

Becoming
the best

NHS

University Hospitals
of Leicester

NHS Trust



Our 3 Year
Quality Strategy
and Priorities
2019-2022

This document is designed to give everyone who works in our Trust, our partners and the public, a clear sense of where the Trust is heading, what we consider to be important, how we're going to get there and how long it might take.

Introduction

We work in interesting and challenging times for perhaps the only national organisation anywhere on the planet that can justifiably say it is involved in the lives of every citizen in the country. Every day we are party to joy and despair, often in equal measure; we bring babies into the world, fix broken bodies, relieve suffering, cure illness and at life's end we try to give people a good death.



On the whole the public recognise this, despite what they see in the media, our staff perform major and minor miracles on a daily basis almost unnoticed; though of course when we get things wrong, it makes the news.

All of which means that anybody working in the NHS, and at Leicester's Hospitals, should be proud of their contribution to the health and wellbeing of the people we serve, regardless of the jobs they do. Sure, doctors, nurses and other health professionals are at the centre of care, but let's not forget that the cleaner who pays particular attention to their ward is playing their role in infection prevention; the clinic clerk who makes sure their clinic operates like clockwork is helping to manage waiting lists, and the porter who wheels a patient to theatre and chats on the way is soothing a troubled mind.

So, for every lifesaving procedure which takes place in theatre there is a cast of hundreds of people who contribute in some way and we should therefore recognise that when 'the team' is at their best, they are unbeatable.

This document is designed to give everyone who works in our organisation, our partners and the public, a clear sense of where we are heading, what we consider to be important, how we are going to get there and how long it might take.

What you will read in this booklet builds on the earlier 'Delivering Caring at its Best' (our 5 year plan), and therefore is a development of our thinking rather than a change in direction; that is a very important point because we have known through the work we have done over many years what our objective is: to create a clinically and financially sustainable Trust with the right clinical services on the right sites in support of our ultimate goal - to deliver "Caring at its Best" for every patient, every time. That has proved easier to say than do! We know that to reconfigure the hospitals will require money, around £400m in fact, and though we are quietly confident that our case for investment is well positioned nationally we are some way off approval. But whilst reconfiguration to finally address the flaws in our historic distribution of services is crucial it is by no means our only strategic imperative.

Caring at its best

Contradiction and contrast

Our Trust has many strengths; some of our clinical services are genuinely class leading in terms of their clinical outcomes, many of our specialist services are underpinned by strong research portfolios and perhaps most of all we recognise, as do others, (the CQC for example) that our teams are overwhelmingly caring and compassionate.

And yet, despite these inherent strengths we have struggled to achieve and particularly maintain consistently high standards of quality and performance. Which is why in two successive CQC inspections we have been fairly judged as 'Requires Improvement'.

Some of this arises out of the historic lack of investment in Leicester's Hospitals. So, for example it is interesting to contrast how cutting edge technology and equipment has been designed into our new Emergency Department and at the same time our outpatient clinics are reliant on an army of people pushing around patient notes in trolleys.

In the same vein, the fact that our staff are recognised as being caring and compassionate is creditable but if we don't have enough staff, it makes creating the time to care more difficult.

Whilst it is recognised that some of the issues we want to address require significant investment, or in the case of staffing, simply more new nurses out of

training, there are many other improvements we can make that don't necessarily carry a huge price tag.

If that is the case, the question is why have we struggled to do it?

Organisation and focus

We have spent a great deal of time lately looking at the characteristics of successful and high quality hospitals; in doing so, some themes emerge, most notably that the best hospitals have two things in common. First, a clearly understood and universally practised approach to Quality Improvement (QI) that starts with the Trust Board. And second, a determined focus on a relatively small number of key quality priorities.

That being the case, and reflecting on our approach to date, we have not got this right, yet. Specifically, we have not had a universally understood approach to quality improvement and we have tried to do too much at once.

Our Trust has many strengths, yet despite this we have struggled to maintain consistently high standards of quality and performance



The next section describes how we plan to change with a new approach, 'Becoming the Best'.

'Becoming the Best': Our Quality Strategy

The purpose of our quality strategy is to address the issues we have **just talked about** and thus move us closer to our ultimate goal - delivering "Caring at its Best" for every patient, every time. It is a major shift away from how we have done things in the past and reflects how the best hospitals work.

'Becoming the Best' provides a framework for conversations across the Trust. These conversations will be important in harnessing the collective expertise of everyone in our organisation, not least because it is most often the people doing the job who know best about how to improve it.

There are six core elements which will frame these conversations:



Becoming
the best



Let's look at those in a little more detail...

The Six Core Elements

Becoming
the best

Understanding what is happening in our services

In order to decide what needs to be improved, it is essential to understand what is really happening in our services. Let's be honest, we are not short of data when it comes to measuring performance and processes, but we often confuse data with 'insight'. Data might well tell us that something has happened, but it is insight that leads us to understand why; and whether it is likely to happen again.

Sometimes the opposite is also true and we accept received wisdom as fact when the data shows that the truth is something entirely different... this leads to problems 'hiding in plain sight'.

Thus the cornerstone of our new approach to Quality Improvement (QI) will be to properly investigate and understand the nature of the things we want to change before we set about thinking about how to change them.

Clear priorities and plans for improvement

For the last five years, our priorities for improvements in the quality and safety of our services have been set out in our Quality Commitment, whilst other priority schemes were captured in our 'Annual Priorities'. This year and for the future we have changed that approach in favour of a unified set of priorities all of which are all designed to improve quality and safety, either directly or in a supporting way.

At the same time we have been more realistic about the number of priorities we will pursue and thus we will focus on six quality priorities and six supporting priorities during 2019-2022. (See diagram on page 7).

The right kind of leadership

The CQC report "Quality Improvement in Hospital Trusts" states that "the most important determinant of quality of care is leadership. Leaders must model appropriate improvement-focused leadership behaviours and a visible, hands-on approach." Leadership here includes leaders at all levels, not just those in senior positions.

Embedding an empowered culture of high quality care (including patient empowerment)

Successful, sustained improvement requires not only the right skills/methodology, but also the right culture.

Feedback from our last two CQC inspections indicates that our staff have a good understanding of the values and vision of the organisation. But scores for engagement and empowerment remain moderate. Equally we often hear from staff who have tried their best to get an improvement idea off the ground but have felt thwarted at every turn by the 'system' or our own internal structures.

Changing and sustaining a renewed culture takes time, energy and effort but will be central to the success of the Quality Strategy.

Giving people the skills to enable improvement

Improvement or just simple 'change' is difficult, largely because it starts with the idea that whatever currently exists could be bettered, and if you are part of the current set up you may think it is perfectly fine as it is. Improvement in healthcare can also be complex, involving lots of moving parts, so upskilling staff to take part in, or lead, improvement work means we have to equip them with tools that enable them to deal with both operational complexity and the equally complex nature of human relationships.

Working effectively with the wider system

Within our local system there have been, and continue to be, good examples of collaborative, cross-boundary, improvement work. Examples include the frailty and multi-morbid pathway improvement programme, work to reduce the number of stranded patients and improve discharge processes.

Recognising that there is little that we do in hospital that does not have an impact on other players in the system, we will expect all of our QI activity to have considered and included the implications for the system in the work.



Involving patients, the public and stakeholders

In Quality Improvement methodology the central role of patient involvement is explicit and in the construction of our 2019-22 priorities the voices of patients and stakeholders were influential. Our reconfiguration plans have been informed over many years by patient feedback and when we receive permission to formally consult on those plans we will once again test them with our stakeholders.

As we said at the very start, the NHS is unique inasmuch as it is involved in the lives of every citizen in the country. It is also unique in another way, though being 'free at the point of need'; it is in fact for many people a service which they have paid for through taxation, years in advance of being frequent users. With that in mind, being asked about, and involved in, the planning of services is both a 'right' and an expectation.

In saying that we also need to be clear that the outcome of involvement, engagement and consultation rarely, if ever, pleases all parties largely because it seeks to navigate a path between what is clinically safe and acceptable, what is most desirable for the many and the few and ultimately what is affordable. Nonetheless, our desired approach has to be that given the significant changes in health and social care that we want to bring about, we should recognise that we stand a greater chance of 'getting it right' if we involve the people who use our services in the planning of those services. This is particularly important when considering the population we serve. It is only by actively engaging with our many and diverse local communities that we can understand their experience of health care and build services that are mindful of their needs and expectations.



Resource for Quality Improvement

There is no shortage of talent in our hospitals but time is often our scarcest commodity. The day job feels all-consuming and can stand in the way of the time required to think and plan for an alternative, better future. It is noticeable and with hindsight, obvious, that some of our most successful improvement work, for example the recognition and treatment of sepsis, has been enabled by committing dedicated resource to the project.

But resource doesn't have to mean 'more', it can also be created by thinking differently about the resources we already have and being absolutely clear about what the priorities are.

So, whilst we absolutely will be putting money into resourcing for Quality Improvement (over £1m in fact), the more important thing to bear in mind is that our greatest resource is the 16,000 people who work for our hospitals and if we can harness their ambition, drive, creativity and passion then we will have created a real force to be reckoned with.



Focus and stamina

We are one of the top five largest Trusts in the country, with 66 different clinical services, three large hospitals, 16,000 staff and an income of nearly £1 billion. In that context deciding where to focus our quality improvement work was no easy task. That said the guiding principle was that we know we have to focus on fewer things and execute them brilliantly.

We also had in mind that if the things we chose as priority areas for improvement were easy to accomplish, we would have done them by now; so in a significant change to previous years we have narrowed our focus down to 12 priorities and set ourselves up to three years to achieve them.

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Our Priorities 2019-2022



Our priorities for the next three years are depicted in this diagram.

You will see that there are six quality priorities and six supporting priorities.

Sitting below the priorities in the diagram are the Quality Improvement Methodology and our long standing and well regarded Values.

In other words the priorities are the **WHAT** we are going to do; the method is the **HOW**; and the values govern how we behave on the journey called 'Becoming the Best'.

Linking the cogs together is the chain of Patient and Public Involvement which reminds us that our patients and the wider public are the people we are trying to get this right for.



Our quality priorities



We will embed safe and effective care in every ward and clinic by introducing a Trust wide **assessment and accreditation** framework

There are 100 wards across our three hospitals and hundreds of outpatient clinics. One of the things which they have in common is that overwhelmingly the staff are caring and compassionate. However there is also too much clinical variation across wards and outpatient clinics meaning that best practice in terms of quality, safety and patient experience is not as universally applied as it ought to be. The assessment and accreditation scheme will support wards, clinics and their leaders to understand and address issues where they find them and measure the success of their improvements in a standardised way.

"Patient harm in healthcare is one of the top ten causes of death and disability in the world. Reducing harm is everyone's job and has been high on our agenda for the last few years but we still have serious Patient Safety Incidents and Never Events which would have been entirely preventable if individuals and clinical teams had properly followed checking processes designed to keep patients safe. This has got to change - we wouldn't get on a plane if we thought the pilot and crew weren't doing the pre-flight checks properly and it should be no different in healthcare for our patients.

We are determined that through training, support and learning from these mistakes, we will make our hospitals safer for our patients so that Never Events become a thing of the past."

We will consistently implement the **safest practice for invasive procedures**, with a focus on consent, NatSSIPS* and the Five Steps to Safer Surgery; and we will improve our learning when things go wrong

It is often said, but not always fully understood, that hospitals are inherently dangerous places. Medicines, if wrongly administered can be toxic; infections can spread easily without the right degree of personal and environmental hygiene and invasive procedures can put patients in harm's way if safety checks are not followed. It is therefore the duty of all of us who work in hospital to minimise the risks to patients at all times.

It is hard to argue with that, yet we still see too many occasions where something has gone wrong which would have been entirely avoidable if only the right procedures had been followed. In the most serious cases these are called 'Never Events' and are defined as 'a serious incident or error that should not occur if proper safety procedures are followed'. For clarity this is not about missed diagnosis or the failure to spot a deteriorating patient, rather it is a failure to abide by simple, common sense rules that are designed to make it impossible to, for example, carry out a procedure on the wrong patient; leave a swab in a patient post procedure or insert the wrong device into a patient.



"We want to make sure that no matter which ward or clinic you are cared for in that they all have the same standards, processes and approach to caring for our patients. Making sure that all of our wards are delivering safe, high quality, compassionate care is central to this work."

Carolyn Fox
Chief Nurse

Andrew Furlong
Medical Director

*NatSSIPS (National Safety Standards for Invasive Procedures)



We will implement **safe and timely discharge** for all patients in our care, seven days a week, by embedding safer discharge processes and eliminating avoidable delays

On the whole, nobody would want to stay in hospital a moment longer than is absolutely necessary. For many patients a delay to their discharge is not just frustrating and inconvenient, it is actually detrimental to their health and independence.

We discharge between 150 and 300 patients a day and though most of those patients will have a good experience of the discharge process, a significant minority will not. Medications To Take Out (TTOs) are often not written up early enough, the discharge summaries which explain to GPs what has happened to a patient and what needs to happen next are sometimes of poor quality, and the process can take so long that the patient who was expecting to go home or to a care home has to be put back into one of our beds for another night.

Recognising that discharges are increasingly complex because our patients are increasingly complex, we know that this is as much an issue for the system to resolve as it is the Trust. Nonetheless, we must make sure that our end of the process is better managed, so amongst other improvements we will expect that all patients admitted to hospital will have an Expected Date of Discharge set the day they are admitted.

"20% of pensioners who attended an outpatient appointment reported feeling worse afterwards because of the stress involved in the journey alone."

Royal College of Physicians

"A patient over 80 who spends 10 days in hospital loses 10 per cent of muscle mass – equivalent to 10 years of ageing"

Dr Stephen Powys, NHS England Medical Director

We will provide high quality and timely diagnosis and treatment for patients on **cancer pathways** by redesigning those pathways in conjunction with our partners

In the last few years we have seen unprecedented growth in the numbers of patients referred to us for cancer diagnosis and treatment. At the same time our teams have worked hard to keep up with the demand, but with, for example, a 10 per cent a year increase in referrals for Urology and 18 per cent in skin cancers, we know that just trying to do things in the same way only faster will not work.

Instead, through a combination of investment and innovation we will seek to redesign our key cancer pathways to eliminate delays and unproductive waits for patients and the clinical teams.



Our quality priorities

We will work as a system to create safe, efficient and timely **urgent and emergency care**, with a focus on embedding acute frailty and same day emergency care

Despite having the most modern Emergency Departments in the country, our performance against the 4 hour standard remains poor. The fact that most of the rest of the NHS is now also struggling with the target and that the target itself is being reviewed does not change the fundamental issue that too many patients wait too long before being seen, treated, discharged or admitted.

Clearly it is a complex problem and not all the solutions will be within our direct control, but that does not absolve us of the responsibility to improve, especially those things that are directly under our own control. Hence we will seek to better understand what is driving demand and prioritise changes across the system whilst at the same time ensuring our internal pathways are as safe and as efficient as they can be.

Much of the growth in admitted emergency activity is for frail and multi-morbid patients who spend one to two days in hospital. Many of these patients could be safely and effectively managed using a 'same day emergency care' approach which aims to deliver assessment, diagnosis and treatment on the same day, without an overnight stay. Recognising and streaming these patients to the right service will be a key factor in improving emergency care performance, not to mention clinical outcomes.

We will provide high quality, efficient integrated care by **redesigning pathways** in key clinical services to manage demand, improve use of resources and deliver financial improvement

We provide 66 different clinical services across the Trust, more if we include sub-specialties. In a perfect world we would have the time and resource to devote to improvement activity, pathway redesign and productivity in each service but the world is not perfect and therefore we have to focus our efforts where the opportunity is greatest.

Over the last year, using information from our own performance and quality metrics, supplemented by national peer comparisons from the likes of the 'Getting it Right First Time' (GIRFT), programme, we have begun to focus on a number of services which in the round have the greatest potential for quality, performance and financial improvement. We call them the 'Vital Few'.

It is important to recognise that in most if not all of our services, activity is increasing whilst our ability to cope with the activity is not keeping pace. As a consequence a key principle of the work on integrating and redesigning care pathways is that we should only bring patients into hospital for work that cannot be done safely and effectively elsewhere. This may seem problematic given that every patient we see brings income to the Trust, but the fact is that as we move ever closer to becoming a genuinely Integrated Care System, we will increasingly need to plan our services in such a way that we continue to serve the best interests of our patients but then elevate what is 'best for the system' over what is 'best for the Trust'.

"We will increasingly need to plan our services in such a way that we continue to serve the best interests of our patients but then elevate what is 'best for the system' over what is 'best for the Trust.'"

Mark Wightman

Mark Wightman
Director of Strategy and Communications



The system through which we are paid is being changed to make it easier for us to do that.

A major part of the work to integrate and redesign care pathways will centre upon outpatients. We currently see almost 1 million outpatients a year... most of them are follow up appointments. In the NHS as a whole outpatients has been somewhat overlooked so whilst resource, time and innovation have gone into improving emergency care, cancer treatment, stroke and other high profile services, the delivery model for the vast majority of our patient contacts has remained largely the same since the birth of the NHS 71 years ago.

For example, we routinely bring multi-morbid patients into single disease outpatient clinics; we routinely follow up patients face to face rather than in virtual/ telephone/ multimedia enabled clinics; and we rarely use patient initiated follow ups which would give patients some control over the management of their condition.

The NHS Long Term Plan clearly sets out the expectation that there should be a 30 per cent reduction in outpatient appointments over the next five years. That is not about rationing, rather about targeting time and resources effectively to the people who need it most instead of perpetuating a model that has had its day.

"Much of the growth in admitted emergency activity is for frail and multi-morbid patients who spend one to two days in hospital, many could be safely and effectively managed using a Same Day Emergency Care approach which aims to deliver assessment, diagnosis and treatment on the same day, without an overnight stay."

Rachel Marsh

Rachel Marsh
Clinical Director for Emergency and Specialist Medicine



Our supporting priorities

Underpinning the six direct Quality Priorities, are six Supporting Priorities

We will begin implementation of our new **Quality Strategy**, focussing initially on developing the right culture, leadership and skills to encourage and enable improvement

The first part of this document explained in some detail the approach we are taking in the Quality Strategy. Suffice to say that, 'Becoming the Best' is not a flash in the pan initiative that is here today and gone tomorrow, but a concerted, resourced and evidence-based approach to quality improvement that we will follow with rigour and stamina.

We will implement our **People Strategy**, with a focus on attracting and retaining the staff that we need and developing new roles where these will help improve care

It has become a cliché to say that staff are the NHS's greatest asset but it is nonetheless true; without the right staff, with the right skills in the right numbers, the job is harder and sometimes nigh on impossible to do.

Using nursing as the example, we recognise that whilst the job is rewarding, it is hard work physically and intellectually and often demands extraordinary degrees of emotional resilience. We currently employ 99 per cent of the nurses who train locally, but when retirements and leavers are factored in we are really only trading water.

Our People Strategy seeks to address this, not only in nursing, but across all roles. Our aim is to encourage more people from all disciplines to consider our Trust as their employer of choice by promoting our Values, being explicit about career development opportunities and supporting people to be their best. We can achieve this by being creative in thinking about new roles and enabling people to operate at the full extent of their potential and by being as flexible and innovative as possible in recognition that family, children and friends and having the time to take care of oneself should not suffer when work is hard.

Our People Strategy goes beyond legal compliance as we strive to achieve excellence in equality, diversity and inclusion in all that we do.



Our supporting priorities

We will invest in our current estate in order to provide safe and effective care including delivering the next stages of our reconfiguration and pursuing the business case for our longer term plan

Our overall reconfiguration plan should be well known, (for a reminder see page 14). But whilst we continue to refine our case for the major investment, there is still work to do.

Following the interim intensive care and associated services investment (£30m) that we received in 2018, work is underway. We are moving Level 3 intensive care and associated services from the General to the Royal and Glenfield Hospitals. Construction work for the scheme started in February 2019 with a final completion date of March 2020. Detailed planning work has started across the Trust for the delivery of a series of complex service moves between sites. The service moves are currently expected to take place in early 2021. Arising from this we expect significant benefits will be delivered by streamlining patient pathways and improving our delivery of daycase services.

At the same time the first phase of our plan to create a standalone Children's Hospital, the only one in the East Midlands, will begin this year as we start the enabling work on the Kensington Building so that we can bring the East Midlands Congenital Heart Centre from Glenfield to the Royal in December 2020.

Whilst it is encouraging that we are making continual, incremental improvements to our estate, it should also be recognised that we are in a slightly precarious position whereby the more time that elapses between our current configuration and where we need to be when fully reconfigured, the more the pressures and risks build in some key clinical services and key infrastructure.

For example, we recognise that in neonatology the current split site working between the Royal and the General is causing significant issues with our ability to effectively manage consultant on call rotas, in simple terms we have too few neonatologists, spread too thinly across two sites.

In our Intensive Care Unit at the Royal we know that we are well short of the required capacity to manage expected caseloads and as a consequence we are routinely living hand to mouth in terms of available beds.

More mundane, but still critically important to our ability to function, is the fact that our 'backlog maintenance' list grows larger and more expensive the longer we are caught between current and future state. This means that our estates colleagues are constantly having to create sticking plaster solutions to issues that really require a permanent solution.

We are confident that reconfiguration will happen but in the meantime, we are balancing our very limited capital with increasing levels of clinical and estates risk.



We will support safe and effective care by progressing our e-Hospital plans to implement user friendly and integrated solutions that make people's jobs easier to do

For those of us working in the NHS it is interesting and often frustrating to consider the comparative ease with which we are able to use technology to take the hassle out of life outside work (online banking, travel, school reports, shopping etc). Whilst patients using our services are often surprised that their information and records are not readily accessible to all those people who are involved in their treatment and care.

We know that technology, even at its simplest, has the potential to improve the quality and experience of care, to improve safety and to make people's jobs easier to do. We have long held the ambition to have a single Electronic Patient Record accessible to all clinical teams so that clinical decisions can be made with full access to all relevant information; so that lost and duplicate notes are a thing of the past; and to avoid us having to ask patients for their name/ date of birth/ NHS number and address at every contact. As such by 2022 we aim to have all information available about a patient through a robust single patient record.

To support and hasten the integration of health services across the local system we will introduce an easy access system for GP/ partner information. And to improve safety we will automate clinical escalation so that our teams are prompted when results and monitoring show that a patient is at risk of deteriorating.

This will mean that our staff will spend less time looking for information because the information will be readily available in an easy to read manner. We will spend less time writing to patients and more time contacting patients using their preferred method. Patients will spend less time and be less frustrated with our administrative processes because they will be increasingly in charge of their data and bookings.

We will maximise the opportunities for our patients to benefit from research, including launching our new 'Academic Health Science Partnership'

We have a good research track record exemplified by our status as a Biomedical Research Centre, but we think we can take that further by working with our partners in the University of Leicester and Leicestershire Partnership NHS Trust.

For research to thrive it has to be seen as core business rather than an adjunct to our clinical services and therefore in part, the research we do must contribute to our ability to care for our patients and wider population in an effective, high quality and sustainable way. As such we are embarking on a new and exciting venture to create an Academic Health Science Partnership which will focus on population health management, genomics, frailty and multi-morbidity and 'big data'. The success of this partnership and the themes we wish to pursue will attract funding and talent to Leicester, which in turn will benefit the local economy and the health and wellbeing of the local population.

"Leicester massively over-punches in terms of both our cutting-edge clinical research and in the quality of training for medical and allied health professionals. This is reflected in the Shanghai Index that ranked us as one of the top centres for clinical medicine in the world – the highest ranked UK centre outside the Oxbridge-London 'golden triangle'.

Our success is built on the strengths of the partnerships between the University of Leicester and the NHS trusts in our city. The creation of the Leicestershire Academic Health Science Partnership is the next step in the evolution of our relationship, as together, we seek to provide the very best possible care for our population."

Prof Philip Baker
Pro-Vice-Chancellor and Dean of Medicine



We will provide more effective and efficient corporate services to support our staff and Clinical Management Groups

There is a tendency in the NHS to group staff into two categories; 'frontline' and 'back office' and as such we often hear that the 'frontline' must be protected even at the expense of the back office. That distinction is false. There are very many people working in our hospitals who have little or no patient contact and are therefore invisible to the average patient or member of the public, but if they were not there, the 'frontline' would very soon grind to a halt. Many of these people are embedded in our Clinical Management Teams and do crucial jobs like scheduling the smooth running of our operating theatres; making sure that supplies arrive on time, maintaining waiting lists and booking clinic appointments.

Then there are 'Corporate' services like Human Resources, Finance and Procurement and Estates and Facilities; these corporate functions ensure that staff are paid on time, that new recruits are successfully inducted, that bills are settled, equipment ordered and essential maintenance is carried out, all of which is crucial to maintain the smooth running of our hospitals.

Hazel Wyton
Director of People & Organisational Development



"Our drive to improve the quality and effectiveness of our clinical services has to be matched with an equivalent ambition for our corporate services. Our plans include faster recruitment processes, better payroll systems and improved finance and business information to support our clinical management teams."

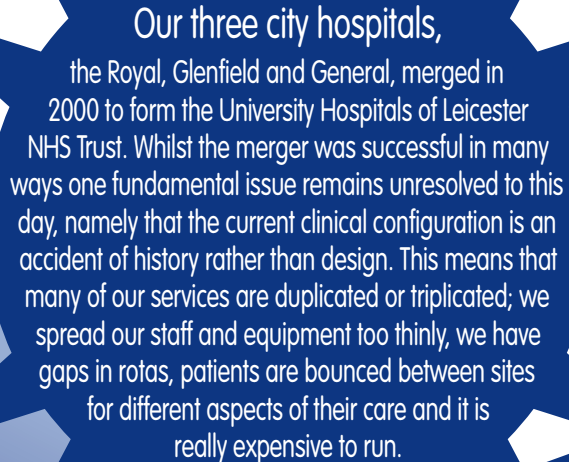
Hazel Wyton



So far we have looked at how we will adopt a universal Quality Improvement approach to our work and where we will focus that effort over the next three years in terms of our priorities. Now here is a reminder of our longer term reconfiguration plans...

A reminder of our reconfiguration plans

To understand what we want to do in the future, it is important to understand how got to where we are now.



Our three city hospitals, the Royal, Glenfield and General, merged in 2000 to form the University Hospitals of Leicester NHS Trust. Whilst the merger was successful in many ways one fundamental issue remains unresolved to this day, namely that the current clinical configuration is an accident of history rather than design. This means that many of our services are duplicated or triplicated; we spread our staff and equipment too thinly, we have gaps in rotas, patients are bounced between sites for different aspects of their care and it is really expensive to run.

Our first attempt

to sort this out for all of our services hit the buffers in 2007, it was called 'Pathway' but the scheme collapsed when the investment required from government reached £900m. There was then a 10 year period of minimal investment. This ended in 2017 when we opened the first phase of the new Emergency Floor at the Royal. This was followed in 2018 by the second phase, bringing the total investment to £50m.

We also spent £14m

creating a new base for our Vascular service and a hybrid theatre at Glenfield. And as described earlier, work is underway with plans to move our level 3 intensive care and associated services, and relocate congenital heart surgery, bringing the total investment to date in our hospitals to **over £108m**. Although we have made progress, there is much work still to do.



Our Plans

So far we have described some of the improvements that have either happened or are in progress now. Here are some of the main building blocks of what still needs to be done



Glenfield Hospital

Treatment Centre

The core of our long held clinical strategy is to separate emergency and planned care so that the one does not overwhelm the other when demand is at its highest.



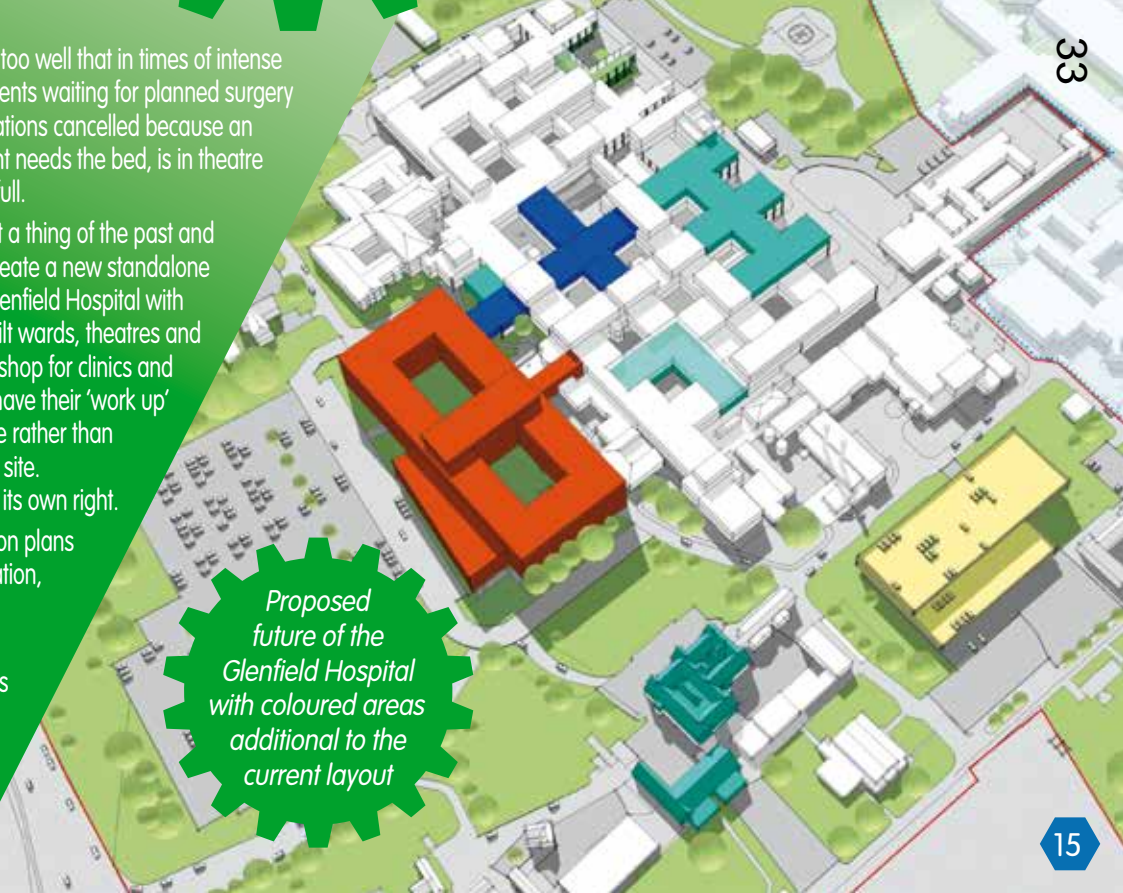
We know all too well that in times of intense pressure, patients waiting for planned surgery have their operations cancelled because an emergency patient needs the bed, is in theatre or intensive care is full.

We want to make that a thing of the past and to do that we want to create a new standalone treatment centre at the Glenfield Hospital with state of the art, purpose built wards, theatres and imaging facilities; a one stop shop for clinics and investigations so that patients have their 'work up' done in one day and in one place rather than being bounced around from site to site. Essentially it is a day case hospital in its own right.

In common with all of our reconfiguration plans this is of course subject to public consultation, but we believe that it would be genuinely transformative for our patients and our staff.

The scale of the Treatment Centre only becomes apparent when viewed alongside the current layout of Glenfield. It will increase the overall size of Glenfield by around 30 per cent.

Proposed future of the Glenfield Hospital with coloured areas additional to the current layout



New Intensive Care Unit

Our existing ICU at the Royal is very cramped and does not have enough bed capacity for all the patients that require intensive care.

We therefore plan to spend £30m creating a new ICU which will have 48 beds in comparison to the current 21. The new unit will have much larger bed spaces to create an environment which is better for both patients and staff.

The increased capacity will mean that patients who need ICU care will get it, which will in turn relieve pressure on our other wards. The expansion at the Royal will be complemented by expansion of the ICU at Glenfield.

Proposed future of the Royal Infirmary with coloured areas additional to the current layout

New Maternity Hospital

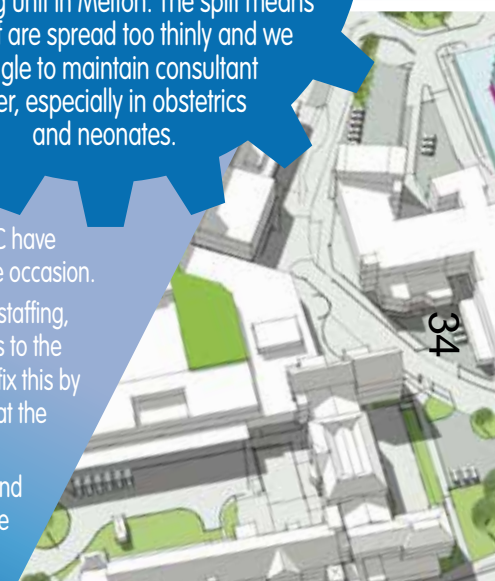
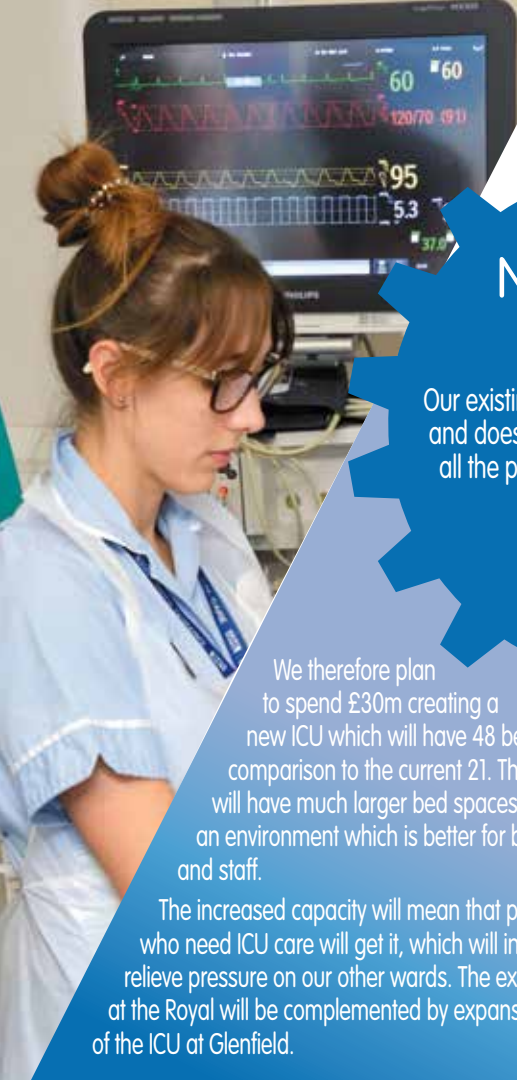
Our maternity and neonatology service is currently split across two main sites at the General and the Royal, with a small midwife led birthing unit in Melton. The split means that staff are spread too thinly and we struggle to maintain consultant cover, especially in obstetrics and neonates.

In the longer term that is not good for safety or sustainability as the CQC have pointed out to us on more than one occasion.

At times of high demand and/or low staffing, our maternity units have to divert mums to the other site for their deliveries. We want to fix this by bringing maternity and neonates together at the Royal in a new dedicated Maternity Hospital.

This would allow us to offer obstetric led birth and a co-located midwife led unit with neonates in the same building. This would mean that women could choose a less 'medical' delivery but be close enough to the staff and equipment to support them should something go wrong whilst their baby is being born. Just as importantly, it concentrates skilled staff and expensive equipment in one place, meaning we are less pressured when demand is high.

Separately, we will consult on closing the Midwife Led Birthing Unit in Melton which is under used – just one baby delivered every two and a half days – and move the service to the General where we think it will be better used and be better accessed for more of the local population.



Royal Infirmary

Leicester Children's Hospital

We want to create a new standalone Children's Hospital.

Proposed standalone Children's Hospital

We have the biggest Children's Hospital in the East Midlands, but you would not know it. Not least because the majority of our children's services are dotted around the Royal Infirmary amongst adult inpatient areas. Then of course we have children's heart surgery based at the Glenfield.

So the plan is that when we vacate the Kensington Building and move the maternity services into the new maternity hospital, we will turn the Kensington Building into a new standalone Children's Hospital. As with all our plans the key theme is getting all the right services into the right place. With the Children's Hospital this is doubly important because not only does it mean we have all the children's clinical team together at last but it also means we can create an environment that is age appropriate, welcoming and less scary for our youngsters.

Given the long term nature of this plan, it is very important that whilst it is being implemented, we continue to fully support the work of the General and the services based there. This is likely to mean investing in additional staff to ensure that safe services can be maintained, and ongoing investment in the estate. As mentioned earlier, some day case care will be moved to the General to provide an interim solution.

General Hospital

The General

When this plan is complete (which will not be for seven to ten years), the General will no longer house acute services in the way that it does now. Instead it will be a smaller campus with a focus on community health.

In future, the General will be home to:

- The Diabetes Centre of Excellence
- A GP led community hub with on-site imaging and diagnostics
- The Stroke Rehabilitation Service
- A Midwife Led Birthing Unit, *(subject to the outcome of consultation)*
- The City Community Crisis Response Teams
- Some Trust corporate functions

The spare land which will eventually be freed up by this will then be sold for housing including key worker and affordable homes and the money raised will be reinvested into our hospitals. In the meantime and in advance of the creation of the fully fledged Treatment Centre at the Glenfield we will move some daycase activity to the General to create an interim daycase unit.

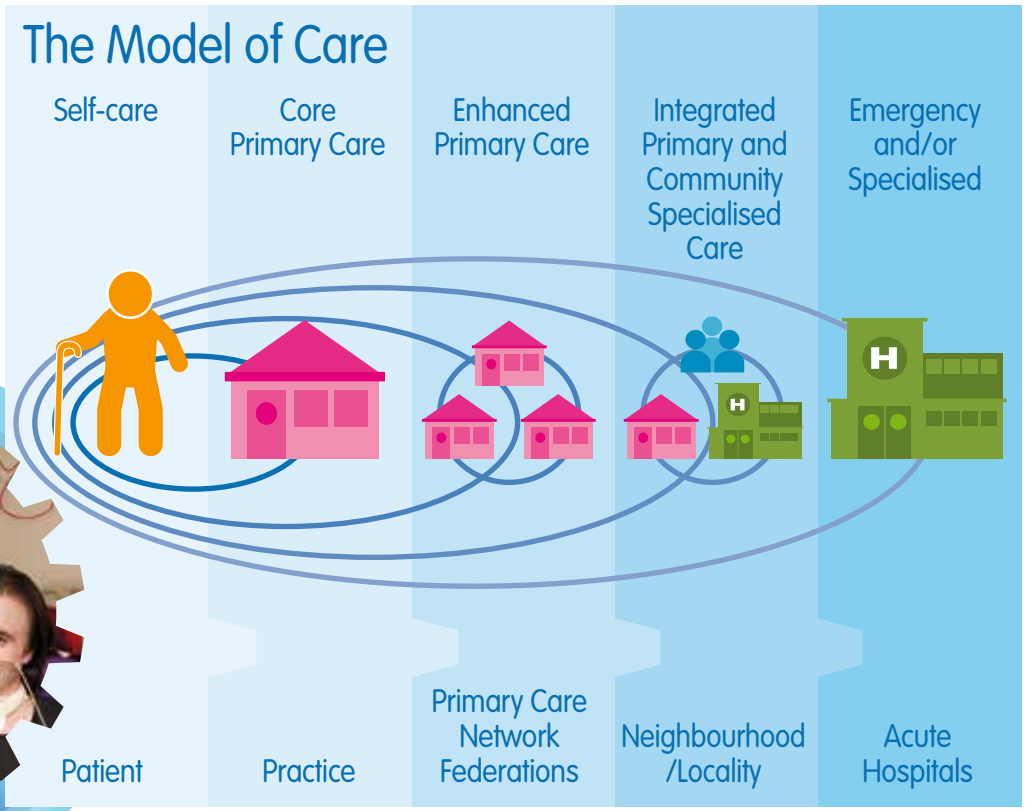
Proposed Leicester General Community Hub

35

Our role in the wider health and social care system

One of the key themes running through our priorities, our reconfiguration plans and our overall approach to improvement, is that none of the work we need to do will be truly successful if it is only successful in the context of our hospitals.

So what does this really mean?



Well, think about it this way; the National Health Service from the point of view of a big acute hospital could probably be more accurately called the 'National Treatment Service'. In other words, much of the work we do in hospital is triggered by patients who have reached a crisis point in their health, meaning that they need an admission to hospital and treatment. As a consequence, over the years, hospitals have used up resources and staffing to cope and other parts of the system, like primary, community, mental health and social care, have struggled.

In turn, this has created a model of health care which is overly focused on treatment at the point of crisis and not on prevention. The old proverb that 'prevention is better than cure' has never been more relevant than it is now. The NHS is waking up to the fact that the current model of care that most of us have grown up with is out of date, costly and worst of all can actually be detrimental to a growing cohort of patients. Think tanks, like the King's Fund, have pointed out, it is relatively easy to predict which patients in a population are likely to be most at risk of a hospital admission because they share certain recognisable characteristics, like their

degree of frailty or the number of long term conditions they have. Knowing this, the challenge then becomes how do we move from responding to their needs at the point of crisis to responding to their needs to avoid the crisis in the first place? This is called 'population health management'. The model of care shown above shows the approach we are taking as a system. By increasing the resource, skills and expertise of primary, social and community teams, we should be better able to support and maintain a person's health in the community and reduce the need for hospitalisation. In that sense, the change required is to stop thinking about hospital as the default destination for anyone

who is a too complex for community and start thinking that hospital is the place of last resort and every unplanned admission a failure.

By increasing the resource, skills and expertise of primary, social and community teams, we should be better able to support and maintain a person's health in the community and reduce the need for hospitalisation

The NHS Long Term Plan, published in January 2019, is explicit about the future direction for our services:

“The longstanding aim has been to prevent as much illness as possible. Then illness which cannot be prevented should, where possible, be treated in community and primary care. If care is required at hospital, its goal is treatment without having to stay in as an inpatient wherever possible. And, when people no longer need to be in a hospital bed, they should then receive good health and social care support to go home”.



This ‘population health management’ or just ‘integrated care’ is in its infancy and whilst it appears to most of us as the logical response to caring for an increasingly older, sicker and frailer population, delivering it effectively and at pace is not without its difficulties.

Perhaps foremost amongst them is that the current architecture of health and social care is almost perfectly designed to make the integration of services harder. Locally ‘Primary care’ (GPs) are managed by Clinical Commissioning Groups; Community and mental health is run by Leicestershire Partnership NHS Trust; Social Care is managed by the City and County Councils and we are an organisation in our own right too. Each of those seven organisations have their individual budgets and responsibilities, and more often than is comfortable, that fact can pull us in different and contradictory directions.

In recognition of this, the NHS Long Term Plan states that by 2021 there will be ‘Integrated Care Systems’ everywhere in the country.

Integrated Care Systems are a way of working, collaboratively, between a range of health and social care organisations, to help improve people’s health. It’s when organisations work together in a shared way; sharing budgets, staff, resources where appropriate, to best meet people’s needs.

Put simply, in Leicester, Leicestershire and Rutland, there is an increasing clinical consensus about the right way to plan and orchestrate our services and pathways to deliver the best possible care for our population; the job for those of us leading those organisations is to make the right way easier to achieve.

Finally, whilst we have described how we will care for over one million people in Leicester, Leicestershire and Rutland as part of an integrated system; we must not forget that we also provide specialised clinical services for a much larger population in the wider East Midlands and, for some highly complex services, nationally.

We also have a responsibility to work in partnership with other local district general hospitals to actively support the continuation and development of services for their patients in their hospitals. Patients should only have to travel to Leicester when they need to receive the most specialised treatments that only a large university teaching hospital can provide.



We are really excited about our new approach and are keen for you to get involved...

Patients/Public

Interested in taking part or to find out more, sign up to our membership mailing list.

Follow this link to sign up for free:

www.leicestershospitals.nhs.uk/members/become-a-trust-member/

www.leicestershospitals.nhs.uk/BecomingTheBest

37

Staff

Visit **INsite**

and click on the Becoming the Best logo on the homepage

19

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0116 250 2959 or email equality@uhl-tr.nhs.uk

اگر آپ کو یہ معلومات کسی اور زبان میں درکار ہیں، تو براہ کرم مندرجہ ذیل نمبر پر ٹیلی فون کریں۔
ਜੇ ਤੁਸੀਂ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸے دوسرے زبان میں دیکھنا چاہتے ہو، تو 'ਕਿਰਪਾ' کر کے 'ہوٹ' دیتے ہو تو 'ٹیلی فون' کرو۔
إذا كنت ترغب في الحصول على هذه المعلومات بلغة أخرى، الرجاء الاتصال على رقم الهاتف الذي يظهر في الأسفل
Aby uzyskać informacje w innym języku, proszę zadzwonić pod podany niżej numer telefonu
જો તમને અન્ય ભાષામાં આ માહિતી જોઈતી હોય, તો નીચે આપેલ નંબર પર કૃપા કરી ટેલિફોન કરો.