas with identified scope for improvement	CCGs
64	Children and young people's mental health services transformation	CCGs
65	**Reducing the rate of low priority prescribing**	CCGs

Contact: Ella Jackson, policy advisor, ella.jackson@nhsproviders.org

Better Care Together Partnership update

A business update for partner boards, governing bodies and members

July/ August 2019

Welcome to the fifth 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.

Delivering for the community

The Integrated Community Programme for Better Care Together (BCT) brings together a range of activities in key areas:

The System Leadership Team (SLT) for BCT has heard of a number of successes of the programme. These include a new model of care being agreed for the community services re-design, the development of integrated crisis response and re-ablement for Home First in the city and county, a pilot scheme for the respiratory integrated discharge team, and the development of three 'early implementer' sites testing multi-disciplinary team working in the integrated neighbourhood teams.

All of this work is bringing teams closer together and providing public and patients with a more tailored and effective service. Improvements made through the Care Homes Sub-Group, comprising of health and care partners, shows that last winter there was a 17% reduction in admissions from care homes in the small pilot group.

Priorities over the next year include:

- Working with place based groups to develop and commission for outcomes for integrated community services
- Organisational development of Integrated Neighbourhood Teams developing population health management approaches at neighbourhood level
- Stimulating provider partnerships/alliances to deliver integrated care
- Developing an integrated therapies model including acute pathways
- Continuing to develop the support offer for care homes including telemedicine
- Integrating end of life care teams, aligning specialist and generalist resources supported by a single access point to triage and co-ordinate care
- Consistent LLR contractual approach for long term conditions management delivered in primary care and by Primary Care Networks
- Improved 'non blue light' response to falls

The implementation of these new ways of working presents some real challenges to the system. These include workforce issues, addressing inconsistent approaches to implementation and limited OD resources.

Steps forward made in primary care

Primary care leaders in LLR have been reflecting on some of the advances made over the past 12 months.

These include having the five-year GP strategy signed off by NHS England, the development of a LLR primary care board, the launch (1 July 2019) of the 25 primary care networks across LLR achieving 100% patient coverage and progress towards meeting the GP Forward View (including the recruitment of 14 international GPs and online consultation roll-out to all practices).

Contd.

Key priorities for the future are turning the GP strategy aims into action and supporting the new primary care networks to help them achieve their objectives.

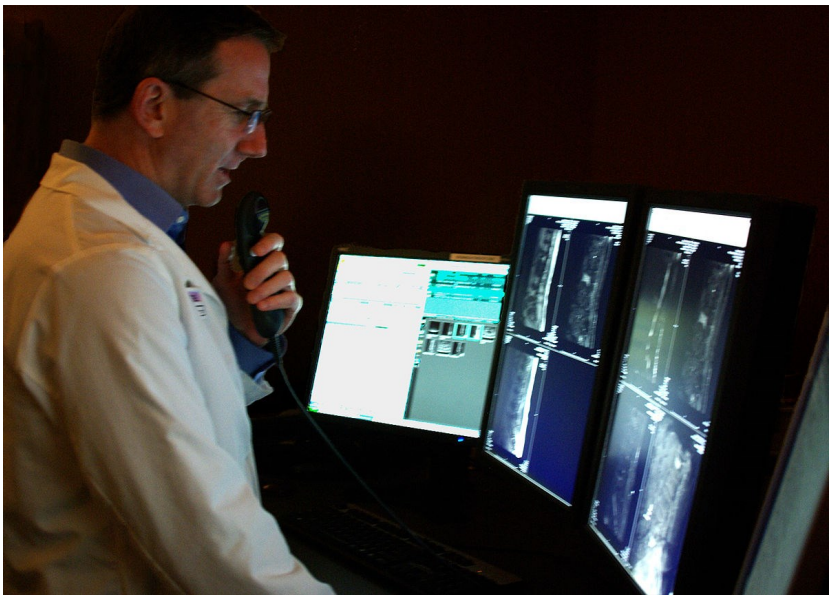
The challenges in primary care and ways to tackle them were also considered by SLT. These include the demand on services through growth and demographic change, workforce shortages and the ability to recruit doctors and nurses as well as other new staffing groups

Improving our planning for planned care

An elective (planned) care transformation plan has been produced covering 2019-20 and has received positive feedback from NHS England and NHS Improvement. The document covers planned care from both commissioner and provider perspectives, reviews progress to date, and sets out priority areas for the year ahead.

The work fits in closely with the NHS Long Term Plan and aims to achieve a reduction in outpatient attendances by 30 per cent over the next five years. Themes covered within the plan include diagnostic imaging, pathology, reconfiguration at UHL and the development of the Planned Care Treatment Centre at Glenfield Hospital, proposals for 'First Contact Practitioner' (advancing care and treatment without the need for a GP referral) and improving the quality of ophthalmology services.

Planned care leaders acknowledge that the way the LLR system delivers both acute and community services has to change over the coming years in order to become both financially and clinically sustainable. Planned care faces a number of pressures – increased demand for services, workforce challenges, and cancellations in elective care due to times of increased emergency admissions at Leicester's hospitals. Improving efficiency of services is key to progress. Planned care pathways are being re-designed so that some outpatient appointments, diagnostic tests and day-case procedures can be carried out in community hospitals and other facilities in primary care. This will reduce unnecessary acute hospital visits, outpatient appointments and follow-ups in acute hospitals.



A number of achievements have been recorded to date. These include:

- Across 31 specialities, there has been a reduction of 2,490 GP-initiated new appointments and 2,750 follow-up appointments, saving £539,000 and £274,000 respectively
- 102 low value treatment policies have been developed and contracts produced
- The introduction of a musculoskeletal (MSK) triage service (for conditions affecting joints, bones, muscles and soft tissues)
- The development, in conjunction with UHL, of four diagnostic pathways to reduce the number of inappropriate tests.

Contd.

There are a number of key initiatives for 2019-20 which include:

- Developing a Referral Support Service across LLR for MSK, dermatology (skin conditions), ear, nose and throat, general surgery, and ophthalmology. The service will help identify patients who would benefit from being seen in primary/community care rather than in hospitals, making the best use of both clinical and financial resources
- Making best use of MRI facilities ensuring the most appropriate patients are sent for imaging diagnosis
- Ensuring that referrals for pathology tests are clinically appropriate and reducing duplication in testing
- Carrying out more eye tests/services in the community rather than in hospital
- Stabilising the referral-to-treatment waiting list
- Improving the productivity of our hospital theatres.

Improving the state of our estates

The SLT has received on update on the progress to date to implement the STP Estates Strategy which was originally submitted to NHS England/NHS Improvement in July 2018.

The Strategy was rated as 'good', but feedback indicated where further improvements could be made.

In response to the national recommendations, there is now a regular LLR Estates Group which meets every six weeks, linking in with the SLT.

Following feedback that efforts should be adequately resourced, the project management office function is delivered by one provider (University Hospitals of Leicester) which has the single biggest reconfiguration scheme in LLR and a strong interest in the estates workstream.

In other feedback, NHS England/NHS Improvement requested that there should be greater consideration of how the primary and community care infrastructure could be best utilised for transformation. It is envisaged that a primary care estates strategy will be in place by October 2019.

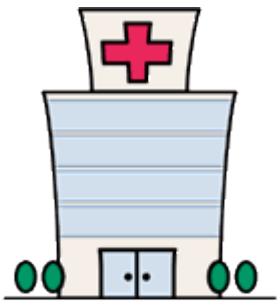
BCT is enhancing its leadership capacity and capability for estates management and has sponsored seven staff to undertake the Better Business Care foundation training, with four members of staff having completed its practitioner level.

End-of- Life improvements

Progress is being made across the board with the end-of-life programme – amber and green (RAG) rating index for the programme has seen eleven projects rated green and three as amber.

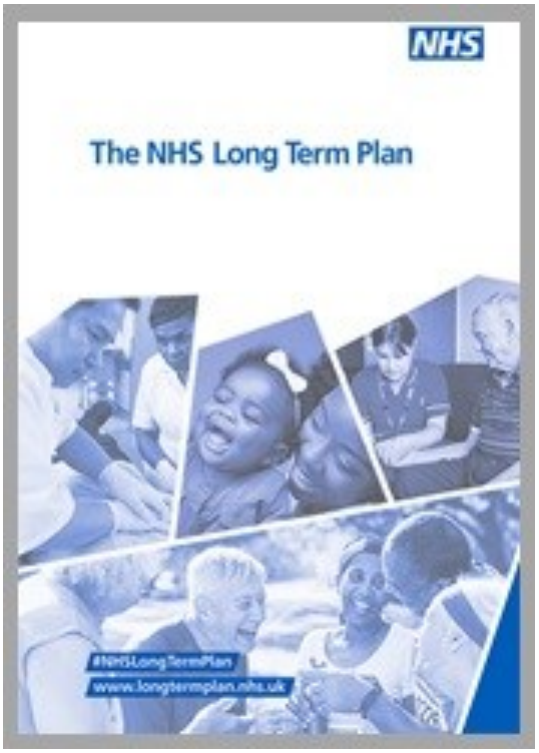
The programme is advancing schemes in training and education, communications and engagement, service improvement, and information management and technology.

Plans on track include the launch of the integrated clinical nurse specialist teams on 1 October 2019 and opening up the palliative care hub to social care.



Getting our partnership fit for the future

BCT leaders are working on their response to the NHS Long Term Plan and the Implementation framework that has recently been published. Local areas are being asked to demonstrate how they will meet key aims of the Long Term Plan and ensure their financial sustainability. It is envisaged in LLR that a draft submission in response will be ready for late September 2019 and a final submission in mid-November 2019.



The three LLR CCGs have developed proposals for streamlining their governance arrangements from October 2019 to support the appointment of a single accountable officer and senior management team. Discussions are ongoing with individual organisations with proposals going to governing bodies for formal approval in September 2019, with collaboration commencing from October 2019.

The CCGs have developed a case for change to support the proposals. This was discussed at a joint governing body development session in July 2019 and will be formally considered in August 2019. This will seek approval to commence engagement on the proposals with stakeholders and member practices.

A workshop has been held to take forward the discussion regarding the formation of a Partnership Group to enhance the system governance arrangements. Group members were keen on its further development and agreed the role and purpose. As a result of the workshop, minor changes are being made to the draft terms of reference and the first formal meeting of the group is likely to be held in September 2019.

In addition, the NHS Long Term Plan has set out a requirement that by April 2021 Integrated Care Systems (ICSs) will cover the whole country, growing out of Sustainability and Transformation Partnerships.

Work has been undertaken to look at the maturity of the current system and an assessment already completed scoring our system on different levels of maturity.

In addition a 'maturity progress self-assessment' has been produced by NHS England to help local areas understand where they are on their journey to an ICS. Questionnaires for this self-assessment have been sent out to key stakeholders as a further tool to take us forward.

Leicestershire County Council has asked that the following statement of position be included in BCT communications:

> "The County Council strongly supports the integration of health and care services whenever possible and to the benefit of those receiving care in any setting. The Council continues to commit significant resources to that end. However, in the case of a move to an 'Integrated Care System' in Leicester, Leicestershire and Rutland, as required by NHS England, the County Council is awaiting clarification from the NHS as to what this would actually mean in practice before it can indicate its support."

This is an update about the Better Care Together programme which aims to transform health and social care in Leicester, Leicestershire and Rutland. Issued on behalf of partner organisations.

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

BCT Bulletin

July/ August 2019

Facebook Twitter Website

Welcome to the July/ August 2019 edition of the Bulletin – the newsletter from the Better Care Together (BCT) partnership, which is responsible for transforming health and social care in Leicester, Leicestershire and Rutland (LLR).

This newsletter

The Better Care Together partnership includes local NHS organisations working alongside local authorities in Leicester, Leicestershire and Rutland and a range of other independent, voluntary and community sector providers. The partnership's aims are to keep more people well and out of hospital; move care closer to home; provide care in a crisis; and deliver high quality specialist care. This newsletter

details some of the progress being made and how you can get involved and have your say.

Primary care networks explained

In the last edition of this newsletter, we let you know about primary care networks, the groups of GP practices that are working together to make resources go further and care for patients in more creative ways.

To help local people understand more about primary care networks and how GP practices have grouped together in Leicester, Leicestershire and Rutland, a patient information guide has been produced. You can download the guide from the Leicester City CCG website.

Next steps for re-designing services in the community

The three clinical commissioning groups in Leicester, Leicestershire and Rutland have confirmed initial plans to begin making changes to community services over a five-year period, supported by increased investment.

This is the next step towards more care being delivered at home and follows

engagement with patients, public, carers, partner organisations and staff on the proposed model for community services earlier this year, as highlighted previously in issues of this newsletter. A summary of the engagement activities that have taken place is available on the Better Care Together website.

The early proposals aim to re-design a number of services provided by Leicestershire Partnership NHS Trust, and how these services work with social care and primary care.

At the heart of the service changes is the aim to deliver integrated, co-ordinated care placing patients at the centre and using a 'Home First' approach. This is to ensure people can remain in their own homes rather than being admitted to hospital wherever possible, as well as aiding faster discharge where patients do need to be treated in hospital. Community nurses will work alongside groups of GP practices and social care, to deliver improved community services, including nursing and therapy.

On-going developments at Leicester's hospitals

There has been significant public and patient engagement in plans by University Hospitals of Leicester NHS Trust to look at how large-scale modern, state-of-the-art healthcare facilities should be provided in the city in the future. The proposals on how Leicester's hospitals might be reconfigured in the future, which will be consulted on, are available on the BCT website.

In the interim, a number of changes are taking place to wards and buildings in order to ensure that the care delivered continues to be safe, high quality, and focused around the needs of patients.

Wards 15 and 16 at the Royal Infirmary (as shown above) are being refurbished which include new bathroom facilities and a new nurses' station. At Glenfield Hospital, teams have now moved into the newly refurbished Mansion House and Snoezelen building, creating space in the hospital for a new interventional radiology department. Work on the extension to the intensive care unit is on-going.

Hospital bosses have apologised to people who have been impacted by noise from the refurbishment and construction work and have thanked everyone for their understanding and patience at this time.

Elsewhere, a planning application is in place for a new build on the Jarrom Street side of the Royal Infirmary's Kensington Building linked to proposals to move the children's congenital heart service (see image below).

Taskforce to tackle end-of-life care

Every year around 6,000 people die in Leicestershire, Leicester and Rutland (LLR). Improving the care that these people receive in the last days and weeks of life, and providing support to carers and loved ones is the focus of a new End of Life (EoL) taskforce under Better Care Together.

The taskforce is chaired by Professor Mayur Lakhani, Clinical Chair of West Leicestershire Clinical Commissioning Group (WL CCG). A working group, chaired

by Carole Ribbins, Interim Chief Nurse at WL CCG, is working alongside the taskforce to drive the delivery of improvements to the services and care people receive at the end of their life across LLR.

The taskforce includes consultants in palliative care from University Hospitals Leicester, staff from Leicestershire Partnership Trust and East Midlands Ambulance Service alongside representatives from Marie Curie and local hospice LOROS.

The taskforce will run for six months to ensure there is a focus on a number of priorities for action to improve the care and support to EoL patients. The work will continue beyond the initial six months but the taskforce will drive a number of actions initially.

The vision of the EoL taskforce is to design and implement a patient-led system of care for patients at the end of their life. What will this mean for patients? More patients will be able to die in a place of their choosing, including at home; the number of emergency admissions in the last 30 days of life will be reduced; and staff will provide appropriate treatment informed by the needs and wishes of the patient as set out in an advanced care plan and ReSPECT form.

Professor Mayur Lakhani said: “All of us will die at some point and we want to help a person in the last stages of life to be as comfortable as possible. In my experience, conversations about dying in the context of patient care are very difficult, and part of our focus will also be training to support NHS staff to have these conversations.

“I am delighted to have the support of the taskforce members, many of whom look after patients in the final stages of life every single day. I know our taskforce partners share a commitment to improving their care.”

When somebody dies in the place of their choosing, free from pain and with their wishes for how they should be cared for understood and respected by healthcare

staff, then it is possible to have a good death. This is what the taskforce wants to make possible for every patient across LLR.

Find out more about the End of Life programme of work on the Better Care Together website: www.bettercareleicester.nhs.uk/the-bct-plan/end-of-life

Any questions or enquiries should be directed to Rebecca Perry, Project Lead – Learning Lessons to Improve Care/EoLC, WL CCG: Rebecca.Perry@westleicestershireccg.nhs.uk

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Giving a little respect

A new project being developed in Leicester, Leicestershire and Rutland will help people with long-term conditions and additional health needs plan ahead for their care for when they might have a health emergency.

The project is called ReSPECT, which stands for Recommended Summary Plan for Emergency Care and Treatment. Completing the ReSPECT plan helps an individual state their preferences for care in a future emergency in which they are unable to make or express choices. It has been used in other parts of the country and is now being taken forward locally, with the project being led by the University Hospitals of Leicester.

People with a ReSPECT plan in place are more likely to avoid unwanted and unnecessary interventions including hospital admissions, and it will allow people to be cared for and die in the place of their choosing.

John Jameson, deputy medical director at Leicester's hospitals, said: *"The best part about being the clinical lead for this project is the huge impact on*

patients' and families' experiences in the event of an emergency when this project is complete and ReSPECT is successfully implemented locally. The conversational process itself will empower people and their loved ones to think about and discuss what is important to them in terms of their future health and care needs, and this information will be readily available for use in the event of an emergency when that person may be unable to express these wishes."

First of its kind community Diabetes Village opens for patients

People registered with a Leicester GP practice and either living with type two diabetes or at risk of developing diabetes can now access a wide portfolio of support services all under one roof. A new 'diabetes village' has opened at the Merlyn Vaz Health and Social Care Centre on Spinney Hill Road, Leicester for an initial six-month pilot.

The village has been developed by Leicester City CCG in partnership with Silver Star Diabetes, a local health charity. It is home to a range of services that are important for effective diabetes management, including blood sugar checks, lifestyle coaching advice, foot care, eye screening and diabetes education classes.

Previously, patients would have had to make multiple visits to their GP practice and other services for their checks and care. The new village concept means patients can drop-in on a Thursday between 10am and 6pm and choose the services they require all in one location.

In Leicester City, there is a higher than average number of people with diabetes (8.9% compared to 6.4% nationally) and this is expected to rise further to 12% by 2025. Leicester has a higher proportion of Black Minority Ethnic (BME) residents compared to the UK national average and they are genetically more likely to get diabetes (at a higher risk).

Professor Azhar Farooqi, Chair of Leicester City CCG and lead on diabetes, said: *“We want people to use the village and come to us and tell us whether the diabetes village is a service they want to keep and whether it’s a service they will use. This is a first for the UK and we want to make sure we get it right for patients.”*

Keith Vaz, chair of the All Party Parliamentary Group on Diabetes and MP for Leicester East, said: *“I am thrilled that Leicester City CCG has taken up the challenge of creating the first diabetes village in the UK. The idea was born out of the needs of diabetics such as myself and others having to make up to eight visits to different professionals on different days at different times and at different venues. There will now be a one-stop shop so it will take just one visit.”*

An online survey is being carried out, with paper copies in GP practices, to assess the success of the new service.

New chief executive now in place

Angela Hillery, pictured above, has begun her role as chief executive of Leicestershire Partnership NHS Trust, while also continuing her position as chief executive of Northamptonshire Healthcare NHS Foundation Trust in a new shared appointment.

Cathy Ellis, chair of Leicestershire Partnership, said: *"Angela comes with an impressive track record and her appointment is a positive step in our improvement journey. Her focus is on ensuring this shared role is a positive experience for all and moving towards improvements in our Care Quality Commission ratings.*

"To be clear, this is not a precursor to a merger between our Trusts, but a focus on improving care for patients and service users. Angela brings significant and relevant experience in moving integrated mental health and community health trusts forward."

Angela said to Leicestershire Partnership staff: *“For me, the root of any success has always been about teamwork and empowerment and I will be ensuring that we have a strong and aligned team in each organisation and good networks between us.”*

Angela has worked in the NHS for more than 30 years. She has held a variety of leadership positions during this time and has been chief executive of Northamptonshire Healthcare since 2013. Angela has a clinical background as a speech and language therapist and has served on the national management board of the Royal College of Speech and Language Therapy. She replaces Dr Peter Miller as Leicestershire Partnership chief executive who has retired following six years at the Trust and 32 years in NHS.

Have you experience of treatment for cancer?

Local people who are undergoing treatment for cancer or have recently completed treatment are being asked to complete a survey to help improve care.

The survey has been put together by Leicester’s hospitals, Macmillan Cancer Support, GPs and other healthcare professionals.

Dr Paul Danaher, GP and clinical lead for cancer at Leicester City CCG, said: *“More people than ever before are living longer after a cancer diagnosis, with numbers set to double in the UK over the next 20 years. The local health community has been working closely with Macmillan Cancer Support to improve the experience for patients, from when cancer is first diagnosed, through treatment, to living well and feeling supported when back at home.*

“There are various possibilities for how people can receive support. In some parts of the country, cancer information clinics in the community have worked well, others find that social media forums, like Facebook, work for them and others prefer to join self-help and fitness groups. As we develop our local support, we want to hear from as many people as possible who are living with cancer, or who have received treatment in the past, to find out what matters to them and how we can improve our services.”

To share your views, complete the online survey, pick up a survey form at your local GP practice, or request a survey form by calling 0116 295 1116.

Agnes Unit wins quality stamp from royal college

Leicestershire Partnership NHS Trust’s Agnes Unit, a specialist inpatient unit providing care for people with learning disabilities in Leicestershire and

Rutland, has earned a quality stamp of approval from the Royal College of Psychiatrists.

This is the unit's fifth successive two-year accreditation from the professional body responsible for raising and setting standards in psychiatry.

It has been accredited until February 2022 following a stringent independent assessment by external reviewers. Accreditation provides assurance for patients, carers, commissioners, regulators, staff and the wider public about the quality of inpatient services for adults who have both learning disability and mental health needs.

Team manager Francine Bailey, pictured centre row, third from right, said: *"We are proud and delighted to reconfirm our accreditation, which reflects high standards and the knowledge, skills and compassion of our staff who work hard to provide the best care possible."*

Share your news

We know that there are loads of great examples of innovative and integrated ways of work happening right across Leicester, Leicestershire and Rutland. If you have a story that you would like to share in these newsletters please send us details.