Report by Acting Chief Executive – monthly update: May 2021

Authors: Rebecca Brown and Stephen Ward Sponsor: Rebecca Brown **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 Acting Chief Executive's monthly update report to the Trust Board for May 2021 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]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Yes]

2. Supporting priorities:

People strategy implementation	[Yes]
Investment in sustainable Estate and reconfiguration	[Yes]
e-Hospital	[Yes]
Embedded research, training and education	[Yes]
Embed innovation in recovery and renewal	[Yes]
Sustainable finances	[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: June 2021 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: **6 MAY 2021**

REPORT BY: **ACTING CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – MAY 2021**

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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

2.1 I will report orally at the Trust Board meeting on the current position.

3. Quality and Performance Dashboard – March 2021

3.1 The Quality and Performance Dashboard for March 2021 is appended to this report at **appendix 1.**

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 deliberations of the April 2021 meetings of the People, Process and Performance Committee and Quality and Outcomes Committee, respectively. The month 12 quality and performance report is published on the Trust's website.

3.4 ***Good News***

- **Mortality** – the latest published SHMI (period December 2019 to November 2020) is 101 but remains within the expected range.
- **CAS alerts** - compliant.
- **MRSA** – 0 cases reported.
- **C DIFF** – 7 cases reported this month.
- **90% of Stay on a Stroke Unit** – threshold of 80% achieved with 84.1% reported in February.
- **TIA (high risk patients) –** 60.8% reported in March
- **12 hour trolley wait** - 0 breaches reported.
- **VTE** – compliant at 98.6% in March.
- **Cancelled operations OTD** – 0.5% reported in March.

- **Cancer Two Week Wait** was 95.9% in February against a target of 93%.
- **Cancer Two Week Wait (Symptomatic Breast)** was 96.0% in February against a target of 93%.

3.5 ***Challenges***

- **1 Never Event** reported in March.
- **Fractured neck of femurs operated 0-35hrs** – performance is below target of 72% at 68.0%.
- **UHL ED 4 hour performance** – 71.8% for March, system performance (including LLR UCCs) for March is 79.8%.
- **Ambulance Handover 60+ minutes (CAD)** – performance at 3.5%.
- **Cancer 31 day treatment** was 93.2% in February against a target of 96%.
- **Cancer 62 day treatment** was 62.1% in February against a target of 85%.
- **Referral to treatment** – the number on the waiting list (now the primary performance measure) was above the target and 18 week performance was below the NHS Constitution standard at 51.1% at the end of March.
- **52+ weeks wait –** 12,625 breaches reported in March.
- **Diagnostic 6 week wait** was 35.9% against a target of 1% in March.
- **Patients not rebooked within 28 days following late cancellation of surgery –** 7.
- **Statutory and Mandatory Training** is at 88%.
- **Annual Appraisal** is at 80.2%.

4. <u>Staff Survey 2020</u>

4.1 Our NHS National Staff Survey 2020, was carried out by Quality Health during October and November 2020. A mixed mode (paper and online questionnaires), full census survey was carried out with 5,130 respondents (33%). Our performance against our two main indicators (i.e. 'I would recommend my organisation as a place to work' and 'if a friend or relative need treatment I would be happy with the standard of care provided by my organisation') is the highest it has been in the past five years (2016-2020) demonstrating that Covid-19 has brought us together, across our hospitals, despite the significant challenges experienced by our people.

4.2 Whilst there was no significant change in the theme score for Health and Wellbeing it is encouraging that the scores for the questions; 'Does the organisation take positive action on health and wellbeing,' and 'My immediate manager takes a positive interest in my health and wellbeing,' again are the highest that we have seen over the last five years. We know colleagues who feel supported will deliver safe care and we know all colleagues need our support now like never before. Our continued relentless focus on meaningful rest and decompression for all is the only way we will be able to strengthen our offer to patients over the coming months.

4.3 Overall our staff survey results show that we are heading in the right direction, whilst we recognise that we are below average against a number of themes and we have more work to do.

4.4 A comprehensive report on the results of Staff Survey 2020 was discussed at the April 2021 meeting of the People, Process and Performance Committee, and a summary of the Committee's deliberations and discussions features elsewhere on this Board agenda.

5. Chief Nurse Fellow (CNF) Programme

5.1 The Chief Nurse Fellow (CNF) is a unique, facilitated programme where the organisation develops their programme to provide a bespoke experience for the individual nurse or midwife. At UHL our CNF programme is tailored to the CNF's particular needs and combines clinical excellence, leadership skills and an insight into what a clinical academic career could provide them.

5.2 Our CNF is a 12 month programme aimed at our junior staff (bands 5 & 6) and will develop their clinical excellence and develop foundational clinical and academic skills. A key driver for the programme is to provide junior staff with insight, exposure and skill development and to develop their confidence to progress with their clinical academic careers.

5.3 The CNF initiative involves three main components: a bespoke development/mentorship opportunity with the Chief Nurse, they will experience the challenges of the modern NHS but also its innovation and development. The second component is a series of structured sessions including leadership skills, behavioural insight and the structure of the NHS at a national, regional and local level.

5.4 The third component is an improvement project that will provide exposure and skill development in evidence-based practice that is supported by clinical and academic mentors. The CNF will develop a project within their clinical area/CMG aligned to the Nursing and Midwifery Journey to Excellence, Trust Vision, patient experience or improvement outcomes and which fits with Pathway to Excellence® standards.

5.5 Our staff are our most valuable asset, the pandemic has demonstrated their resilience and also their desire to flourish and develop. The CNF programme will increase the development opportunities for our junior staff and presents an opportunity to create a project that will directly benefit patients, staff and/or a department area, drawn from the following:

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- Personal and Professional Development
- Broadening evidence based practice
- Research experience and broader understanding
- Coaching from the Chief Nurse
- Mentorship access from Senior staff
- Empowerment and Leadership
- Professional networking
- Building communication skills
- Championing Change
- Career pathway insight

5.6 The CNF will be supported throughout by our CNF Leads – Dr Rose Webster, Dr Jackie Elton, Antonella Ghezzi (Nursing and Midwifery Head of Research) and Natalie Green Deputy Chief Nurse.

5.7 The opportunity to apply for the first CNF cohort was open to all nurses and midwives across the Trust, they had to have had 18 months post-graduate experience and be supported by their CMGs to undertake an improvement project and be released one day a week. The programme proved very popular with some CMGs having to hold a selection process in order to put one candidate forward. The senior team decided to select the first cohort by means of a 'Dragons Den' style selection process and 5 applicants were chosen to be UHL's first cohort: Emma Barnett: bd6 NRU/BIU, Cassia Forty: bd5 Staff Nurse ED, Karen Green: bd6 Gastro ward, Gemma Paine: bd6 Midwife and Hazel Perrett: bd6 CICU Nurse.

5.8 Recruitment and retention of nurses and midwives is a national and international challenge against a known shortage and high demand. Organisations recognise that they need to offer several different opportunities by which the staff can develop and thrive in order to retain existing staff as well as becoming known as an organisation that values staff and creates career opportunities to attract new staff. Ultimately, the aim of the CNF programme is to be in line with the People Strategy in improving recruitment and retention, by driving towards being an employer of choice by providing a positive practice environment (Pathway to Excellence®) and providing the CNF a platform to develop, flourish and improve care.

6. East Midlands Operational Delivery Networks

6.1 The White Paper, *Integration and Innovation: working together to improve health and social care for all* (February 2021) describes changes in how the NHS organises itself and encourages greater collaboration between bodies responsible for providing NHS care. To operationalise this ambition, NHS England and Innovation (NHSE/I) has consulted on proposals focussed around Integrated Care Systems (ICS) including the introduction of *Provider Collaboratives* as a mechanism to improve outcomes for patients, assure resilience, enhance productivity and address issues of inequity through adopting a population health approach. The expectation that all Providers will be part of at least one Provider collaborative, including across multiple ICSs, is included in the H1 2021/22 Planning Guidance (March 2021).

6.2 Regionally, the existing clinical networks are seen as having an important role in the journey towards the establishment of *Provider Collaboratives* and/or *Accountable Service Networks* across multiple ICSs. During the pandemic, NHSE/I identified children's, cardiac, neurosurgery and renal *as essential services* which would benefit from a greater regional focus. UHL currently hosts the three children's Operational Delivery Networks (ODN), the radiotherapy ODN and the Haemoglobinopathy Coordinating Centre for the East Midlands. NHSE/I subsequently set out an intention to formalise the cardiac, neurosurgery and renal arrangements as ODNs through the publication of an Expression of Interest (EOI) on 22nd February 2021.

6.3 The Executive Strategy Board (ESB) agreed on the 2nd March 2021 that UHL should position itself in the emerging NHS landscape regionally and submit a collaborative bid with Nottingham University Hospitals (NUH) NHS Trust to host the cardiac, neurosurgery and renal ODNs. A joint bid was submitted to NHSE/I on the 12th March 2021 and on the 25th March NHSE/I indicated that our bid, which included a proposal to establish an East Midlands Acute Providers (EMAP) network, had been

successful. Further work is continuing to refine the UHL/NUH hosting agreements, structures and governance arrangements.

7. Developing Virtual Wards to Manage Long-Term Conditions Across the Midlands

7.1 At its meeting on 4th March 2021 (Minute 73/21/1 refers), the Trust Board received a presentation on the COVID-19 virtual ward initiative. The initiative has been selected by NHSX as a national innovation collaborative study and I have attached details at **appendix 2**, for information.

8. Conclusion

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

Rebecca Brown
Acting Chief Executive

29th April 2021

Quality and Performance Report Board Summary March 2021

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 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. Assurance rates key Green = Reasonable/Substantial Assurance, Amber = Limited Assurance and Red = No Assurance.

Quality and Performance Report Board Summary March 2021

Domain	KPI	Target	Jan-21	Feb-21	Mar-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Safe	Never events	0	0	0	1	7	?			Jan-20
	Overdue CAS alerts	0	0	0	0	0	P			Nov-19
	% of all adults VTE Risk Assessment on Admission	95%	98.7%	98.6%	98.6%	98.6%	P			Dec-19
	Emergency C-section rate	No Target	23.2%	21.7%	21.7%	21.1%				Feb-20
	Clostridium Difficile	108	8	5	7	78	?			Nov-17
	MRSA Total	0	1	0	0	1	?			Nov-17
	E. Coli Bacteraemias Acute	No Target	7	11	7	95				Jun-18
	MSSA Acute	No Target	3	2	4	32				Nov-17
	COVID-19 Community Acquired <= 2 days after admission	No Target	65.7%	61.7%	78.2%	69.8%				Oct-20
	COVID-19 Hospital-onset, indeterminate, 3-7 days after admission	No Target	15.1%	16.5%	8.3%	12.9%				Oct-20
	COVID-19 Hospital-onset, probable, 8-14 days after admission	No Target	11.3%	13.0%	6.8%	9.9%				Oct-20
	COVID-19 Hospital-onset, healthcare-acquired, 15 or more days after admission	No Target	7.9%	8.8%	6.8%	7.4%				Oct-20
	All falls reported per 1000 bed days	5.5	5.2	5.4		4.6	?			Oct-20
	Rate of Moderate harm and above Falls PSIs with finally approved status per 1,000 bed days	No Target	0.17	0.10		0.10				Oct-20
	Pressure Ulcers - All Validated	No Target	90	82	60	696				New KPI

Domain	KPI	Target	Jan-21	Feb-21	Mar-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Caring	Staff Survey Recommend for treatment	No Target	Reporting will commence once national reporting resumes							Aug-17
	Single Sex Breaches	0	National reporting commences in April 2021				?			Mar-20
	Inpatient and Day Case F&F Test % Positive	TBC	98%	99%	98%	98%		H		Mar-20
	A&E F&F Test % Positive	TBC	93%	94%	90%	94%		L		Mar-20
	Maternity F&F Test % Positive	TBC	96%	95%	97%	96%				Mar-20
	Outpatient F&F Test % Positive	TBC	95%	95%	94%	94%				Mar-20
	Complaints per 1,000 staff (WTE)	No Target								Jan-20

Domain	KPI	Target	Jan-21	Feb-21	Mar-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Well Led	Staff Survey % Recommend as Place to Work	No Target	Reporting will commence once national reporting resumes							Sep-17
	Turnover Rate	10%	8.8%	9.3%	9.3%	9.3%	P	H		Nov-19
	Sickness Absence (Excludes E&F staff)	3%	8.7%	7.3%		7.2%	F			Mar-21
	% of Staff with Annual Appraisal (Excludes E&F staff)	95%	79.4%	78.9%	80.2%	80.2%	F	L		Mar-21
	Statutory and Mandatory Training	95%	87%	88%	88%	88%	?	L		Feb-20
	Nursing Vacancies	No Target	12.9%	12.3%	11.9%	11.9%		H		Dec-19

Quality and Performance Report Board Summary March 2021

Domain	KPI	Target	Jan-21	Feb-21	Mar-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Effective	Mortality Published SHMI	100	100	100	101	101 (Dec 19 to Nov 20)				Sep-16
	Mortality 12 months HSMR	100	105	108	112	112 Jan 20 to Dec 20				Sep-16
	Crude Mortality Rate	No Target	3.3%	2.6%	1.5%	1.9%				Sep-16
	Emergency Readmissions within 30 Days	8.5%	9.8%	9.9%		9.5%				Sep-20
	Emergency Readmissions within 48 hours	No Target	1.1%	1.0%		1.2%				Sep-20
	No of #neck of femurs operated on 0-35hrs	72%	75.8%	73.0%	68.0%	66.8%				Sep-20
	Stroke - 90% Stay on a Stroke Unit	80%	86.5%	84.1%		86.6%				Mar-20
	Stroke TIA Clinic Within 24hrs	60%	67.1%	53.8%	60.8%	67.6%				Mar-20

Domain	KPI	Target	Jan-21	Feb-21	Mar-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Responsive	ED 4 hour waits UHL	95%	63.9%	68.7%	71.8%	73.1%				Mar-20
	ED 4 hour waits Acute Footprint	95%	74.5%	77.8%	79.8%	81.1%				Data sourced externally
	12 hour trolley waits in A&E	0	17	0	0	32				Mar-20
	Ambulance handover >60mins	0.0%	10.9%	4.2%	3.5%	4.7%				Data sourced externally
	RTT Incompletes	92%	56.3%	52.8%	51.1%	51.1%				Nov-19
	RTT Waiting 52+ Weeks	0	8,424	10,942	12,625	12,625				Apr-21
	Total Number of Incompletes	66,397 (by year end)	80,593	84,470	87,968	87,968				Nov-19
	6 Week Diagnostic Test Waiting Times	1.0%	44.3%	39.3%	35.9%	35.9%				Nov-19
	Cancelled Patients not offered <28 Days	0	39	32	7	265				Nov-19
	% Operations Cancelled OTD	1.0%	1.1%	0.9%	0.5%	0.9%				Apr-21
	Long Stay Patients (21+ days)	135	175	184	162	162				Sep-20
	Inpatient Average LOS	No Target	3.3	3.4	4.1	3.6				Sep-20
	Emergency Average LOS	No Target	5.6	5.3	5.1	5.0				Sep-20

Domain	KPI	Target	Dec-20	Jan-21	Feb-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Responsive - Cancer	2WW	93%	94.8%	92.7%	95.9%	91.8%				Dec-19
	2WW Breast	93%	95.1%	91.3%	96.0%	95.4%				Dec-19
	31 Day	96%	94.7%	87.2%	93.2%	91.6%				Dec-19
	31 Day Drugs	98%	100%	99%	98.6%	99.6%				Dec-19
	31 Day Sub Surgery	94%	74.3%	62.7%	78.7%	73.0%				Dec-19
	31 Day Radiotherapy	94%	94%	94.8%	97.5%	93.0%				Dec-19
	Cancer 62 Day	85%	73.6%	65.8%	62.1%	69.5%				Dec-19
	Cancer 62 Day Consultant Screening	90%	97.0%	63.3%	45.0%	65.7%				Dec-19

Domain	KPI	Target	Jan-21	Feb-21	Mar-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Outpatient Transformation	% DNA rate	No Target	6.9%	6.5%	6.5%	6.4%				Feb-20
	% Non Face to Face Appointments	No Target	50.9%	48.7%	45.8%	53.6%				Feb-20
	% 7 day turnaround of OP clinic letters	90%	84.0%	84.6%	83.1%	86.1%				Feb-20

Domain	KPI	Target	Jan-21	Feb-21	Mar-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Draft Urgent Care Standards	Mean Time to Initial Assessment	No Target	11.4	7.9	7.8	9.1				TBC
	Mean Time in ED	No Target	263	230	213	213				TBC
	Number of 12 hour waits in the Emergency Department	No Target	765	374	285	4032				TBC

Delivered in partnership with

The AHSN Network

NHS X

Innovation Collaborative.

Developing virtual wards to manage long term conditions across the Midlands.

Part one: planning and implementation.

REGIONAL INNOVATION SERIES
SUPPORTING DIGITAL TRANSFORMATION

Overview

Across Leicester, Leicestershire and Rutland the COVID-19 pandemic has helped to drive forward a rapid expansion of remote monitoring schemes which is allowing clinical teams to keep track of patients with chronic conditions safely and in the comfort of their own home.

Inspired by efforts to establish 'virtual wards' for heart and lung patients after the pandemic began, the region is upscaling and extending the use of technology across four care pathways:

1. **Phase 1** - Heart failure and COPD patients (first established spring 2020)
2. **Phase 2** - Digital rehabilitation for heart failure and COPD patients (summer 2020)
3. **Phase 3** - COVID-19 virtual wards for supporting hospital discharges or 'step down' (autumn 2020)
4. **Phase 4** – Virtual ward for supported hospital discharges extended to include patients on weaning doses of oxygen. (January 2021)

It forms part of a wider plan to improve digital health services for people with long term conditions, aiming to reduce the pressure on hospital services and improve outcomes by detecting and addressing signs of deteriorating health earlier among recently discharged and chronically ill patients.

3000

Remote monitoring devices to be deployed across the region in 2020/21

4000+

Patients treated for COVID-19 who have been discharged from the acute trust to date

(Source: University Hospitals of Leicester NHS Trust)

15-20k

People live with COPD or heart failure across the region

(Source: estimates based on British Heart Foundation and British Lung Foundation data)

31.6%

Of non-intensive care hospital beds were occupied by patients with COVID-19 at peak across the region

(Source: University Hospitals of Leicester NHS Trust)

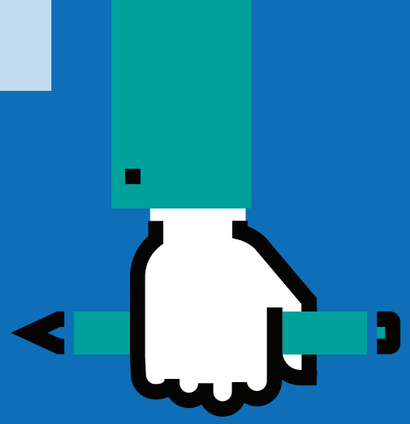
ABOUT THIS SERIES

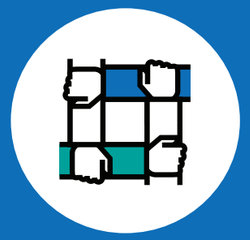
Health and care teams across England are increasingly using new technology to enable more care to be provided at home in response to the COVID-19 pandemic, supported by additional funding from NHSX. NHSX is also working with the AHSN Network to deliver the Innovation Collaborative to enable regional teams to accelerate deployment, and share learning and best practice.

The **Regional Innovation Series** takes an in-depth look at some of the exciting projects underway across the country. It explores the challenges and opportunities presented by new technologies and looks at their impact on people, processes, cultures and the practical tools available to patients, service users and frontline professionals.

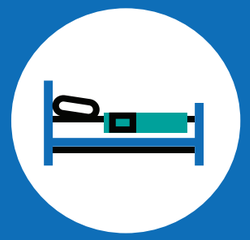
Each study will be followed by a second report capturing the key insights and reflections, once the project is fully established, with the aim of helping others embarking on similar programmes.

Project aims and ambitions





Protect clinically vulnerable patients by reducing the need for community clinics and home visits.



Reduce unplanned hospital admissions involving people with long term conditions, including those recovering from an admission with COVID-19.

Provide patients with better information and support to help them manage their condition and wider health and wellbeing.

Provide a viable blueprint to expand the use of digital technologies across the region and other care pathways in the future.

Who is involved

Three Sustainability and Transformation Partnerships (STPs) are working in partnership across the Midlands to develop, scale and evaluate the use of technology to support patients with long term conditions.

The Leicester, Leicestershire and Rutland project includes the following organisations:

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS

East Midlands Academic Health Science Network
Igniting Innovation

NHS
University Hospitals of Leicester
NHS Trust

NHS
Leicestershire Partnership
NHS Trust

What digital technologies are being used?

Across all four pathways, the technology is set up to help **patients self-manage their condition at home** while giving them support and reassurance that the monitoring equipment will ensure their clinical teams can act swiftly if their health deteriorates.

Patients capture relevant clinical data using monitoring equipment provided by their clinical team according to an agreed management plan. They then upload their patient data using a **computer, tablet or smartphone which connects to a web-based remote monitoring platform called CliniTouch Vie.**

This data allows health professionals to **spot long-term trends** in a patient's condition and **identify signs of deterioration earlier** and before they require hospital admission. The technology enables patients to have an assessment via video call with their health professionals if required and clinicians can send direct messages to their patients. The remote monitoring service is offered to all suitable COVID-19, COPD, heart failure and pulmonary rehabilitation patients and a **tablet is provided to any patient who needs one** – which they can keep for as long as they need to use the service.

Any changes to a patient's care and condition are documented in Electronic Patient Records (TPP SystmOne). Work is underway to assess interoperability across a wider range of systems.

Our approach is to always put the patient at the heart of this process. We haven't thought about organisational boundaries but have instead tried to walk in the patient's shoes as they move along the care pathway so we fully understand their perspective. As a result, I hope we've created a model that genuinely supports their needs.

Zoe Harris, Cardio-Respiratory Service Lead, Leicestershire Partnership NHS Trust

The impact on processes and practices

The model has been built around the needs of the patient, ensuring firstly that they receive the support they need to use the technology, and secondly that this enhances their control over their condition and enriches the dialogue they have with their clinical team.

Set up

Patients are given **personalised support to set up and use the technologies,** including a patient user guide, a demo session as part of their hospital discharge, telephone and video calls and even socially-distanced, face-to-face training at home if more help is needed.

Monitor

A management plan is discussed and agreed with the patient and they submit answers to **a set of questions and take vital measurements relating to their condition.** They upload this data which feeds through in real-time to the platform's central dashboard.

Alert

Parameters for individual patients based on their baseline data informs an algorithm in the system which **automatically flags patients who may be at risk or who are deteriorating using a red, amber, green health status.**

Intervene

A **multidisciplinary team,** made up of clinicians, nurses and physiotherapists, then work together to diagnose and treat the problem and prevent an unplanned hospital admission wherever possible.

The pandemic has made us think thoroughly about how we can co-ordinate different teams to improve the way we work with patients, carers and clinical teams. Our main aim is to give our patients the best possible care and reassurance, even more so in these challenging times, and a digital approach can help us achieve that. It also means we can be smart about how we use our resources so that we're able to cope with a bigger case load of potentially deteriorating patients more efficiently.

Irene Valero-Sanchez, Consultant Respiratory Physician and Clinical Lead for Integrated Care, University Hospitals of Leicester

Key actions and insights

We asked the core project team to highlight the key actions that helped them make progress on implementation and adoption by patients and practitioners. Here are their three reflections on the process so far.

Working across boundaries through clear governance structures

"A particular challenge for us was working across different STPs to define accountability and quickly develop a robust but straightforward governance and operational framework that we could then apply and adapt quickly and easily to future complex services. Working as a system rather than a single provider made this happen.

"Within this framework, we were able to bring together the right experts to predict potential issues and manage them head on, such as how we calculate and weight patient data calculations to a defined RAG status for the dashboard or the incorporation of data protection principles.

"We took the time to get these governance principles right and the solid foundations we laid in the very early days are now yielding success. This is demonstrated by the speed in which we've implemented successive projects, sometimes in just as little as one week. We're now in the position where we can expand our care offering at real speed."

Nisha Patel, Senior Elective Care Services Manager, Leicester, Leicestershire and Rutland CCGs

Active listening to put the end user at the heart of the process

"We've never shied away from listening to our clinical team's feedback, who act as our 'critical friends'. For us it's the natural thing to do, as we are all invested in the project's success – and their clinical insights have helped to create a service that really does embody the care principles that we set out to achieve and reflect in this new pathway putting the patient at the centre of all our decision making.

"Throughout the project we've made a conscious point of using the 'You said, we did' model in regular meetings, forums and training sessions to demonstrate that feedback is listened to and incorporated throughout the project stages.

"Within any project there's a lot for colleagues to take on board and adapt to, but our active listening approach has also supported the emergence of 'champions' who've supported colleagues to culturally and practically adopt the various pathway processes."

Zoe Harris,
Cardio-Respiratory Service Lead,
Leicestershire Partnership NHS Trust

Creating 'front of house' ambassadors for technology

"We realised that creating new, dedicated roles or adapting existing administrative roles within our hospital wards to support the virtual ward process was, and continues to prove to be, critical to the success of the patient onboarding process.

"The unpredictable nature of the pandemic meant we needed a group of colleagues, with the capacity protected within their roles, to talk to patients about the positive impact remote monitoring could have on their physical health and emotional well-being while providing the context for the rationale of using technology in this way.

"These colleagues work closely with front-line practitioners and as 'virtual ward ambassadors' they are on hand to offer the opportunity to any patient who wants to be cared for in this way while providing the vital administrative support."

Irene Valero-Sanchez,
Consultant Respiratory Physician
and Clinical Lead for Integrated Care,
University Hospitals of Leicester

> Thanks for getting me well. I came in needing a lot of oxygen. With the care, dedication and support of the team I was able to leave 8 days later and I have continued to improve. Thank you for setting up the 'remote monitoring app'. It gives confidence you are still being monitored.

Thank you note from a patient with COVID-19 who joined the remote monitoring programme following their discharge from hospital

> Any system is only as good as the people that use it. I feel more able to manage my heart failure as I have learnt what's normal for me as I have recorded my data. I am reassured that my nurse is reviewing my data on a daily basis and will contact me if needed to see how I am and make any changes to my care.

Testimonial from a patient with heart failure who was supported by the project

IMPACT

900+

Patients have been supported across the four pathways including

700+

Patients with heart failure and COPD

(1 April 2020 – 5 March 2021)

50

Patients with heart failure and respiratory conditions have been supported so far through the digital rehabilitation pathway

(1 September 2020 – 5 March 2021)

172

COVID-19 patients have been discharged after a hospital admission with remote monitoring at home with only eight people being readmitted to hospital during their 14-day monitoring period.

(2 November 2020 – 5 March 2021)

20

Oxygen weaning patients have accessed the COVID-19 virtual ward

(20 January 2021 – 5 March 2021)

For more information about this project supported by NHSX:

Zoe Harris, Cardio-Respiratory Service Lead,
Leicestershire Partnership NHS Trust
E: zoe.harris@leicspart.nhs.uk

Irene Valero-Sanchez, Consultant Respiratory Physician and Clinical Lead for Integrated Care, University Hospitals of Leicester
@Ire_Valero

Nisha Patel, Senior Elective Care Services Manager
Leicester, Leicestershire and Rutland CCGs
E: nisha.patel@westleicestershireccg.nhs.uk

To find out more about the Innovation Collaborative:

Existing members can access the Innovation Collaborative Digital Health workspace on the FutureNHS platform by visiting **future.nhs.uk/innovationcollaborative**.

Please e-mail **InnovationCollaborative-manager@future.nhs.uk** to request to join.