LEICESTER, LEICESTERSHIRE, AND RUTLAND INTEGRATED CARE SYSTEM

QUALITY AND PERFORMANCE IMPROVEMENT STRATEGY

Contents

Introduction

What is an Integrated Care System?

1. An Integrated Care System (ICS) is a way of working collaboratively, between a range of health and social care organisations, to help improve people's health. Across the LLR system, we are now approved as an Integrated Care System (ICS), consisting of the NHS bodies of the LLR Clinical Commissioning Groups (CCGs), the three local authorities: Leicester City Council, Leicestershire County Council, and Rutland County Council, and wider partners such as the voluntary and community sector and key provider agencies. These organisations work collectively for the needs of the population, sharing budgets, staff, and resources where appropriate. This ambition combines quality of care alongside performance improvement at System, Place and Neighbourhood levels driving the delivery of quality assurance. Delivering safe, high quality health, social care and support to people in Leicester, Leicestershire and Rutland (LLR) is at the centre of our ICS ambitions.

What is its Purpose?

2. The purpose of the LLR ICS is working together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives. This is driven and underpinned by the 10 System Expectations that we have committed to. The LLR 10 System Expectations in summary can be seen below with a full document in appendix 1.

    - Safety First
    - Equitable Care for All
    - Involve our Patients and the Public
    - Have a virtual by default approach
    - Arrange care in local settings
    - Provide excellent care
    - Enhanced care in the community
    - Have an enabling culture
    - Drive technology, innovation, and sustainability
    - Work as one system with a system workforce.

How will the ICS achieve its purpose?

3. To continue our journey of System improvement nine Design Groups have been established to establish meaningful change which will in due course evolve into Collaboratives which is the coming together of providers to plan, design and deliver services. These alliances are models of care at system level for transformation, service delivery and quality through a pathway approach rather than by organisation.

4. Uniting Quality and Performance Improvement as an ICS outlines the cultural shift away from monitoring performance and quality metrics through a contractual framework to reviewing performance improvement and quality as a collaborative health and social care system.

5. Quality Improvement (QI) need to be at the centre of service transformation and service delivery for meaningful change to occur. As UHL state, “a clearly understood and universally practised approach to QI starts with the Trust Board and a determined focus on a relatively small number of key quality priorities”.

How will high quality care be achieved in the ICS?

6. In order to deliver high quality care within a culture where there is shared accountability for both quality and performance improvement, it is crucial that the ICS has the following in place:

    - Strong united system leadership and clear vision;
    - Contributions from health, local authority and voluntary sector stakeholders;
    - Uniting with the Clinical Leadership Strategy;
    - Engagement of Design Groups with clinical and social care leadership supported by the wider infrastructure;
    - Improved patient and carers safety and experience through forums in place;
    - coproduction and evaluation with our population including those who use services and those who represent our service users;
    - Horizontal and vertical assurances of improved outcomes;
    - Measurement and evaluation of the impact of a change;
    - Performance improvement at System, Place and Neighbourhood levels driving the delivery of quality assurance;
    - Health and Wellbeing boards in place for promoting greater integration and partnership between bodies from the NHS, public health and local government

7. A key component in the delivery of safe, high quality care is to create agile, multidisciplinary, clinical, and professional networks with involvement operationally at System, Place and Neighbourhood.

8. Clinical engagement needs to be central to local governance and scrutiny meetings and transformation and improvement should remain clinically led and co-produced with the local population. Patient involvement and feedback, as one of the three pillars of quality, needs to be explicit and in the construction of our priorities the voices of patients and stakeholders are influential. 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. It is only by actively engaging with our many and diverse local communities that we can understand their experience and build services that are mindful of their needs and expectations.

What does national quality information require?

9. The quality of health and care matters because we should all expect care that is consistently safe, effective and provides a personalised experience. This care should also be delivered in a way that is well-led, sustainable and addresses inequalities. This means that it enables equality of access, experiences and outcomes across

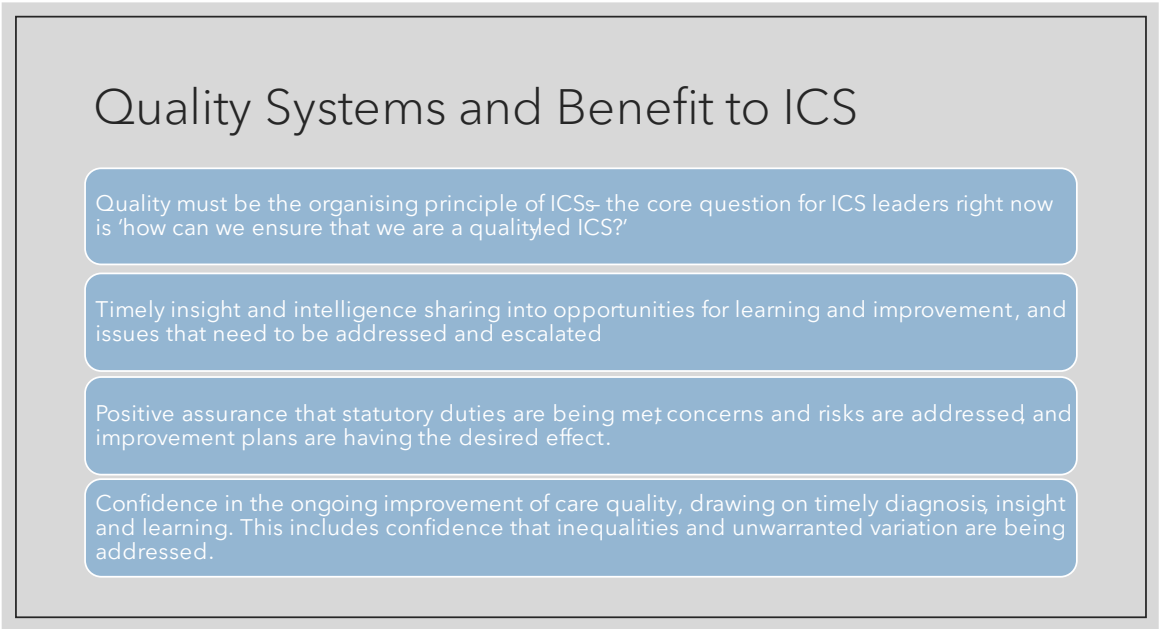
health and care services. This definition of quality forms the National Quality Board's (NQB) Shared Commitment and Position Statement for Integrated Care Systems (ICSs), published in April 2021.

10. The LLR ICS Quality and Performance Improvement Strategy is built on the foundations of the National Quality Board (NQB) System requirements thus meeting both national and local requirements. The seven steps to improving quality from the National Quality Board can be seen in Table 1.

Table 1 – NQB Improving Quality Steps

Set a clear direction and priorities
Bring clarity to quality
Measure and publish quality
Recognise and reward quality
Maintain and safeguard quality
Build capability, improving leadership and culture
Stay ahead by developing research and innovation

11. In summary the benefits to having quality systems within the ICS in LLR can be seen below.



Vision, Ambition and Principles

Vision:

10. The integrated Care System (ICS) Vision is 'to develop an outstanding, integrated health and care system that delivers excellent outcomes for the people of LLR'. Our overall vision is to nurture safe, healthy, happy & caring communities in which people start well and thrive together throughout their lives. To do this, the principles we adhere to are seen in Table 2 where quality appears at the forefront.

Table 2 – the Principles of the LLR ICS

Principles **We will work together with respect, trust, openness and common purpose to**		
Ensure that everyone has equitable access and high-quality outcomes	**Make decisions that enable great care**	**Deliver services as locally as possible**
Develop and deliver services in partnership with our citizens	**Make LLR health and care a great place to work and volunteer**	**Use our combined resources to deliver the very best value for money and to support the local economy and environment**

Purpose:

11. The purpose of the ICS is to "work together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives". As stated in the Rutland Wellbeing Strategy - good health is the result of much more than clinical healthcare. It is also the product of our circumstances, our lifestyles and choices, our environment, and our engagement with the communities in which we live.

Ambition:

12. Our ambition is to optimise wellbeing of the population and reduce inequalities and unwarranted variation for our population. The vision will be delivered through the development of strategic partnership working with service providers, the NHS, public sector agencies, universal services and the voluntary sector; and the creation and delivery of a person-centred leadership framework (PCLF) which is underpinned by four key enablers.
    - Transformation;
    - Integration;
    - Communication, Engagement and Inclusion;
    - Multi-professional and System Leadership.

What is Quality?

13. Since the publication of High-Quality Care for All in 2008, the NHS has used a three-part definition of quality. NHS England describes this as: 'the single common definition of quality which encompasses three equally important parts". These are care that is:

- Clinically effective - not just in the eyes of clinicians, but in the eyes of patients themselves
- Safe
- Provides as positive an experience for patients as possible.

Clinically Effective:

14. To ensure the system is clinically effectively LLR will work towards preventing people from dying prematurely, enhancing quality of life, and helping people to recover following episodes of ill health. This will be done through a workforce who are adequately upskilled, supported and adaptable as per the Professional Leadership Strategy.

Safe Care:

15. NHSEI describe patent safety as the "avoidance of unintended or unexpected harm to people during the provision of health care. We support providers to minimise patient safety incidents and drive improvements in safety and quality. Patients should be treated in a safe environment and protected from avoidable harm". Learning from incidences nationally and locally and reviewing services in line with new policy is crucial to delivering safe care and part of the ICS Quality and Performance Improvement remit within LLR.

16. Safeguarding leads across the LLR ICS will work collaboratively to seek and gain assurance to ensure that children and adults at risk of abuse or neglect are supported to live safe lives through the priorities of prevention, learning, awareness and quality.

Positive Experience:

17. To determine if quality is improving, it is essential that services are co-produced with patients and the public and that the patient voice is heard throughout the process. Health and social care leaders in LLR are looking at the Think Local, Act Personal methodology within system groups to capture this information. Patient reported outcome measures need to be considered as part of the improvement process with learning from thematic complaints, serious incidents, surveys, audits, and a wealth of other data which is available to health and social care organisations.

18. The ICS is currently developing a Public Involvement and Engagement Strategy 2022-24 which aims to build on the established firm foundations of participation, involvement and engagement with commissioners, providers and partners; combining this strong track record with modern and effective systems of engagement that link into ICS governance systems and processes.

"Within our local system we work collaboratively and recognise that when we involve the people who use our services in the planning of those services, we are able to "get it right". 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"

Values required to achieve co-production

19. Alongside this quality improvement also needs to be:

Sustainable	***Accountable & Assurance Focused***
Quality improvement needs to be sustainable. The Kings Fund describes it as 'the systematic use of methods and tools to try to continuously improve quality of care and outcomes for patients. Improving quality, care and performance outcomes can be undertaken using methodologies such as Lean; PDSA (Plan, Do, Study, Act), and Six Sigma. However, whichever methodology is utilised needs to provide assurances that the process is effective, leading to a culture of continued improvement against operational and contractual commitments and within the financial envelope available to the system.	The system in Leicester, Leicestershire and Rutland has developed a Performance and Quality Improvement Framework to provide assurance and accountability at "each level of the system and organisation to improve quality and encourage innovation" (Greater Manchester Quality Strategy 2017). Having a system framework meets the five elements that Matthews et al 2016 define as a requirement of a Quality Improvement Framework: - Define a unifying purpose - Establish a fractal organisational structure - Develop a common framework for understanding quality and safety - Develop tools for communication and reporting; and - Create a system of shared leadership responsibility.

	Assurance needs to be provided vertically and horizontally across the System.
Intelligence Driven Triangulating data and reviewing qualitative and quantitative intelligence drives improvement whilst also providing the system with assurance. One of the initiatives NHSE/I developed in 2020 is the need for ICS areas to have System Quality Groups to "share intelligence on early warning signs and quality risks." The purpose of the System Quality Groups will be to understand the key issues such as: • Where are we most worried about the quality of services? • What risks are we missing? • Do we need to do more as a system to address concerns, or collect more information? • Are we confident that enough action is being/has been taken? • Is there learning that we can take from other systems/regions to address the issue and/or improve quality? • Are there any potential risks/unintentional consequences for the system that we need to factor in?	***Equitable*** The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. Systematic variation in these factors constitutes social inequality, an important driver of health inequalities. Local Authorities have influence and responsibility over some of the wider determinants such as education, housing, transport, clean air, licensing of food and alcohol outlets etc. A joint outcomes framework will be developed from the strategy which will be a useful engagement tool to demonstrate ownership of performance and quality at every level of the system, not just the top.

20. Whilst recognising the importance of driving quality and performance improvement we can focus on the benefits for the service users and their carers but must remember the workforce who drive this work. Leicestershire Partnership Trust (LPT), one of the ICS key partners already has a commitment to workforce to drive quality both internally and externally by
    - Looking after our people – with quality health and wellbeing support for everyone
    - Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face
    - New ways of working and delivering care – making effective use of the full range of our people's skills and experience
    - Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return.

What is Performance Improvement?

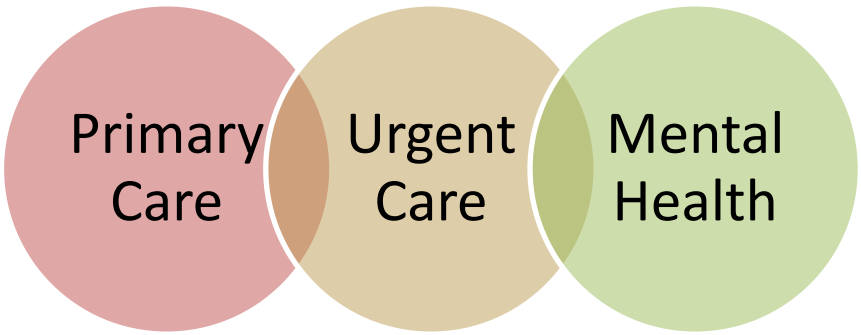
21. Improving performance is at the heart of what LLR strives to achieve and this will enable continuous improvement in delivering quality, efficient and patient-focused services through a cycle of Plan-Do-Review.

22. An organisational approach to improvement is one where a culture of continuous improvement and learning within the system are drivers for change. This needs the leadership, governance, financial means, and clinical drivers at each level to make it a reality. It is essential that there is a shared vision that is understood and supported at every level of the organisation to drive performance improvement; "this vision is then realised through a coordinated and prioritised programme of interventions aimed at improving the quality, safety, efficiency, timeliness and person-centredness of the organisation's care processes, pathways and systems" (The Health Foundation, 2020).

23. It is crucial at system level in LLR that the governance which wraps around quality and performance improvement is defined, shared and agreed. In addition, the system needs to consider and review performance improvement from an integrated health and social care perspective. In LLR the primary purpose of a Quality and Performance Improvement Strategy is to provide the system with a structure with which to make systematic, continuous improvements to performance enabling achievement of its objectives.

24. Metrics are only one source of intelligence. The current metrics being measured as an ICS are primarily the system oversight framework indicators for which NHSE/I require submissions alongside the provider Quality Schedules. The latter are contractual and contain national and local indicators. The purpose of the ICS System Performance Improvement will be to use data and intelligence to determine areas of success, pressure and challenge and where transformation can be made.

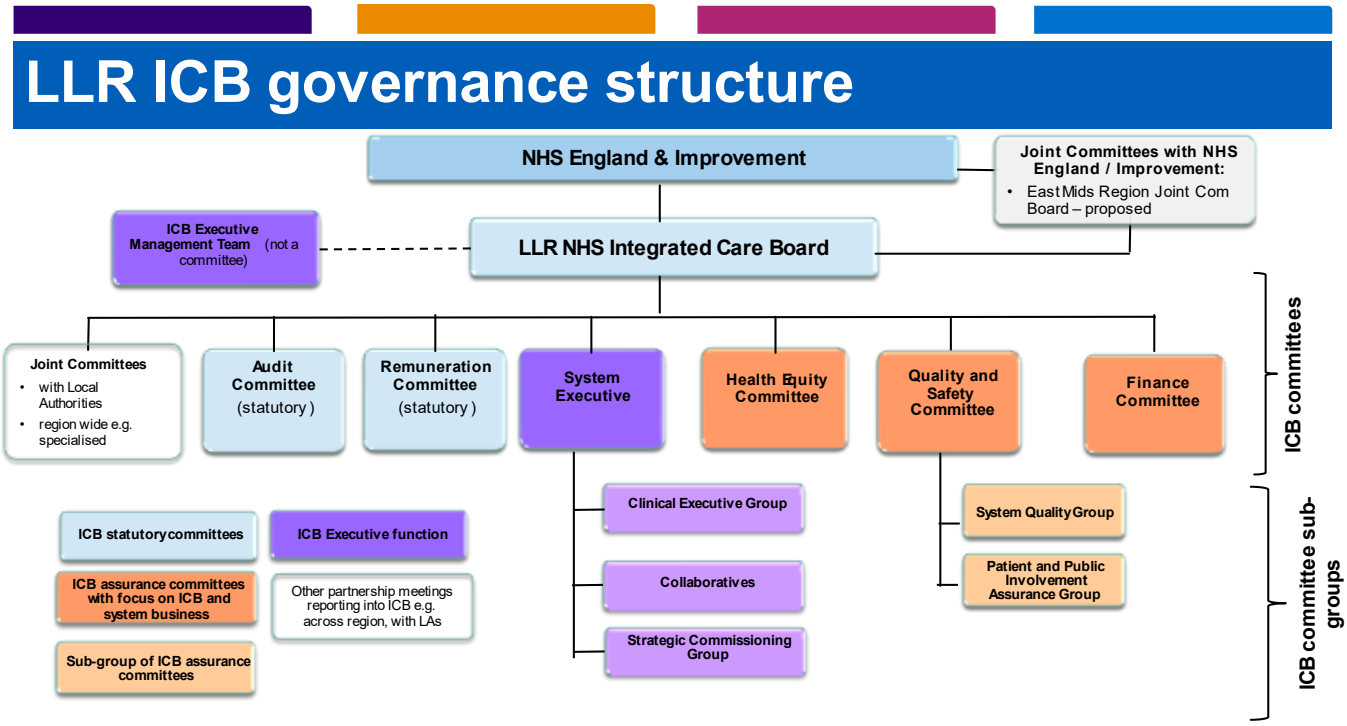
25. Processes to improve the achievement of the standards have been implemented and significant progress has been made and will continue against the following standards:



ICS Assurance: Measuring and Monitoring Quality of Health and Social Care

System Governance

26. The national quality board has determined that each ICS needs to have a separate assurance function to the system quality group. This will be the case in LLR where the governance will be as follows:



Assurance

27. In August 2021 an ICS Quality and Performance Improvement Assurance Committee (QPIAC) had its inaugural meeting as the System Quality Group in LLR ICS. This meeting was then superseded by the System Quality Safety Committee who receive intelligence from the System Quality Group and provide assurance to the Integrated Care Board.

28. The LLR ICS quality governance structure recognises the relationships between health and social care that are mutually accountable for opportunities to improve the quality of care and the outcomes in performance for the patient. There is the recognition that within LLR it is essential that our services and performance are benchmarked against similar peers nationally to enable continual learning within the system and improvement in performance and quality. Cultural change of this type requires strong leadership in relation to the importance of the vision along with person-centred values and behaviours.

System Quality Group

29. Intelligence will feed into the Assurance Committee from the System Quality Group.

30. The System Quality Group will include intelligence from health inequalities, provider, place, system, pathway and performance information:

What may come to a System Quality Group?

31. Within the new Integrated Care Board quality intelligence around some of the bigger system partners such as University Hospitals of Leicester, Leicestershire Partnership Trust and Derbyshire Health United will also come through the ICB governance structure from their own quality committees. This provides an opportunity for assurance, learning and shared ownership and two way communication within the system.

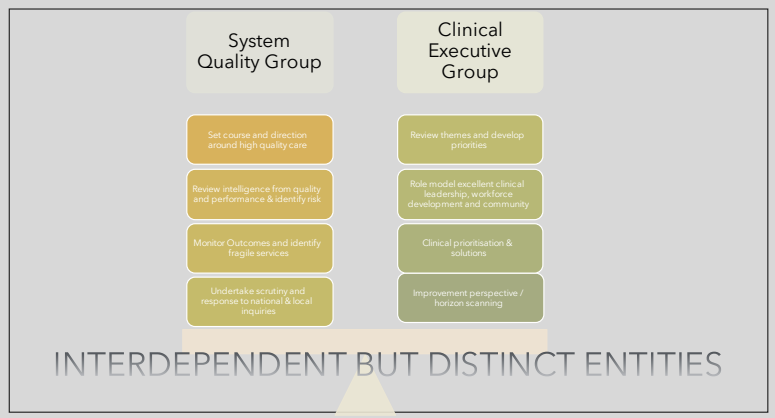
32. Smaller providers are currently receiving quarterly phone calls from the ICB to understand how they are achieving the indicators with their NHSE standard contract quality schedule and what support they require from the system. The oversight for the findings from these phone calls is seen by the System Quality Group.

33. Design groups and collaboratives are at differing levels of maturity and as such the ICB is supporting them through the development of a self-assessment framework to understand how they assurance themselves of the quality of care within their area of work and what gaps they may have that need system input and support. This will provide both a baseline for the ICB to understand quality at a population level and a benchmark for the design groups to review how they are conducting their quality improvement compared to other areas for increased learning and support.

Clinical Executive Group

34. Interdependent but separate to the quality functions of the LLR ICS is the Clinical Executive Group (CEG) which will provide executive clinical leadership to the

Integrated Care System, including: approving the clinical strategy for LLR; approving the implementation of new clinical pathways across the system; driving clinical culture change to improve pathways for the population of LLR ensuring integration of health and social care; promoting and overseeing major service change; monitoring clinical risk across the system associated with major change; providing senior health and social care professional leadership across LLR for transformational change by empowering clinical leaders across the system and unblocking barriers to change.



Internal

35. As the CCG moves to an ICS to share intelligence within the Clinical, Quality and Performance directorate there is a monthly Quality Review Meeting. This internal meeting allows the triangulation of intelligence where information is collated and coordinated which will feed into the System Quality Group. It also provides the opportunity to have a proportional assurance approach to quality at provider, place and system level as per the NQB requirements of a System Quality Group.

Conclusion

"Every system is perfectly designed to deliver the results it does" - Paul Batalden, 2007.

36. To have a fully functioning ICS Quality and Performance Improvement Strategy within LLR which serves to improve outcomes for our population, quality and performance assurance must have the governance around it to operate effectively. LLR is clinically led, independently assured, and managerially supported to unite common health and social care objectives at system level.

37. Improvement outcomes need to be based around a population health management approach across the life course to have the person at the centre of their care at System, Place and Neighbourhood level. Each of these three levels needs intelligence which is timely; triangulated with health and social care indicators; and demonstrates value in its widest sense to support planning to meet local needs, improving population level outcomes, and tackle inequalities. The ICS will lead the way on ensuring quality and improvement are central to the work that is being undertaken to deliver sustainable outcomes.

APPENDIX 1

Our 10 System Expectations and their associated actions

1	**Safety first approach** We will adopt a safety-first approach to markedly reduce the infection hazard for patients and staff
	• We will make sure that every service applies the latest Infection, Prevention and Control guidance • We will ensure that every provider of services has appropriate cohorting arrangements in place for patients and staff • We will have the right Personal Protective Equipment to maintain safety for our staff and patients • As we transform our models of care we will ensure we adapt our safeguarding arrangements • We will provide health and well-being support to all our staff
2	**Equitable care for all** We will pursue high-quality, equitable care for all focusing on health inequalities, community development and the impact of COVID-19 on our BAME community and staff
	• We will ensure that physical and mental health have parity • We will direct resources to where there is greatest need based on population health data by 1st April 2021 • We will develop Place and Locality Based Plans that will contribute to closing the health inequalities gap and support community resilience by 31st December 2020 • We will work with our academic and research partners to focus on the risk factors for COVID-19 and develop appropriate interventions by 30th September 2020 • We will work with our BAME staff to manage the enhanced risks that this group has from infection of COVID-19
3	**Involve our patients and public** We will transform our public and patient involvement and seek to co-produce strategies which improve the health and wellbeing of local people
	• We will develop and implement a new approach and dialogue with our public to ensure advice and care is accessible when needed from the right setting by 31st December 2020 • We will develop innovative ways of engaging with our population and we will always involve patients in shaping our transformational programmes • We will develop a compact with local people which sets what they can expect from their NHS and what we would ask them to do in return by 30th December 2020
4	**Have a virtual by default approach** Remote consultations at the front-end of all care pathways in all health and care settings especially before escalations of care
	• We will ensure that prior to an escalation of care every patient is reviewed remotely by a relevant clinician seeking specialist opinion when appropriate to ensure that the patient is seen in the right setting by 30th September 2020 • We will adopt a primary care 'total triage' approach for patients that need a consultation and this will be done remotely unless there is a clinical reason not to do so by the end of August 2020 • We will ensure that all referrals to UHL for elective services will be done via a fully completed PRISM form by 30th November 2020

	• We will ensure that all relevant specialities will have advice and guidance in place including a telephone/video option by 30th December 2020 • We will conduct 70% of outpatient appointments and follow-ups virtually either by telephone or video consultation by 30th December 2020 • We will ensure there is an alternative for those that cannot access the virtual option
5	**Arrange care in local settings** There will be a decisive shift away from hospitals to care in local settings based around Primary Care Networks
	• We will produce 'Place Based Plan's for the three 'places' (Leicestershire, Leicester City and Rutland) and the seven 'localities' across Leicestershire (North West Leicestershire; Charnwood; Hinckley & Bosworth; Oadby & Wigston; Harborough; Melton; and Blaby) by 31st December 2020 • We will provide a 2 hour community based response from a multi-disciplinary team to keep people at home and avoid admissions by 31st October 2020 • We will discharge patients from hospital to the right setting on the day they are deemed medically fit by 31st October 2020 • We will manage our actual and virtual bed base as one resource across Leicester, Leicestershire and Rutland with all discharges co-ordinated through a central service by 31st October 2020 • We will develop community based integrated multi- disciplinary teams including appropriate specialist support that will work as one team around the patient 31st October 2020 • We will work with out of county providers to make sure that pathways are clear and understood by patients and clinicians
6	**Provide excellent care** We develop standardised end-to end LLR pathways/clinical networks, tackling unwarranted variation, quality improvement, through a population health management approach
	• We will develop and implement standardised pathways for major conditions that improve outcomes, reduce health inequalities and reduce unwarranted variation by 31st March 2021 • We will use population health management approaches to risk stratify and segment our population and use this information to support transformation and commissioning of care • We will provide Primary Care Networks with data to identify unwarranted variation by 31st July 2020 • We will encourage all clinicians to work at the top of their licence by 30th November 2020 • We will deliver NHS performance requirements across all services by 31st March 2022
7	**Enhanced care in the community** Working with local government and the third sector we will provide enhanced care in the community
	• We will use population health management approaches to identify those at risk patients and use our multi-disciplinary integrated teams to support them by 31st October 2020 • We will ensure all patients that need a care plan have one, which is regularly reviewed and can be accessed by all those caring for the patient by 31st October 2020 • We will provide an enhanced offer to Care Homes by 30th November 2020

	• We will work with communities to harness the volunteer and third sector to support local people by 31st March 2021
8	**Have an enabling culture** We will put in enabling mechanisms to create a culture where our workforce thrive and are nurtured and there is simplified decision-making and governance structures
	• We will review and implement a new simplified system wide governance structure that enables transformation to be undertaken rapidly by 30th June 2020 • We will develop a single system wide Programme Management Office to support system efficiency and transformation by 30th June 2020 • We will establish clinical networks that enable specialists, general practice, primary care networks and other professionals to work together across the system by 30th June 2020 • We will develop clinical and managerial opportunities for secondment, rotation and shadowing by 31st March 2021 that supports our underrepresented groups • We will ensure all staff involved in transformation are trained and competent in applying the quality improvement methodology adopted by the system • We will embed a culture of learning from best practice and research
9	**Drive technology, innovation and sustainability** Technology, innovation, financial and environmental sustainability will underpin all our services
	• We will work with our partners to increase IT literacy skills in our population • We will ensure that multi-disciplinary team meetings are supported by the right technology which enables clinicians and services to review individual patients' needs together by 30th September 2020 • We will undertake an assessment of remote patient monitoring technology and AI to enable improved productivity and support to patients by 30th September 2020 • We will deliver interoperability between NerveCentre and Systm1 by 30th June 2020 • We will use technology to support flexible, mobile and home based working to reduce our office footprint, environmental impact and running cost by 30th December 2020 • We will develop a clear, deliverable plan by 30th September 2020 to restore the system's finances
10	**Work as one system with a system workforce** We will take collaborative working to a new level by dissolving boundaries between services providers.
	• We will explore and implement volunteer models that support our population and services by 31st March 2021 • We will develop integrated workforce models that enable our pathway approach to be delivered and do not duplicate resources by 31st March 2021 • We will use our experience from the COVID-19 emergency to develop mutual aid protocols and arrangements across our providers by 30th September 2020 • We will explore opportunities for shared service teams for our back office functions by 31st March 2021 • We will become an Integrated Care System by 31st March 2021