Report by Acting Chief Executive – Monthly Update: August 2020

Authors: Rebecca Brown and Stephen Ward Sponsor: Rebecca Brown **Trust Board paper D revised**

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 Acting Chief Executive's monthly update report to the Trust Board for August 2020 is attached.

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	[Yes]
Safely and timely discharge	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Yes]

2. Supporting priorities:

People strategy implementation	[Yes]
Estate investment and reconfiguration	[Yes]
e-Hospital	[Yes]
More embedded research	[Yes]
Better corporate services	[Yes]
Quality strategy development	[Yes]

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**	There are several risks which feature on the organisational risk register relating to matters covered in this paper.
New Risk identified in paper: What ***type*** and ***description***?	N/A	N/A
None		

5. Scheduled date for the **next paper** on this topic: September 2020 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: **6TH AUGUST 2020**

REPORT BY: **ACTING CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – AUGUST 2020**

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1. Introduction

1.1 My report this month is confined to a number of issues which I think it important to highlight to the Trust Board.

2. UHL response to COVID-19

Current Position

2.1 I will report orally at the Trust Board on the current position and the Trust's response and plans.

Stepping Back Up of Key Reporting and Management Functions

2.2 I attach at **appendix 1**, for information, a copy of a letter dated 6th July 2020 addressed to all Chief Executives by the Chief Operating Officer, NHS England and NHS Improvement which identifies actions to be taken to step back up key reporting and management functions.

2.3 The Board agreed on 2nd July 2020 (Minute 122/20/1 refers) to extend UHL's revised Trust Board and Board Committee governance arrangements until the end of September 2020, and requested the Trust Chairman to liaise with myself and the Director of Corporate and Legal Affairs to develop initial proposals for UHL's Board and Board Committee governance going forwards. While we will continue to hold meetings virtually, the Director of Corporate and Legal Affairs will be working with the Chairman and myself to bring forward proposals on future arrangements to the next meeting of the Board on 3rd September 2020.

Next Phase

2.4 At their most recent public Board meeting, NHS England and NHS Improvement discussed some of the steps they wish to take in the next phase of the response of the NHS to COVID-19.

2.5 On the evening of Friday, 31st July 2020 the Trust received the letter attached at **appendix 1a**, addressed to all NHS Trusts, setting out the next – 3rd – phase of the NHS response to COVID-19, effective from 1st August 2020,

2.6 As will be seen, in this letter NHSE/I:

- provide an update on the latest COVID-19 national alert level;
- set out priorities for the rest of 2020/21;
- outline financial arrangements heading into Autumn as agreed with the Government.

2.7 The new guidance is to be considered by the Executive Team at its meeting week commencing 3rd August 2020, and I will report orally at the Board meeting on our response to this latest guidance.

3. Quality and Performance Dashboard – June 2020

3.1 The Quality and Performance Dashboard for June 2020 is appended to this report at **appendix 2.**

3.2 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.

3.3 The more comprehensive monthly Quality and Performance report has been reviewed as part of the July 2020 People, Process and Performance Committee assurance call. The month 3 quality and performance report is published on the Trust's website.

4. Reconfiguration Programme – Update

4.1 We have now established regular monthly meetings with Department of Health and Social Care (DHSC) officials on the progress of the programme as a whole, including the approvals of the Pre-Consultation Business Case to enable us to commence public consultation.

4.2 We are now engaged with the other National Health Infrastructure Plan (HIP1) schemes, in order to share knowledge and learning – for example the 'digital hospital' and considerations around sustainability.

4.3 We are working closely with the Clinical Commissioning Groups to finalise the consultation documentation which includes a detailed plan on how the consultation exercise will be undertaken in light of the social distancing restrictions caused by COVID-19. This planning is in readiness for when we get approval to commence the consultation exercise after the Pre Consultation Business Case has been approved.

4.4 It is clear that our experience following the COVID-19 pandemic will have an impact on our reconfiguration plans. We have had a number of discussions with clinical teams within the Trust on this and agreed that the best way forward will be to develop a set of 'design principles' which will need to be taken into account when designing the new facilities after the consultation has concluded.

4.5 A further update on the Reconfiguration Programme will be made to the Board at its next meeting.

5. JAG Accreditation Award – Glenfield Hospital

5.1 The Joint Advisory Group on GI Endoscopy has recently confirmed that, following reassessment, the endoscopy unit at Glenfield Hospital has met the accreditation standards and is therefore awarded JAG accreditation.

5.2 Accreditation is awarded for five years, subject to successful completion of an annual review. In the fifth year, a full re-accreditation assessment is undertaken to renew the accreditation.

5.3 This is an excellent achievement by the clinical team and their managers who will now take forward the necessary work to ensure that accreditation is maintained.

6. Healthwatch Leicester and Healthwatch Leicestershire – Annual Report 2019/20

6.1 I am pleased to enclose a copy of Healthwatch Leicester and Healthwatch Leicestershire 2019/20 annual report, attached at **appendix 3**.

6.2 Healthwatch is the independent champion for people who use local health and social care services. They find out what matters to people and help to make sure that the views of the public shape the support that is needed.

6.3 Their focus for 2019/20 included:

- hospital discharge,
- patient transport,
- medicine management,
- the NHS (National Health Service) Long Term Plan.

6.4 During 2019/20, 3,001 people shared their experiences with Healthwatch, in addition to 4,607 people engaging online via the website or social media.

6.5 We remain committed to working with Healthwatch Leicester and Healthwatch Leicestershire to ensure that public health and social care experiences are at the heart of our decision making.

7. Conclusion

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

Rebecca Brown
Acting Chief Executive

31st July 2020

Publications approval reference: 001559

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
Copy to:
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Chairs of ICSs and STPs
NHS Regional Directors

6 July 2020

Dear colleague,

Stepping back up of key reporting and management functions

We wrote to you on 28 March 2020 setting out measures that would allow providers and commissioners to free up as much capacity as possible to prioritise their workload and focus on what was necessary to manage the response to the COVID-19 pandemic.

We have now passed the initial peak of COVID-19 and are well into phase 2 of our recovery planning. NHS organisations are working to stand back up critical services across the country. Later in the summer we will launch phase 3 of our recovery planning, where we will ask the NHS to put in place robust plans for the rest of this year – including winter planning, ongoing recovery of NHS services, and ensuring sufficient surge capacity remains in place to deal with any resurgence of COVID-19.

We will continue to support systems, and commissioners and providers within them, to prioritise their efforts to respond to this work. However, as we are turning on critical services there is now a requirement to reactivate some other activities that we have previously delayed.

Unless otherwise stated here, the position outlined in the letter of 28 March 2020 remains in place.

Governance and meetings

Our advice remains that face-to-face meetings should continue to be avoided, and meetings should be held virtually where possible. However, NHS organisations

should consider which meetings or governance events paused in the 28 March letter can now effectively be held virtually. These should include Councils of Governors, Members' Meetings, and membership engagement.

Where it is not possible to effectively hold meetings virtually (for example, some organisations have raised issues with holding AGMs virtually), these should be deferred until later in the year.

Organisations should continue to hold board meetings virtually and should determine their own approach to meetings of audit, remuneration and other board level committees. Providers should aim to return to full compliance on quorum requirements set out in their constitution, but can determine their own approach to doing so.

Regulations regarding quality accounts have been amended and a revised deadline of **15 December 2020** is appropriate for their preparation, given the pressures caused by COVID-19. Further details can be found here.

The latest information regarding financial accounting and reporting can be found here.

Reporting and assurance

While we are keen to keep the data burden on trusts at an absolute minimum, we are now at a point in time where the need for certain data and our understanding of the impact of COVID-19 on particular areas has increased. Some collections will remain paused in the coming quarter; however, we have identified a small number of data collections that we need to re-instate, linked to our need to understand key aspects of delivery and clinical outcomes during the pandemic:

- **National clinical audits and outcome review programmes (HQIP):** in order to support NHS recovery and NHS recovery, the Healthcare Quality Improvement Partnership (HQIP) will begin to work with national clinical audit and outcome review programme providers to identify key data items for collection from national clinical audits and outcome review programmes. This is in addition to intensive care, child mortality database and maternity audits, which have continued to collect data throughout the surge period.
- **Referral to treatment patient tracking list (RTT PTL):** with specific challenges in the restoration of elective care, the RTT PTL will enable national, regional and local oversight of waiting lists and waiting times,

particularly for the longest waiting patients. While the return should continue to be provided at trust level, where primary accountability for PTL management continues to reside, we expect complementary work to be undertaken at a system level, to allow greater sharing of demand and capacity across system footprints.

- **Ambulance clinical outcomes (AmbCO):** reactivating AmbCO will mean the full suite of ambulance systems indicators (AmbSYS) will be in place. This will help our understanding of patients on urgent and critical care pathways such as those used to treat strokes, for example.

Trusts were also asked to continue collecting data on the following mental health indicators, where capacity allowed:

- Children and young people's eating disorders waiting time
- Physical health checks for people with severe mental illness
- Out of area placements.

We are now confirming that these data collections resume as normal for the Q2 reporting period.

In light of responses to our consultation, we will also be permanently stopping the Quarterly Activity Return from Quarter 1 of 2020/21 and reducing the scope of the Monthly Activity Return to cover referrals only starting with the collection for June 2020.

Vulnerable staff

Systems should continue to proactively support members of staff who are particularly vulnerable, including those who are shielded, those from black and Asian minority ethnic (BAME) backgrounds, and those with other risk factors.

All employers should conduct risk assessments based on advice from NHS Employers and from the Faculty of Occupational Medicine particularly for vulnerable groups, to understand the specific risks staff members face from exposure to COVID and actions that employers can take to keep staff safe. Further details can be found here.

Staff members who are shielded should continue to be supported by their employer to stay well and where possible, make adjustments so that they can work from home.

Where this is not possible, employers should continue to follow the guidance which supports full pay during this period.

Leave

Ensuring staff take annual leave is an important part of supporting and improving health and wellbeing. Systems should ensure that organisations are adhering to usual leave policies, and staff at all levels should be strongly encouraged to take their annual leave spread throughout the year, so that they are getting regular respite, and can take time off as normal. Senior leaders should role model this behaviour as well as encouraging it amongst their staff. There should be regular reviews of accrued annual leave at service and organisational levels in order to enable effective rostering and workforce planning.

Thank you to you and your teams for the incredible amount of commitment and hard work going on across the NHS in these challenging times.

Yours sincerely,

Amanda Pritchard

Chief Operating Officer, NHS England & NHS Improvement

Appendix 1a

Skipton House
80 London Road
London SE1 6LH
england.spoc@nhs.net

From the Chief Executive Sir Simon Stevens
& Chief Operating Officer Amanda Pritchard

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Regional Incident Directors & Heads of EPRR
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

31 July 2020

Dear Colleague

IMPORTANT – FOR ACTION – THIRD PHASE OF NHS RESPONSE TO COVID-19

We are writing to thank you and your teams for the successful NHS response in the face of this unprecedented pandemic, and to set out the next – third – phase of the NHS response, effective from 1 August 2020.

You will recollect that on 30th January NHS England and NHS Improvement declared a Level 4 National Incident, triggering the first phase of the NHS pandemic response. Since then the NHS has been able to treat every coronavirus patient who has needed specialist care – including 107,000 people needing emergency hospitalisation. Even at the peak of demand, hospitals were still able to look after two non-Covid inpatients for every one Covid inpatient, and a similar picture was seen in primary, community and mental health services.

As acute Covid pressures were beginning to reduce, we wrote to you on 29 April to outline agreed measures for the second phase, restarting urgent services. Now in this Phase Three letter we:

- update you on the latest Covid national alert level;
- set out priorities for the rest of 2020/21; and
- outline financial arrangements heading into Autumn as agreed with Government.

Current position on Covid-19

On 19 June 2020 the Chief Medical Officers and the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level from four to three, signifying that the virus remains in general circulation with localised outbreaks likely to occur. On 17 July the Government set out next steps including the role of the new Test and Trace programme in providing us advance notice of any expected surge in Covid demand, and in helping manage local and regional public health mitigation measures to prevent national resurgence.

Fortunately, Covid inpatient numbers have now fallen nationally from a peak of 19,000 a day, to around 900 today. As signalled earlier this month, the current level of Covid demand on the NHS means that the Government has agreed that the NHS EPRR incident level will move from Level 4 (national) to Level 3 (regional) with effect from tomorrow, 1 August. This approach matches the differential regional measures the Government is deploying, including today in parts of the North West and North East. The main implications of this are set out in Annex One to this letter.

However Covid remains in general circulation and we are seeing a number of local and regional outbreaks across the country, with the risk of further national acceleration. Together with the Joint Biosecurity Centre and Public Health England (PHE) we will therefore continue to keep the situation under close review, and will not hesitate to reinstate the Level 4 national response immediately as circumstances justify it. In the meantime NHS organisations will need to retain their EPRR incident coordination centres and will be supported by oversight and coordination by Regional Directors and their teams.

NHS priorities from August

Having pulled out all the stops to treat Covid patients over the last few months, our health services now need to redouble their focus on the needs of all other patients too, while recognising the new challenges of overcoming our current Covid-related capacity constraints. This will continue to require excellent collaboration between clinical teams, providers and CCGs operating as part of local 'systems' (STPs and ICSs), local authorities and the voluntary sector, underpinned by a renewed focus on patient communication and partnership.

Following discussion with patients' groups, national clinical and stakeholder organisations, and feedback from our seven regional 'virtual' frontline leadership meetings last week, we are setting out NHS priorities for this third phase. Our shared focus is on:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

As part of this Phase Three work, and following helpful engagement and discussion, alongside this letter yesterday we published a more detailed 2020/21 People Plan, and will shortly do the same on

inequalities reduction. DHSC are also expected to set out equivalent phase three priorities and support for social care.

Nationally, we will work with the wide range of stakeholders represented on the NHS Assembly to help track and challenge progress against these priorities. As we do so it is vital that we listen and learn from patients and communities. We ask that all local systems act on the Five principles for the next phase of the Covid-19 response developed by patients' groups through National Voices.

A: Accelerating the return of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter

A1. **Restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021 to:**

- To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.

- Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:

  - Ensuring that sufficient diagnostic capacity is in place in Covid19-secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres
  - Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.
  - Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
  - Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
  - Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.

- Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days.

A2. **Recover the maximum elective activity possible between now and winter**, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals.

In setting clear performance expectations there is a careful balance to be struck between the need to be ambitious and stretching for our patients so as to avoid patient harm, while setting a performance level that is deliverable, recognising that each trust will have its own particular pattern of constraints to overcome.

Having carefully tested the feasible degree of ambition with a number of trusts and systems in recent weeks, trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:

- **In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October** (while aiming for 70% in August);

- This means that systems need to very swiftly return to **at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October**.

- **100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).**

Block payments will flex meaningfully to reflect delivery (or otherwise) against these important patient treatment goals, with details to follow shortly once finalised with Government.

Elective waiting lists and performance should be **managed at system as well as trust level** to ensure equal patient access and effective use of facilities.

Trusts, working with GP practices, should ensure that, between them, **every patient whose planned care has been disrupted by Covid receives clear communication** about how they will be looked after, and who to contact in the event that their clinical circumstances change.

Clinically urgent patients should continue to be treated first, with next priority given to the **longest waiting patients**, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.

To further support the recovery and restoration of elective services, a modified national contract will be in place giving **access to most independent hospital capacity** until March 2021. The current arrangements are being adjusted to take account of expected usage, and by October/ November it will then be replaced with a re-procured national framework agreement within which local contracting will resume, with funding allocations for systems adjusted accordingly. To ensure good value for money for taxpayers, systems must produce week-by-week independent sector usage plans from August and will then be held directly to account for delivering against them.

In **scheduling** planned care, providers should follow the new streamlined patient self isolation and testing requirements set out in the guideline published by NICE earlier this week. For many patients this will remove the need to isolate for 14 days prior to a procedure or admission.

Trusts should ensure their e-Referral Service is fully open to referrals from primary care. To reduce infection risk and support social distancing across the hospital estate, clinicians should consider avoiding asking patients to attend physical **outpatient appointments** where a clinically-appropriate and accessible alternative exists. Healthwatch have produced useful advice on how to support patients in this way. This means collaboration between primary and secondary care to use advice and guidance where possible and treat patients without an onward referral, as well as giving patients more control over their outpatient follow-up care by adopting a patient-initiated follow-up approach across major outpatient specialties. Where an outpatient

appointment is clinically necessary, the national benchmark is that at least 25% could be conducted by telephone or video including 60% of all follow-up appointments.

A3. **Restore service delivery in primary care and community services.**

- General practice, community and optometry services should **restore activity to usual levels where clinically appropriate**, and **reach out proactively** to clinically vulnerable patients and those whose care may have been delayed. Dental practices should have now mobilised for face to face interventions. We recognise that capacity is constrained, but will support practices to deliver as comprehensive a service as possible.

- In restoring services, GP practices need to make rapid progress in addressing the backlog of childhood **immunisations** and cervical **screening** through specific catch-up initiatives and additional capacity and deliver through their Primary Care Network (PCN) the service requirements coming into effect on 1 October as part of the Network Contract DES.

- GPs, primary care networks and community health services should build on the enhanced support they are providing to **care homes**, and begin a programme of structured medication reviews.

- CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time. All GP practices must offer face to face **appointments** at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate – whilst also considering those who are unable to access or engage with digital services.

- Community health services **crisis responsiveness** should be enhanced in line with the goals set out in the Long Term Plan, and should continue to support patients who have recovered from the acute phase of Covid but need **ongoing rehabilitation** and other community health services. Community health teams should fully resume appropriate and safe **home visiting care** for all those vulnerable/shielding patients who need them.

- The Government is continuing to provide funding to support timely and appropriate discharge from hospital inpatient care in line with forthcoming updated Hospital Discharge Service Requirements. From 1 September 2020, hospitals and community health and social care partners should fully embed the **discharge to assess** processes. New or extended health and care support will be funded for a period of up to six weeks, following discharge from hospital and during this period a comprehensive care and health assessment for any ongoing care needs, including determining funding eligibility, must now take place. The fund can also be used to provide short term urgent care support for those who would otherwise have been admitted to hospital.

- The Government has further decided that CCGs must resume NHS **Continuing Healthcare assessments** from 1 September 2020 and work with local authorities using the trusted assessor model. Any patients discharged from hospital between 19 March 2020 and 31 August 2020, whose discharge support package has been paid for by the NHS, will need to be assessed and moved to core NHS, social care or self-funding arrangements.

A4. **Expand and improve mental health services and services for people with learning disability and/or autism**

- Every CCG must continue to **increase investment** in mental health services in line with the Mental Health Investment Standard and we will be repeating the independent audits of this. Systems should work together to ensure that funding decisions are decided in partnership with Mental Health Providers and CCGs and that funding is allocated to core Long Term Plan (LTP) priorities.

- In addition, we will be asking systems to validate their existing LTP **mental health service expansion** trajectories for 2020/21. Further advice on this will be issued shortly. In the meantime:
  - IAPT services should fully resume
  - the 24/7 crisis helplines for all ages that were established locally during the pandemic should be retained, developing this into a national service continue the transition to digital working
  - maintain the growth in the number of children and young people accessing care
  - proactively review all patients on community mental health teams' caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with SMI in the community;
  - ensure that local access to services is clearly advertised
  - use £250 million of earmarked new capital to help eliminate mental health dormitory wards.

- In respect of support for people with a **learning disability, autism or both**:
  - Continue to reduce the number of children, young people and adults within a specialist inpatient setting by providing better alternatives and by ensuring that Care (Education) and Treatment Reviews always take place both prior to and following inpatient admission.
  - Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020.
  - GP practices should ensure that everybody with a Learning Disability is identified on their register; that their annual health checks are completed; and access to screening and flu vaccinations is proactively arranged. (This is supported by existing payment arrangements and the new support intended through the Impact and Investment Fund to improve uptake.)

B: Preparation for winter alongside possible Covid resurgence.

B1. Continue to follow good **Covid-related practice** to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave. This includes:

- Continuing to follow PHE's guidance on defining and managing communicable disease **outbreaks**.

- Continue to follow PHE/DHSC-determined policies on which patients, staff and members of the public should be tested and at what frequency, including the further PHE-endorsed

actions set out on testing on 24 June. All NHS employers should prepare for the likelihood that if background infection risk increases in the Autumn, and DHSC Test and Trace secures 500,000+ tests per day, the Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine **Covid testing** of all asymptomatic staff across the NHS.

- Ongoing application of PHE's infection prevention and control guidance and the actions set out in the letter from 9 June on minimising **nosocomial infections** across all NHS settings, including appropriate Covid-free areas and strict application of hand hygiene, appropriate physical distancing, and use of masks/face coverings.

- Ensuring NHS staff and patients have access to and use **PPE** in line with PHE's recommended policies, drawing on DHSC's sourcing and its winter/EU transition PPE and medicines stockpiling.

B2. **Prepare for winter** including by:

- Sustaining current NHS staffing, beds and **capacity**, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.

- Deliver a very significantly expanded seasonal **flu vaccination** programme for DHSC-determined priority groups, including providing easy access for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine if and when a vaccine becomes available.

- Expanding the **111 First** offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty 'hot' clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres (UTCs). DHSC will shortly be releasing agreed **A&E capital** to help offset physical constraints associated with social distancing requirements in Emergency Departments.

- Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.

- Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.

- Continuing to **work with local authorities**, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/PHE policies (see A3 above).

C: Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.

C1. **Workforce**

Covid19 has once again highlighted that the NHS, at its core, is our staff. Yesterday we published We are the NHS: People Plan for 2020/21 - actions for us all which reflects the strong messages from NHS leaders and colleagues from across the NHS about what matters most. It sets out practical actions for employers and systems, over the remainder of 2020/21 ahead of Government decisions in the Autumn Spending Review on future education and training expansions. It includes specific commitments on:

- Actions all NHS employers should take to keep staff safe, healthy and well – both physically and psychologically.
- Specific requirements to offer staff flexible working.
- Urgent action to address systemic inequality that is experienced by some of our staff, including BAME staff.
- New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.
- Growing our workforce, building on unprecedented interest in NHS careers. It also encourages action to support former staff to return to the NHS, as well as taking steps to retain staff for longer – all as a contribution to growing the nursing workforce by 50,000, the GP workforce by 6,000 and the extended primary care workforce by 26,000.
- Workforce planning and transformation that needs to be undertaken by systems to enable people to be recruited and deployed across organisations, sectors and geographies locally.

All systems should develop a local People Plan in response to these actions, covering expansion of staff numbers, mental and physical support for staff, improving retention and flexible working opportunities, plus setting out new initiatives for development and upskilling of staff. Wherever possible, please work with local authorities and local partners in developing plans for recruitment that contribute to the regeneration of communities, especially in light of the economic impact of Covid. These local People Plans should be reviewed by regional and system People Boards, and should be refreshed regularly.

C2. **Health inequalities and prevention.**

Covid has further exposed some of the health and wider inequalities that persist in our society. The virus itself has had a disproportionate impact on certain sections of the population, including those living in most deprived neighbourhoods, people from Black, Asian and minority ethnic communities, older people, men, those who are obese and who have other long-term health conditions and those in certain occupations. It is essential that recovery is planned in a way that inclusively supports those in greatest need.

We are asking you to work collaboratively with your local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and

regularly assess this progress. Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:

- Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.

- Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.

- Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes. This should include more accessible flu vaccinations, the better targeting of long-term condition prevention and management programmes, obesity reduction programmes including self-referral to the NHS Diabetes Prevention Programme, health checks for people with learning disabilities, and increasing the continuity of maternity carers including for BAME women and those in high risk groups.

- Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.

- Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later 31 December, with general practice prioritising those groups at significant risk of Covid19 from 1 September.

Financial arrangements and system working

To support restoration, and enable continued collaborative working, current financial arrangements for CCGs and trusts will largely be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government. More detail is set out in Annex Two.

Working across systems, including NHS, local authority and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:

- Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.

- Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed governance and decision-making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.

- Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.

- A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health.

Finally, we are asking you – working as local systems - to return a draft **summary plan by 1 September** using the templates issued and covering the key actions set out in this letter, with **final plans due by 21 September**. These plans need to be the product of partnership working across STPs/ICSs, with clear and transparent triangulation between commissioner and provider activity and performance plans.

Over the last few months, the NHS has shown an extraordinary resilience, capacity for innovation and ability to move quickly for our patients. Like health services across Europe, we now face the double challenge of continuing to have to operate in a world with Covid while also urgently responding to the many urgent non-Covid needs of our patients. If we can continue to harness the same ambition, resilience, and innovation in the second half of the year as we did in the first, many millions of our fellow citizens will be healthier and happier as a result. So thank you again for all that you and your teams have been – and are – doing, in what is probably the defining year in the seven-decade history of the NHS.

With best wishes,

Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX ONE: IMPLICATIONS OF EPRR TRANSITION TO A LEVEL 3 INCIDENT

As previously signalled, effective 1 August 2020 the national incident level for the Covid19 response will change from level 4 (an incident that requires NHS England National Command and Control to support the NHS response) to level 3 (an incident that requires the response of a number of health organisations across geographical areas within an NHS England region), until further notice.

It is entirely possible that future increases in Covid demands on the NHS mean that the level 4 incident will need to be reinstated. In which case, there will be no delay in doing so. However this change does, for the time being, provide the opportunity to focus local and regional NHS teams on accelerating the restart of non-Covid services, while still preparing for a possible second national peak.

The implications of the transition from a level 4 to level 3 incident are as follows:

- *Oversight*: Transition from a national command, control and coordination structure to a regional command, control and coordination structure but with national oversight as this remains an incident of international concern.

- *Reporting*: We will be stopping weekend sit rep collections from Saturday 8 August 2020 (Saturday and Sunday data will be collected on Mondays with further detail to follow). Whilst we are reducing the incident level with immediate effect reports will still be required this weekend (1 and 2 August 2020) and we will subsequently need to be able to continue to align to DHSC requirements. Additional reporting will be required for those areas of the country experiencing community outbreaks in line with areas of heightened interest, concern or intervention.

- *Incident coordination functions*: The national and regional Incident Coordination Centres will remain in place (hours of operation may be reduced). The frequency of national meetings will decrease (for example IMT will move to Monday, Wednesday, Friday). Local organisations should similarly adjust their hours and meeting frequency accordingly. It is however essential that NHS organisations fully retain their incident coordination functions given the ongoing pandemic, and the need to stand up for local incidents and outbreaks.

- *Communications:* All communications related to Covid19 should continue to go via established Covid19 incident management channels, with NHS organisations not expected to respond to incident instructions received outside of these channels. Equally, since this incident continues to have an international and national profile, it is important that our messaging to the public is clear and consistent. You should therefore continue to coordinate communications with your regional NHS England and NHS Improvement communications team. This will ensure that information given to the media, staff and wider public is accurate, fully up-to-date and aligns with national and regional activity.

ANNEX TWO: REVISED FINANCIAL ARRANGEMENTS

The current arrangements comprise nationally-set block contracts between NHS providers and commissioners, and prospective and retrospective top-up funding issued by NHSE/I to organisations to support delivery of breakeven positions against reasonable expenditure. The M5 and M6 block contract and prospective top-up payments will be the same as M4. Costs of testing and PPE will continue to be borne centrally for trusts and general practices funded by DHSC who continue to lead these functions for the health and social care sectors.

The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government.

The revised framework will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and the restoration of elective services. The intention is that systems will be issued with funding envelopes comprising funding for NHS providers equivalent in nature to the current block and prospective top-up payments and a system-wide Covid funding envelope. There will no longer be a retrospective payment mechanism. Providers and CCGs must achieve financial balance within these envelopes in line with a return to usual financial disciplines. Whilst systems will be expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions. The funding envelopes will comprise:

- CCG allocations – within which block contract values for services commissioned from NHS providers within and outside of the system will continue to be nationally calculated;

- Directly commissioned services from NHS providers – block contract values for specialised and other directly commissioned services will continue to be nationally calculated;

- Top-up – additional funding to support delivery of a breakeven position; and

- Non-recurrent Covid allocation – additional funding to cover Covid-related costs for the remainder of the year.

Funding envelopes will be calculated on the basis of full external income recovery. For relationships between commissioners and NHS providers we will continue to operate nationally calculated block contract arrangements. For low-volume flows of CCG-commissioned activity, block payments of an appropriate value would be made via the Trust's host CCG; this will remove the need for separate invoicing of non-contract activity.

However block payments will be adjusted depending on delivery against the activity restart goals set in Section A1 and A2 above.

Written contracts with NHS providers for the remainder of 2020/21 will not be required.

For commissioners, non-recurrent adjustments to commissioner allocations will continue to be actioned – adjustments to published allocations will include any changes in contracting responsibility and distribution of the top-up to CCGs within the system based on target allocation.

Reimbursement for high cost drugs under the Cancer Drugs Fund (CDF) and relating to treatments under the Hepatitis C programme will revert to a pass-through cost and volume basis, with adjustments made to NHS provider block contract values to reflect this. For the majority of other high cost drugs and devices, in-year provider spend will be tracked against a notional level of spend

included in the block funding arrangements with adjustments made in-year to ensure that providers are reimbursed for actual expenditure on high cost drugs and devices. This will leave a smaller list of high cost drugs which will continue to be funded as part of the block arrangements.

In respect of Medical pay awards, on 21 July 2020 the Government confirmed the decision to uplift pay in 2020/21 by 2.8% for consultants, specialty doctors and associate specialists, although there is no uplift to the value of Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points for 2020/21. We expect this to be implemented in September pay and backdated to April 2020. In this event, NHS providers should claim the additional costs in September as part of the retrospective top-up process. Future costs will be taken into account in the financial framework for the remainder of 2020/21, with further details to be confirmed in due course.

Appendix 2

Quality and Performance Report Board Summary June 2020

This dashboard uses icons to indicate if a process is showing special cause or common cause variation. It also indicates whether the process is able to meet any stated target. Here is a key to the icons

Icon	Description
	Special cause variation - cause for concern (indicator where high is a concern)
	Special cause variation - cause for concern (indicator where low is a concern)
	Common cause variation
	Special cause variation - improvement (indicator where high is good)
	Special cause variation - improvement (indicator where low is good)

These icons are used to indicate statistical variation. We have identified special cause variation based on three rules which are shown below. If none of the rules are present then the metric is showing common cause variation.

- An upwards or downwards trend in performance for seven or more consecutive months.
- Seven or more months above or below the average.
- One month or more outside the control limits .

Icon	Description
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

These icons are used to indicate if a target is likely to be achieved next month, has the potential to be achieved or is expected to fail.

Green indicates that the metric has passed the monthly or YTD target while **Red** indicates a failure to do so.

The trend shows performance for the most recent 13 months.

Data Quality Assessment – The Data Quality Forum panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance by best endeavours that it is of suitably high quality. The forum provides scrutiny and challenge on the quality of data presented, via the attributes of (i) Sign off and Validation (ii) Timeliness and Completeness (iii) Audit and Accuracy and (iv) Systems and Data Capture to calculate an assurance rating.

Quality and Performance Report Board Summary June 2020

Domain	KPI	Target	Apr-20	May-20	Jun-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Safe	Never events	0	1	0	0	1				Jan-20
	Overdue CAS alerts	0	0	0	0	0				Nov-19
	% of all adults VTE Risk Assessment on Admission	95%	Data collection paused as part of COVID-19 reducing the burden							Dec-19
	Emergency C-section rate	No Target	17.2%	21.2%	20.6%	19.7%				Feb-20
	Clostridium Difficile	108	10	4	4	18				Nov-17
	MRSA Total	0	0	0	0	0				Nov-17
	E. Coli Bacteraemias Acute	No Target	1	6	13	20				Jun-18
	MSSA Acute	No Target	1	1	1	3				Nov-17
	COVID-19 Community Acquired <= 2 days after admission	No Target	82.4%	62.4%	77.8%	77.9%				TBC
	COVID-19 Hospital-onset, indeterminate, 3-7 days after admission	No Target	8.0%	11.6%	10.2%	8.7%				TBC
	COVID-19 Hospital-onset, probable, 8-14 days after admission	No Target	4.5%	16.9%	7.4%	7.8%				TBC
	COVID-19 Hospital-onset, healthcare-acquired, 15 or more days after admission	No Target	5.1%	9.0%	4.6%	5.6%				TBC
	All falls reported per 1000 bed stays	5.5	4.8	5.5		5.2				Jun-18
	Rate of Moderate harm and above Falls PSIs with finally approved status per 1,000 bed days	No Target	0.10	0.02		0.06				TBC

Domain	KPI	Target	Apr-20	May-20	Jun-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Caring	Staff Survey Recommend for treatment	No Target	Data collection paused as part of COVID-19 reducing the burden							Aug-17
	Single Sex Breaches	0	Data collection paused		0					Dec-16
	Inpatient and Daycase F&F Test % Positive	96%	Data collection paused as part of COVID-19 reducing the burden							Jun-17
	A&E F&F Test % Positive	94%	Data collection paused as part of COVID-19 reducing the burden							Jun-17
	Maternity F&F Test % Positive	96%	Data collection paused as part of COVID-19 reducing the burden							Jun-17
	Outpatient F&F Test % Positive	94%	Data collection paused as part of COVID-19 reducing the burden							Jun-17
	Complaints per 1,000 staff (WTE)	No Target	Data collection paused as part of COVID-19 reducing the burden							Jan-20

Domain	KPI	Target	Apr-20	May-20	Jun-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Well Led	Staff Survey % Recommend as Place to Work	No Target	Data collection paused as part of COVID-19 reducing the burden							Sep-17
	Turnover Rate	10%	7.7%	7.8%	7.6%	7.6%				Nov-19
	Sickness Absense	3%	11.1%	8.8%		9.9%				Oct-16
	% of Staff with Annual Appraisal	95%	84.9%	83.4%	74.1%	74.1%				Dec-16
	Statutory and Mandatory Training	95%	96%	96%	96%	96%				Feb-20
	Nursing Vacancies	No Target	10.0%	10.0%	10.1%	10.1%				Dec-19

Quality and Performance Report Board Summary June 2020

Domain	KPI	Target	Apr-20	May-20	Jun-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Effective	Mortality Published SHMI	99	95	95	95	95 (Feb 19 to Jan 20)				Sep-16
	Mortality 12 months HSMR	99	95	93	93	93 (Mar 19 to Feb 20				Sep-16
	Crude Mortality Rate	No Target	3.7%	2.3%	1.6%	2.5%				Sep-16
	Emergency Readmissions within 30 Days	8.5%	10.1%	10.2%		10.2%				Jun-17
	Emergency Readmissions within 48 hours	No Target	1.3%	1.2%		1.2%				Jun-17
	No of #neck of femurs operated on 0-35hrs	72%	28.3%	32.1%	86.1%	49.0%				Jul-17
	Stroke - 90% Stay on a Stroke Unit	80%	80.4%	91.5%		87.1%				Apr-18
	Stroke TIA Clinic Within 24hrs	60%	86.0%	63.8%	45.5%	60.9%				Apr-18

Domain	KPI	Target	Apr-20	May-20	Jun-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Responsive	ED 4 hour waits UHL	95%	86.7%	82.7%	78.2%	82.0%				Sep-18
	ED 4 hour waits Acute Footprint	95%	90.5%	87.5%	84.5%	87.1%				Aug-17
	12 hour trolley waits in A&E	0	0	0	0	0				Mar-19
	Ambulance handover >60mins	0.0%	1.0%	0.5%	0.4%	0.6%				TBC
	RTT Incompletes	92%	69.4%	60.8%	51.5%	51.5%				Nov-19
	RTT Waiting 52+ Weeks	0	281	778	1495	1495				Nov-19
	Total Number of Incompletes	66,397 (by year end)	65,404	64,959	66,082	66,082				Nov-19
	6 Week Diagnostic Test Waiting Times	1.0%	36.5%	20.7%	24.4%	24.4%				Nov-19
	Cancelled Patients not offered <28 Days	0	85	7	7	99				Nov-19
	% Operations Cancelled OTD	1.0%	1.0%	0.7%	0.5%	0.7%				Jul-18
	Delayed Transfers of Care	3.5%	Data collection paused as part of COVID-19 reducing the burden							Oct-17
	Long Stay Patients (21+ days)	70	76	103	123	123				TBC
	Inpatient Average LOS	No Target	4.7	3.4	3.8	3.9				TBC
	Emergency Average LOS	No Target	5.0	4.5	4.8	4.8				TBC

Domain	KPI	Target	Mar-20	Apr-20	May-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Responsive - Cancer	2WW	93%	95.4%	86.4%	86.9%	86.7%				Dec-19
	2WW Breast	93%	97.3%	90.0%	95.5%	95.2%				Dec-19
	31 Day	96%	93.0%	94.7%	89.3%	92.1%				Dec-19
	31 Day Drugs	98%	100%	100%	100%	100%				Dec-19
	31 Day Sub Surgery	94%	78.1%	71.9%	83.2%	78.9%				Dec-19
	31 Day Radiotherapy	94%	77.1%	57.7%	90.4%	74.9%				Dec-19
	Cancer 62 Day	85%	71.1%	64.1%	56.1%	61.3%				Dec-19
	Cancer 62 Day Consultant Screening	90%	85.7%	95.7%	25.0%	61.5%				Dec-19

Domain	KPI	Target	Apr-20	May-20	Jun-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Outpatient Transformation	% DNA rate	No Target	7.1%	5.8%	5.9%	6.2%				Feb-20
	% Virtual clinic appointments	No Target	9.6%	9.2%	7.4%	8.9%				Feb-20
	% 7 day turnaround of OP clinic letters	90%	89.9%	92.5%	94.3%	92.5%				Feb-20

Appendix 3

healthwatch Leicester

healthwatch Leicestershire

Guided by you

Healthwatch Leicester and Healthwatch Leicestershire
Annual report 2019-20

Contents

Message from our chair

I am very pleased to present the Annual Report for Healthwatch Leicester & Leicestershire (HWLL) for the year 2019 - 2020.

The Healthwatch Advisory Board (HAB) meets monthly and we have held our meetings at venues across the City and County. We were sad to see Colin Norman leave the board earlier in the year. We have appointed a new member, Joe Johal, who has taken responsibility for representing at us Leicester City Clinical Commissioning Group. He has previously led the Board of Directors of a County Health Authority in the USA, been trained in health procurement and has a thorough knowledge of the care sector.

Members of the HAB attend board meetings held by providers and commissioners across Leicestershire. They represent HWLL, ask questions, scrutinise and ensure that issues affecting patients and the public are taken into consideration.

The past 12 months have been very busy for us and we have now settled properly as a countywide organisation. We have successfully worked on a range of priorities, completing some excellent work on patient experiences of the Discharge Lounges at Glenfield Hospital and Leicester Royal Infirmary, which highlighted some inconsistencies. We had planned further visits as part of our Enter and View programme but have had to reschedule due to the Coronavirus outbreak.

We have examined access to GPs and reviewed the experiences of patients using the Healthcare Hubs and made recommendations.

We have also undertaken three research projects to take the experience of users of the services. The first was to evaluate the impact of changes made to the Children and Adolescent Mental Health Service (CAMHS).

Message from our chair

Our second project was to explore the experiences of children identified with Special Educational Needs and Disabilities who use dental services.

The third project explores the experiences of looked after children (LAC) in managing their own health and wellbeing and how the care system prepares them to do so when living independently.

During the Coronavirus pandemic, Healthwatch has continued to work albeit in different ways. We have added a page to the website about where to get information and the support that is available to the community. While working from home, our team members have increased our local involvement to offer support to our Health and Social care colleagues and to the voluntary response, for example, delivering food parcels.

As a result of the Coronavirus disease, this year is seeing many changes to how services are delivered. We will continue to champion the patient voice and ensure that they are kept informed on how the massive changes are affecting them.

Our priorities for the next 12 months are:

Examining the impact of COVID-19
Domiciliary Care
Mental Health Care at the point of crisis

May I take this opportunity to thank all who have engaged with us at Healthwatch Leicester & Leicestershire in the last twelve months, shared their experiences and those that have made changes as a result of our feedback.

Harsha Kotecha
Healthwatch Leicester and Healthwatch Leicestershire Chair

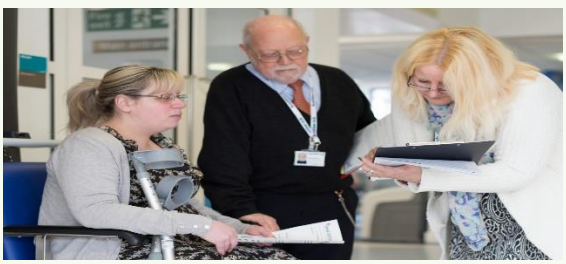
Our priorities

Last year 3001 people told us about the improvements they would like to see health and social care services make in 2019-20. These were our six priorities for the year based on what you told us.

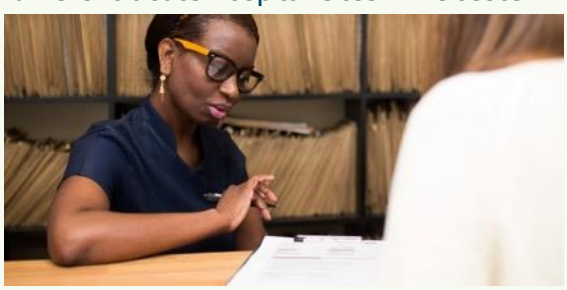
- Medicines Management – Looking at the patient experience of prescription as part of their discharge from Hospitals, then their GP

- Personal Budgets – What has been the impact of personal budgets on those using them since their introduction?

- Patient Discharge from Hospital – Understanding what is the lived experience of being discharged from the different acute hospital sites in Leicester



- Social prescribing – How much does the wider public understand the concept of "Social Prescribing"?



- Lifestyle services – Following substantial review of Lifestyle services in Leicester and Leicestershire, we want to understand what impact these changes have had on the service.

- Supported Living – Following feedback from residents in supported living we want to build a better picture of what its like to live in Supported Living locations locally.

"It has been great to see Healthwatch Leicester and Leicestershire continue to drive change for the better in health and social care. Close working with local communities, strong commitment from volunteers and focused reports on issues such as medicines management and hospital discharge are some of the key ingredients that are really making a difference." - **Cllr Louise Richardson, County Council Cabinet Lead Member for equalities, community engagement and rural partnership**

About us

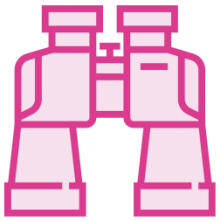
Here to make care better

The network's collaborative effort around the NHS Long Term Plan shows the power of the Healthwatch network in giving people that find it hardest to be heard a chance to speak up. The #WhatWouldYouDo campaign saw national movement, engaging with people all over the country to see how the Long Term Plan should be implemented locally. Thanks to the thousands of views shared with Healthwatch we were also able to highlight the issue of patient transport not being included in the NHS Long Term Plan review – sparking a national review of patient transport from NHS England.

We simply could not do this without the dedicated work and efforts from our staff and volunteers and, of course, we couldn't have done it without you. Whether it's working with your local Healthwatch to raise awareness of local issues, or sharing your views and experiences, I'd like to thank you all. It's important that services continue to listen, so please do keep talking to your local Healthwatch. Let's strive to make the NHS and social care services the best that they can be.

> I've now been Chair of Healthwatch England for over a year and I'm extremely proud to see it go from strength to strength, highlighting the importance of listening to people's views to decision makers at a national and local level.

Sir Robert Francis – Healthwatch England Chair



Our vision is simple

Health and care that works for you.
People want health and social care support that works – helping them to stay well, get the best out of services and manage any conditions they face.

Our purpose

To find out what matters to you and to help make sure your views shape the support you need.

Our approach

People's views come first – especially those who find it hardest to be heard.
We champion what matters to you and work with others to find solutions. We are independent and committed to making the biggest difference to you.

How we find out what matters to you

People are at the heart of everything we do. Our staff and volunteers identify what matters most to people by:

- Visiting services to see how they work
- Running surveys and focus groups
- Going out in the community and working with other organisations

Find out more about us and the work we do

Website: www.healthwatchll.com
Twitter: @HealthwatchLeic
Facebook: @HealthwatchLL

Highlights from our year

Find out about our resources and the way we have engaged and supported more people in 2019-20.

Health and care that works for you

21 volunteers

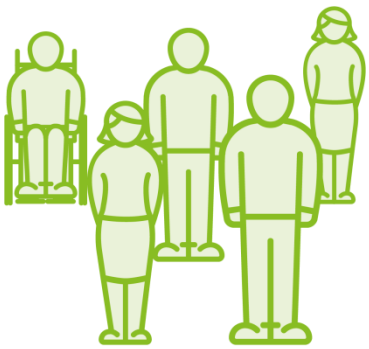
helping to carry out our work. In total, they gave up 964 number of hours or just over 40 days.

We employed
6 staff
100% of whom are full time equivalent, which is a 20% increase from the previous year.

We received
£296,657 in funding

from our local authority in 2019-20, which is unchanged from the previous year.

Providing support



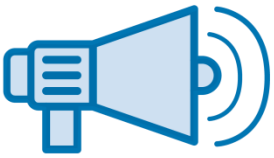
3001 people

shared their health and social care story with us, 600% more than last year.

351 people

accessed Healthwatch advice and information online or contacted us with questions about local support, 80% more than last year.

Reaching out



4607 people

engaged with us through our website, 2541 people engaged with us through social media, and 3001 people engaged with us at community events.

Making a difference to care

We published
11 reports

about the improvements people would like to see with their health and social care, and from this, we made 27 recommendations for improvement.

How we've made a difference

Speaking up about your experiences of health and social care services is the first step to change.

Take a look at how your views have helped make a difference to the care and support people receive in Leicester and Leicestershire.

Being discharged from Hospitals in Leicester

Speaking directly to patients and their families who are about to be discharged from hospitals we wanted to understand how involved they had felt in planning their discharge and how ready they felt to be discharged.

Through 1-2-1 interviews with patients and their families across the main discharge lounges we found the following themes:-

- Patients did not feel involved in their discharge or kept informed
- Felt frustrated by delays on the day of discharge

We also found an unexpected difference of experience between the discharge lounges of the Leicester Royal Infirmary and Glenfield Hospital Sites.

Reporting through a joint NHS and Council Group focused on Patient Discharge our findings were strongly supported. University Hospitals of Leicester(UHL) have accepted our recommendations and an action plan has been designed, taking forward our recommendations. We continue to work with UHL to highlight and improve the patient discharge pathway.

> Whilst I am saddened what the report is saying it is helpful in reinforcing what we already know. The involvement of patients, families and carers in the discharge process is a key element to this work stream. - **Gill Staton – Head of Nursing/Patient flow and discharge**

Our report can be found at - https://healthwatchll.com/our-reports/

Thames Abulance Service Ltd (TASL) – Providing Non-Acute Patient Transport in Leicester and Leicestershire

Non Emergency Patient transport – Getting to Renal Dialysis

Local Patient transport provider TASL approached us to engage with patients and understand what is important to patients being transported to their appointments for Renal Dialysis. Working in partnership with TASL, the local Renal Dialysis service based at Loughborough Hospital and Healthwatch Rutland we designed a short survey asking patients to rank different factors of their transport experience.
Through our report we were able to confirm to TASL that patients felt being picked up before and after their appointment was mattered most to them.

This work was undertaken to better inform TASL in their planning for patient transport and their newly formed – Innovation team, dedicated to develop new ideas for the delivery of patient transport services in a way that meets the priorities of patients.

The feedback within this report will be used by the TASL Innovation Team while preparing future operational models. We would like to thank Healthwatch, volunteers and the patients at Loughborough Renal Unit for taking time to contribute and compile this report. - **Paul Willetts**
Associate Director of Business Development

Our report can be found at - https://healthwatchll.com/our-reports/

Medicines Management – The difference between prescribing in hospitals and GPs

After receiving feedback from members of the public about problems obtaining medicine from their GP after being prescribed it as part of their discharge from hospital. We completed some work to find out what was the reality for patients.

Through a survey and reviewing responses we were able to show that It did show that there were some concerns that patients felt prescriptions covering a longer time would help.

We presented our findings to Leicestershire County Council Health Overview and Scrutiny Committee. Feedback was received from the senior pharmacists of the local NHS trusts and they confirmed that patient experience did not, consistently, meet their prescribing policy of the NHS. Accepting our findings our report has been taken to STP Prescribing Board to take forward recommendations. They were reviewing clinical practice to develop plans for more consistent prescribing in reaction to report.

Our report can be found at - https://healthwatchll.com/our-reports/

Share your views with us

If you have a query about a health and social care service or need help with where you can go to access further support, get in touch. Don't struggle alone. Healthwatch is here for you.

Website: www.healthwatchll.com

Telephone: 0116 2518313

Email: enquiries@healthwatchll.com

Long Term Plan

#WhatWouldYouDo

Highlights

More than 40,000 people shared their views nationally with Healthwatch.

With 597 responses from Leicester, Leicestershire and Rutland

Our network held over 500 focus groups reaching different communities across England.
We held 10 focus groups in Leicester, Leicestershire and Rutland

Healthwatch attended almost 1,000 community events.

NHS Long Term Plan

Following a commitment from the Government to increase investment in the NHS, the NHS published the 'Long Term Plan' in January 2019, setting out its' key ambitions over the next 10 years. Healthwatch launched a countrywide campaign to give people a say in how the plan should be implemented in their communities.

The top issues that people told us they wanted services to focus on is:

- Access to help and treatment when they want it.
- Choosing the right treatment is a joint decision between me and the relevant health or care professional
- Those living with a Long Term Condition - Communication is felt to be inconsistent across services patients' access as part of their treatment

Working with Healthwatch Rutland we asked people #WhatWouldYouDo to improve the NHS locally.

Our report and findings have been shared with the local NHS and Social Care services and has been used in the refresh of the LLR Sustainability and Transformation Plan, as well as being used to influence our local priorities.

"I should be at the centre of my care and given the right information about my illness so I can make the right decision about my illness. Having a named GP is important." – **Patient feedback**

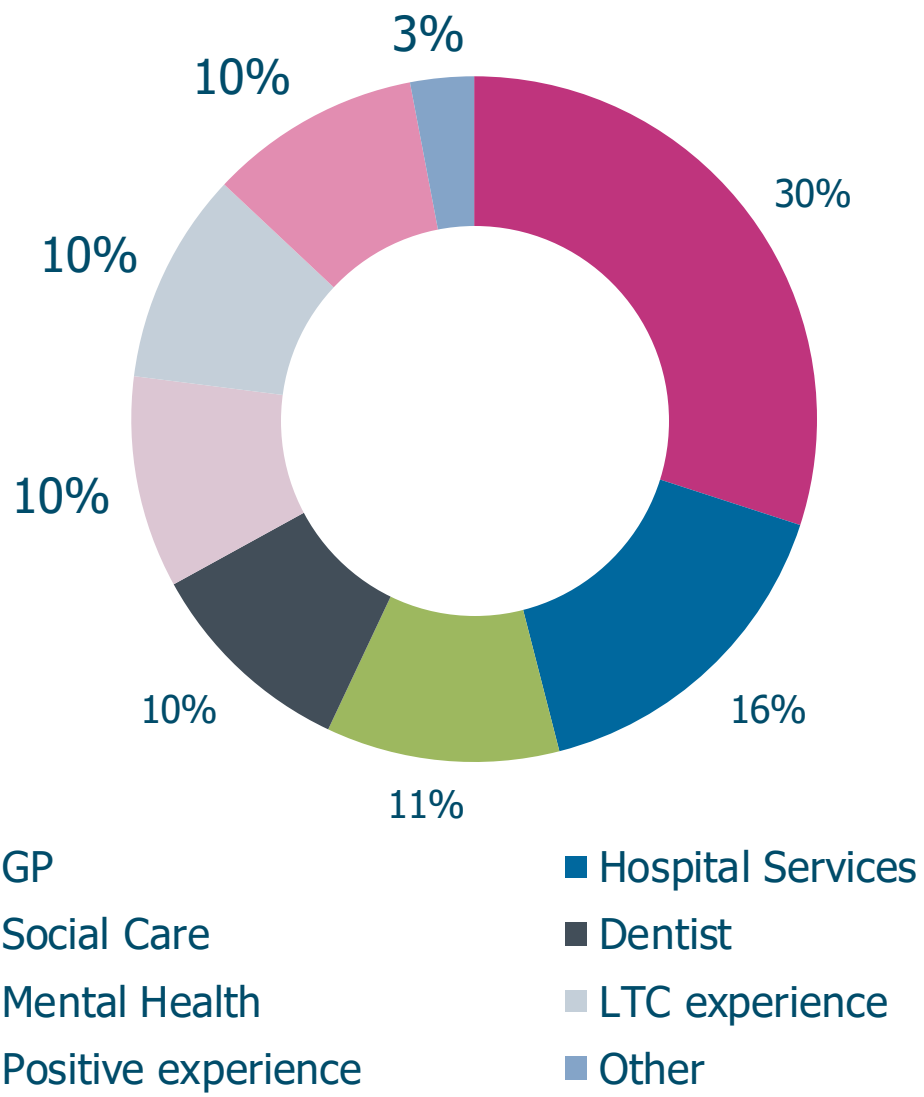
Helping you find the answers

Finding the right service can be worrying and stressful. Healthwatch plays an important role in helping people to get the information they need to take control of their health and care and find services that will provide them with the right support.

This year we helped 351 people get the advice and information they need by:

- Providing advice and information articles on our website.
- Answering people's queries about services over the phone, by email, or online.
- Talking to people at community events.
- Holding community drop in clinics in community hubs
- Promoting services and information that can help people on our social media.

Here are some of the areas that people asked about.



Case study: Information about Hidden disabilities

From feedback received from attending community groups and from our findings from the Long Term Plan work we realised that an important area, not only to raise awareness of, but to help signpost people with hidden disabilities to services that are able to offer support.

A total of 17 community groups and support services were able to take part in the market stall event and among those taking part were The Alzheimer's Society, The Carers Centre, Fibro Friends, Macmillan and LOROS.

Feedback from members of the public about the event was very positive, with people sharing that they were unaware of many of the services that took part and others requesting for similar events to be held regularly. People shared a variety of difficulties they have encountered such as not knowing how to make applications for adaptations to their home, social exclusion which has a negative impact on their mental health, and concerns about losing their independence and the implications of this, such as having to leave their own home to live in residential care.

Stalls and members of the public from our Hidden Disabilities event

Involvement Centre Drop in

To get a better understanding of the first hand experience of those using Mental Health Services. We have been working with our Mental Health Trust (Leicestershire Partnership Trust) and have a regular drop in clinic at their Involvement Centre based in the Bradgate Unit.

Summer Road show events

Through out summer our Community Outreach leads attended local events all over the County speaking to many members of the public to find our what their local issues are. Through these events we have spoken to more than 3000 people.

Living with Lipoedema

Attending community groups who offer support to those living with long term conditions, is an important way for Healthwatch to capture their lived experience.

One of the groups we visited this year is those living with Lipoedema who experience prejudice because of how their condition manifests physically.

Contact us to get the information you need

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Volunteers

At Healthwatch Leicester and Healthwatch Leicestershire we are supported by 21 volunteers to help us find out what people think is working, and what people would like to improve, to services in their communities.

This year our volunteers:

- Raised awareness of the work we do at events, in the community and with health and care services.
- Visited services to make sure they are providing people with the right support.
- Helped support our day-to-day running.
- Listened to people's experiences to help us know which areas we need to focus on.

Maternity Voices Partnership – Celebrating their involvement

In 2018 we supported the recruitment of volunteers to be a part of the Maternity Voices Partnership, involving young Mums and Dads in reviewing maternity services in Leicester and Leicestershire.

These volunteers act as a sense check for the developments to services and have been instrumental in making sure the service user voice is a part of strategic review for services locally.

As a way to thank the volunteers we were asked to arrange a day of activities for the volunteers and their young ones. As you can imagine, trying to arrange something for both parents and children to take part in was a challenge but our Community Outreach Leads were able to arrange and host a day for making and decorating pottery.

Two of the MVP members painting their pottery

Volunteer with us

Are you feeling inspired? We are always on the lookout for new volunteers. If you are interested in volunteering, please get in touch at Healthwatch Leicester and Healthwatch Leicestershire.

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Telephone: 0116 2518313

Email: enquiries@healthwatchll.com

Our volunteers

We could not do what we do without the support of our amazing volunteers. Meet some of the team and hear what they get up to.

Lynne, 58

The reason I volunteer for Healthwatch, is after being part of the NHS for 30yrs and knowing what a difference it makes to peoples lives and their families, I feel I still have in some small way something to give.

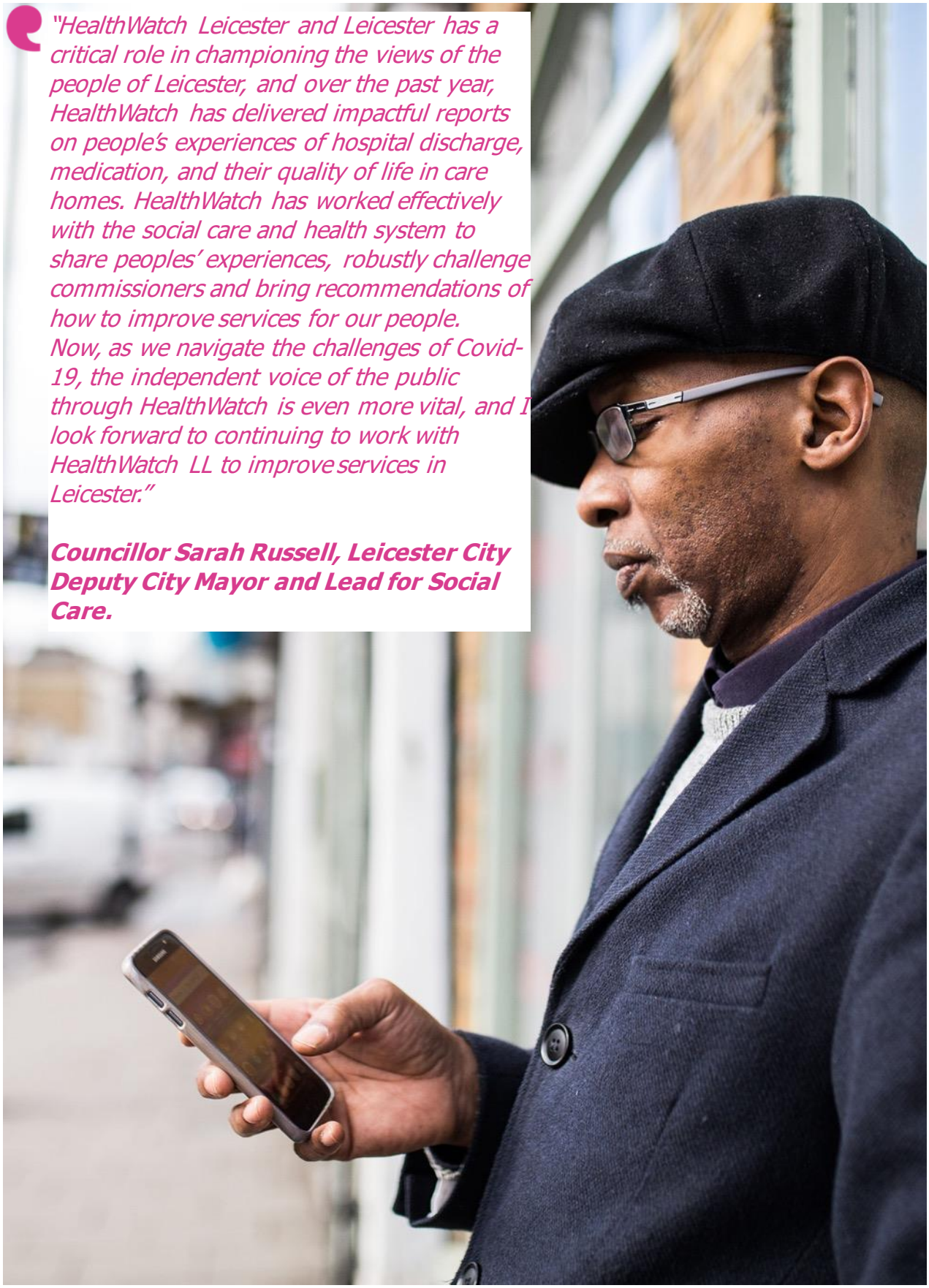
Howard, 64

After several years being Secretary of my GP Practice's PPG, a position I still hold today, I had been considering joining the Healthwatch Enter & view team. I considered the knowledge I had learnt over the years of how GP surgeries are or should be run would be useful to Healthwatch.

As an Enter & View team member, it's been interesting visiting other GP surgeries with the opportunity to speak with both the patients and the Practice team. Once a month I meet up with other members of the Enter & View team to review the visits of that month and to plan the next couple or so visits. In additional to being part of the Enter & View team, I attend some of the health promotion events that Healthwatch participate in.

Moraig, 68

I have been a member of the Enter & View team for a number of years now. I enjoy the experience of going to different places, meeting people and seeing if we can make a difference.

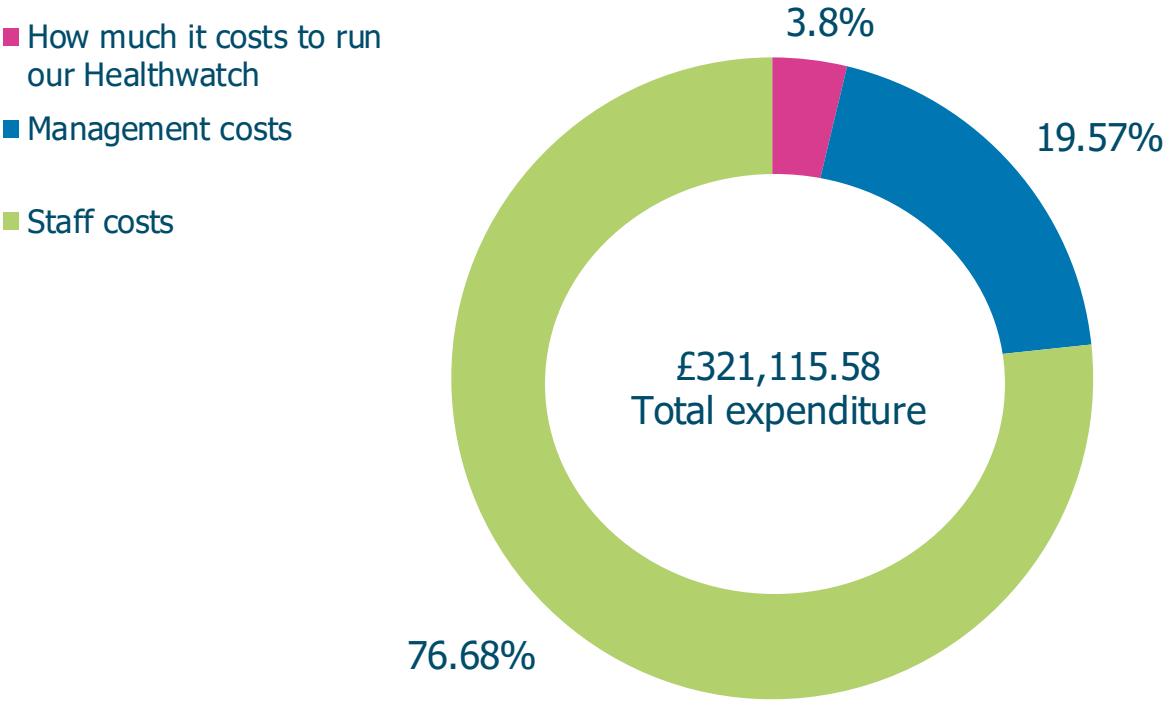


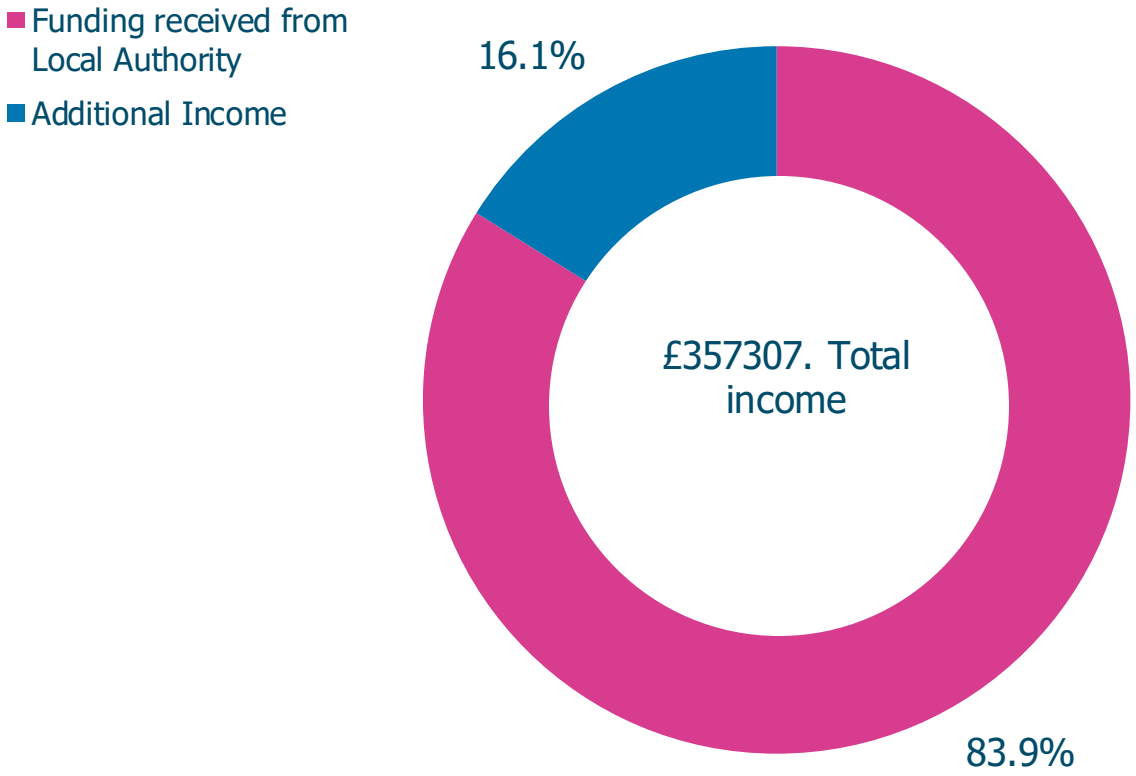
"HealthWatch Leicester and Leicester has a critical role in championing the views of the people of Leicester, and over the past year, HealthWatch has delivered impactful reports on people's experiences of hospital discharge, medication, and their quality of life in care homes. HealthWatch has worked effectively with the social care and health system to share peoples' experiences, robustly challenge commissioners and bring recommendations of how to improve services for our people. Now, as we navigate the challenges of Covid-19, the independent voice of the public through HealthWatch is even more vital, and I look forward to continuing to work with HealthWatch LL to improve services in Leicester."

Councillor Sarah Russell, Leicester City Deputy City Mayor and Lead for Social Care.

Finances

We are funded by our local authority under the Health and Social Care Act (2012). In 2019-20 we spent £321115.58.





Our plans for next year

What is in our future?

Looking ahead

- We have already begun working with the NHS services to understand how services are changing due to Covid 19 and what changes the public want to stay.
- Our focus is also on the why the BAME community has been more impacted by Covid 19
- In addition to how Covid has changed our lives, we will be looking into –

i. Domiciliary Care – Receiving care in your home
ii. Mental Health Care at the point of Crisis

Thank you

- To my dedicated staff team who have shown just how adaptable they can be
- Our HAB members- who represent, you, the public with passion and tenacity.
- All our Authorised Rep volunteers – who have stuck with us through some challenging times.

This year , as always, has been a mixture of celebration and frustration. Adding into the mix living through something few would have predicted.

Our work priorities has seen us highlight some key issues which have been taken on by the Health and Care sector in Leicester and Leicestershire, we have been unable to finish some work due to a lack of engagement around Social Care services. But what has been a consistent has been our good working relationship with the providers and commissioners of Health and Care services.

Micheal Smith - Manager

Understanding how the Covid 19 Pandemic has changed our lives will be an ongoing focus. We want to understand what has changed for the better and how we can support the public to engage in the most effective way.

That is not to say this will be our full focus, what we need from the NHS and Social Care services hasn't changed but in partnership we can bring together what we need with how lockdown has shown different ways of using those services.

Micheal Smith
Senior Manager

Thank you

Thank you to everyone that is helping us put people at the heart of social care, including:

- Our staff team past and present – Gemma, Louise, Mukesh, Gillian, Nazmin, Ana and Bryonie
- Our Volunteers – Howard, Kim, Kash, Moraig, Lynne, Janina, Naina, Merhunissa, Chris, John, Ana, Nigel and Margaret
- Our Advisory Board members – Harsha, Mark, Shireen, Rita, and Joe
- All our stakeholders and partners in Leicester and Leicestershire.

- And finally each and everyone who shared their experiences – we can't do this without you.

Contact us

Address and contact details as of 31/03/2020.

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Email address – enquiries@healthwatchll.com

Social media - @HealthwatchLeic

www.facebook.com/HealthwatchLL

healthwatchleic

Website – www.healthwatchll.com

Healthwatch Leicester and Healthwatch Leicestershire

Clarence House

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LE1 3PJ

Address and contact details of the organisation holding the Healthwatch contract as of 31/03/2020.

Engaging Communities Solutions
Unit 42, Staffordshire University Business Village,
Dyson Way, Staffordshire Technology Park,
Stafford, Staffordshire, ST18 0TW.
Contact – **01785 887809**
http://www.weareecs.co.uk/

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If you need this in an alternative format please contact us.

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