CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – JULY 2019

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

Executive Summary

Context

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

(a) the Quality and Performance Dashboard for May 2019 attached at appendix 1 (the full month 2 quality and performance report is available on the Trust's public website and is hyperlinked within this report);

(b) key issues relating to our Strategic Objectives and Annual Priorities.

Questions

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

Conclusion

1. 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

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Not applicable]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [N/A]

4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

5. Scheduled date for the **next paper** on this topic: [August 2019 Trust Board]

6. Executive Summaries should not exceed **1 page**. [My paper does comply]

7. Papers should not exceed **7 pages.** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **4th JULY 2019**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – JULY 2019**

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1. Introduction

1.1 My monthly update report this month focuses on:-

(a) the Board Quality and Performance Dashboard attached at **appendix 1**;

(b) the Board Assurance Framework (BAF) and Organisational Risk Register;

(c) key issues relating to our Quality Strategy and Annual Priorities, and

(d) a range of other issues which I think it is important to highlight to the Trust Board.

1.2 I would welcome feedback on this report which will be taken into account in preparing further such reports for future meetings of the Trust Board.

2 Quality and Performance Dashboard – May 2019

2.1 The Quality and Performance Dashboard for May 2019 is appended to this report **at appendix 1.**

2.2 The Dashboard aims to ensure that Board members are able to see at a glance how we are performing against a range of key measures.

2.3 The more comprehensive monthly Quality and Performance report continues to be reviewed in depth at a joint meeting of the People, Process and Performance Committee and Quality and Outcomes Committee. The month 2 quality and performance report is published on the Trust's website.

Good News:

2.4 Mortality – the latest published SHMI (period January 2018 to December 2018) is 99, the same as the previous reported SHMI and remains within expected. **Diagnostic 6 week wait –** standard achieved for 9 consecutive months. **52+ weeks wait –** has been compliant for 11 consecutive months. **Delayed transfers of care** - remain within the tolerance. However, there are a range of other delays that do not appear in the count. **12 hour trolley wait** was 0 breaches reported. **Moderate harms and above** – April (reported 1 month in arrears) was within threshold. **C DIFF** – was

within threshold this month. **Pressure Ulcers** - 0 **Grade 4,** 0 **Grade 3** reported during May. **MRSA –** 0 cases reported. **Single Sex Accommodation Breaches** – 0 breaches reported **CAS alerts** – was compliant. **Inpatient and Day Case Patient Satisfaction (FFT)** achieved 97% which is above the national average. **Cancer Two Week Wait** was 95.7% in April. **Fractured NOF** – remains compliant for the 10th consecutive month. **90% of Stay on a Stroke Unit** – threshold achieved with 83.5% reported in April. **TIA (high risk patients) –** threshold achieved with 75.5% reported in May. **Annual Appraisal** is at 92.0%.

Bad News:

2.5 **UHL ED 4 hour performance** – was 73.7% for May, system performance (including LLR UCCs) was 81.5%. Further detail is in the Urgent Care report. **Ambulance Handover 60+ minutes (CAD)** – performance at 5.1%. **Referral to Treatment –** our performance was below the national standard and the numbers on the waiting list were marginally above the NHSI trajectory. **Cancer 31 day treatment** was 85.7% in April. **2 Week Wait Cancer Symptomatic Breast** was 90.5% in April. **Cancer 62 day treatment** was not achieved in April – further detail of recovery actions in is the cancer recovery report. **Statutory and Mandatory Training** reported from HELM is at 89%. Specific focus being applied to Bank and Estates & Facilities staff with compliance deadline of 31/10. **Pressure Ulcers** - 8 Grade 2 reported during May. **Cancelled operations** OTD was 1.5% in May and 18 **Patients were not rebooked within 28 days**.

3. Quality Strategy – Becoming the Best (BtB)

3.1 Considerable activity continues to take place as we begin implementation of our new Quality Strategy. In the last month, this has focussed primarily on the continued delivery of the "discovery" phase of our work on culture and leadership, production of materials for the full launch of the strategy, further embedding of the BtB approach in our Trust Priorities and appointments to key posts.

3.2 The BtB approach continues to be embedded through planning for our 12 Quality and Supporting Priorities. The Executive Boards have now begun to receive the first of the reporting templates for the Priorities. This has enabled assessment as to whether or not the approach being taken is fully aligned to BtB. In some cases, this has not been the case and further work has been requested where applicable

3.3 Successful appointments have now been made to two key roles: Head of Quality Improvement and Head of Communications. The calibre of candidates for these roles is perhaps indicative of the coherence that BtB is starting to deliver i.e. this appears to be something that high quality people would like to be involved in. A co-ordinated recruitment approach is now being planned for further posts so as to maximise this leverage.

3.4 During the month I hosted the four main culture and leadership focus groups. In addition, the OD team hosted a series of drop in sessions and a number of "meeting takeovers". BtB was also discussed at open consultant meetings on all three sites and a special session with the Clinical Senate will take place on 26th June. Both the focus groups and drop in sessions were attended by our new Improvement Agents

who facilitated the group discussions. Through this combination of approaches we will have comfortably exceeded our target of interacting with more than 500 staff on culture and leadership. The next key milestone will be the Synthesis Event on 9th July when we will review all the information coming out of the surveys, groups and other sources and thus decide on the priorities for action.

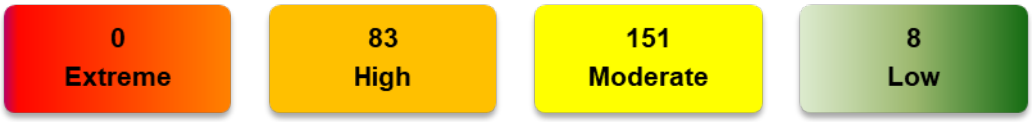
3.5 Final preparations are now being made for the full "launch "of BtB across the organisation. This is happening slightly later than planned due to the time required to develop all the required materials. The process will start with my CEO Briefings in the first week of July when I will be distributing a presentation pack to all leaders with a requirement that they cascade this to their teams within the following two weeks. A Survey Monkey site has been developed to receive feedback from these discussions. In addition, there will be a large scale poster campaign and social media activity. Finally, a new booklet has been produced which describes the BtB approach, our priorities and updates on our estate investment and reconfiguration plans.

4. Board Assurance Framework (BAF) and Organisational Risk Register

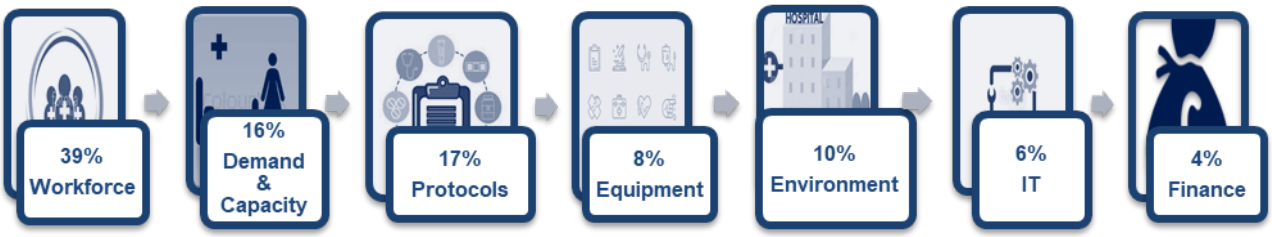
4.1 The process of finalising the Board Assurance Framework (BAF) for 2019/20 is continuing, and the draft of the full document incorporating a redefined set of risks will be reviewed at the Executive Planning Meeting on 26th January and then be presented to the Audit Committee on 5th July. The principal risks around which the BAF is being structured are shown below:

- Failure to deliver key performance standards for emergency, planned or cancer care
- Failure to effectively manage and reduce patient harm
- Serious/catastrophic failure in a specific clinical service
- Failure to effectively implement the Trust's Quality Strategy – Becoming the Best
- Failure to recruit, develop and retain a workforce of sufficient quantity and skills
- Failure or serious disruption to the Trust's critical estates or IT infrastructure
- Failure to progress the Trust's site investment and reconfiguration plans and/or the risks arising from those plans
- Failure to deliver the e-hospital strategy including the required process and cultural change
- Failure to meet the financial control total including through improved productivity
- Failure to work effectively with the wider system
- Failure to effectively progress the Academic Health Science Partnership

4.2 The UHL risk register has been kept under review by the Executive Performance Board and across all CMGs during the reporting period and displays 242 risk entries:



4.3 Thematic analysis across the organisational risk register shows the common risk causation theme concerns workforce capacity and capability (including nursing and medical) across all CMGs. Other risk themes reported on the CMGs risk registers are illustrated in the graphic below:



5. Emergency Care

5.1 Our performance against the 4 hour standard for May 2019 was 73.7% and 81.5% for Leicester, Leicestershire and Rutland as a whole. This was a deterioration from the April position.

5.2 Performance was particularly impacted by the prolonged closure of a medical ward at the Leicester Royal Infirmary due to a CRO outbreak, as well as transient bed closures within the Royal and at several community hospitals due to norovirus. This in turn led to long delays for admission and crowding in the Emergency Department. The ward at the Royal was due to close in any event as it was additional "winter" capacity. However, in the light of the fact that activity levels have not dropped in the way that was planned for, we have now taken the decision to keep open this capacity. This will have a knock-on effect on the ICU and related services reconfiguration scheme as the ward will not be available for refurbishment as originally planned. However, this element is not on the critical path of the scheme as a whole and will not therefore impact on the completion timeline. The position will be reviewed in a month's time.

5.3 At a system level, the A&E Delivery Board has approved a more focussed action plan for 2019/20 which responds to guidance issued nationally and regionally about which interventions are likely to have the most impact. These interventions include:

- More clearly defining and communicating the offer available at the Urgent Care Centres
- Reducing the number of lower acuity (Cat 3 and 4) ambulance conveyances to ED
- A strong focus on delivering Same Day Emergency Care outside hospital wherever possible
- Further reductions in the number of long stay (stranded) patients

5.4 Internally, in addition to re-opening our additional bed capacity as described in section 5.2, we are reviewing our emergency care action plan to ensure that it fully aligns with the approach set out in our Quality Strategy and that the relevant Trust Priorities are also properly integrated. Further work is required in both these areas. The revised plan will be presented to the Executive Quality and Performance Board and the People, Process and Performance Committee at their July meetings.

5.5 Details of the Trust's emergency care performance continue to be the subject of report by the Chief Operating Officer monthly to the People, Process and Performance Committee. Details of the Committee's most recent consideration of the position are set out in the summary of that meeting which features elsewhere on this Board agenda.

6. Better Care Together/Integrated Care System

6.1 There have been a number of significant developments at system level in the past month.

6.2 The System Leadership Team has approved a set of follow-up actions arising from the workshop on 15th May. These actions are summarised in the stakeholder bulletin which is attached as **appendix 2**. These actions represent some important steps in our journey towards becoming an Integrated Care System.

6.3 On 18th June, a further workshop was held which discussed what organisational/ contracting form the delivery vehicle within an ICS might take. There was broad consensus that an "alliance" model, similar to the one already functioning for community-based planned care, would be the preferred model, as opposed to a "lead provider" or "system integrator" model. It was agreed in principle that such a model should be worked up so that it could run in "shadow" form in 2020/21, with full implementation from 2021/22 in accordance with the national timetable for ICS development.

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7. News about colleagues

7.1 I am sorry to have to report that Paul Traynor, our Chief Financial Officer, will be leaving us at the end of October to take up the post of CFO of the Open University. Paul's departure will be a big loss, but I wish him every success in his new role. Recruitment to find a replacement for Paul will begin immediately.

7.2 Conversely, I am very pleased to report that Liz Darlison, Consultant Nurse and Director of Services for Mesothelioma UK, was awarded an MBE in the recent

Queen's Birthday Honours. Liz has worked tirelessly on behalf of patients with mesothelioma, both locally and nationally, and this recognition is extremely well deserved.

8. Conclusion

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

John Adler
Chief Executive

27th June 2019

Quality & Performance

		YTD Plan	YTD Actual	May-19 Plan	May-19 Actual	Trend*	Trend Line	Compliant by?
Safe	S1: Reduction for moderate harm and above (1 month in arrears)	142	8	<=12	8	●		Compliant
	S2: Serious Incidents	<29	5	2	4	●		Jun-19
	S10: Never events	0	0	0	0	●		Compliant
	S11: Clostridium Difficile	61	10	5	5	●		Compliant
	S12 MRSA - Unavoidable or Assigned to 3rd party	0	0	0	0	●		Compliant
	S13: MRSA (Avoidable)	0	0	0	0	●		Compliant
	S14: MRSA (All)	0	0	0	0	●		Compliant
	S23: Falls per 1,000 bed days for all patients (1 month in arrears)	<=4.84	5.6	<=4.84	5.6	●		May-19
	S25: Avoidable Pressure Ulcers Grade 4	0	0	0	0	●		Compliant
	S26: Avoidable Pressure Ulcers Grade 3	<27	0	<=3	0	●		Compliant
	S27: Avoidable Pressure Ulcers Grade 2	<84	12	<=7	8	●		Jun-19
Caring	C3: Inpatient and Day Case friends & family - % positive	96%	97%	96%	97%	●		Compliant
	C6: A&E friends and family - % positive	94%	95%	96%	96%	●		Compliant
	C10: Single Sex Accommodation Breaches (patients affected)	0	0	0	0	●		Compliant
Well Led	W13: % of Staff with Annual Appraisal	95%	92.0%	95%	92.0%	●		Jun-19
	W14: Statutory and Mandatory Training	95%	89%	95%	89%	●		Jun-19
	W16 BME % - Leadership (8A – Including Medical Consultants) - Qtr 4	28%	29%	28%	29%	●		Compliant
	W17: BME % - Leadership (8A – Excluding Medical Consultants) - Qtr 4	28%	16%	28%	16%	●		Dec-23
Effective	E1: 30 day readmissions (1 month in arrears)	<8.5%	9.2%	<8.5%	9.2%	●		See Note 1
	E2: Mortality Published SHMI (Jan 18 to Dec 18)	99	99	99	99	●		Compliant
	E6: # Neck Femurs operated on 0-35hrs	72%	76.5%	72%	76.8%	●		Compliant
	E7: Stroke - 90% of Stay on a Stroke Unit (1 month in arrears)	80%	83.5%	80%	83.5%	●		Compliant
Responsive	R1: ED 4hr Waits UHL	95%	74.6%	95%	73.7%	●		See Note 1
	R2: ED 4 Hour Waits UHL Acute Footprint	95%	82.0%	95%	81.5%	●		See Note 1
	R4: RTT waiting Times - Incompletes (UHL+Alliance)	92%	84.7%	92%	84.7%	●		See Note 1
	R6: 6 week – Diagnostics Test Waiting Times (UHL+Alliance)	<1%	0.9%	<1%	0.9%	●		Compliant
	R12: Operations cancelled (UHL + Alliance)	<1%	1.2%	1.0%	1.4%	●		Jun-19
	R14: Delayed transfers of care	3.5%	1.4%	3.5%	1.8%	●		Compliant
	R15: % Ambulance Handover >60 Mins (CAD)	4.5%	4.8%	4.5%	5.1%	●		See Note 1
	R16: % Ambulance handover >30mins & <60mins (CAD)	12.4%	13.7%	12.4%	14.9%	●		See Note 1
	RC9: Cancer waiting 104+ days	0	32	0	32	●		See Note 1

		YTD Plan	YTD Actual	Apr-19 Plan	Apr-19 Actual	Trend*	Trend Line	Compliant by?
Responsive Cancer	RC1: 2 week wait - All Suspected Cancer	93%	95.7%	93%	95.7%	●		Compliant
	RC3: 31 day target - All Cancers	96%	94.8%	96%	94.8%	●		Jul-19
	RC7: 62 day target - All Cancers	85%	75.6%	85%	75.6%	●		Sep-19

Enablers

		18/19 YTD Plan	18/19 YTD Actual	Qtr4 18/19 Plan	Qtr4 18/19 Actual		Trend Line	Compliant by?
People	W7: Staff recommend as a place to work (from Pulse Check)		59.8%		57.0%			Not Applicable
	C9: Staff recommend as a place for treatment (from Pulse Check)		71.2%		74.0%			Not Applicable

		YTD Plan	YTD Actual	May-19 Plan	May-19 Actual	Trend*	Trend Line	Compliant by?
Finance	Surplus/(deficit) £m	(10.6)	(10.6)	(2.4)	(2.4)	●		Compliant
	Cashflow balance (as a measure of liquidity) £m	1.0	3.8	1.0	3.8	●	-	Compliant
	CIP £m	1.5	1.5	2.9	2.8	●		Compliant
	Capex £m	(9.7)	6.3	(4.9)	3.1	●		Jul-19

		YTD Plan	YTD Actual	May-19 Plan	May-19 Actual	Trend*	Trend Line	Compliant by?
Estates & facility mgt.	Average cleanliness audit score - very high risk areas	98%	95%	98%	95%	●		See Note 2
	Average cleanliness audit score -high risk areas	95%	93%	95%	93%	●		See Note 2
	Average cleanliness audit score - significant risk areas	85%	93%	85%	93%	●		Compliant

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

The above metrics represent the Trust's current priorities and the code preceding many refers to the metrics place in the Trust's Quality & Performance dashboards. Please see these Q&P dashboards for the Trust's full set of key metrics.

Note 1 - **'Compliant by?'** for these metrics a are dependent on the Trust rebalancing demand and capacity.

Note 2 - Compliance is dependent on investment

Better Care Together Partnership update

A business update for partner boards, governing bodies and members

May/June 2019

Welcome to the third of a regular business update from the System Leadership Team (SLT) of Better Care Together. The purpose of this update is to inform governing bodies, boards and members on the key business and strategic work programmes being discussed and taken forward by SLT.

Working towards an Integrated Care System

A System Leadership Team (SLT) development session was held on Thursday 16 May looking at how an Integrated Care System (ICS) could be developed in Leicester, Leicestershire and Rutland (LLR) over the next few years. The session was attended by about 45 people, including SLT members, wider representatives of NHS and local authority organisations, and representatives from the local Healthwatch organisations. The session was held at Leicestershire Voluntary Action in Newarke Street, Leicester. It was hosted by Sue Lock and John Adler, joint ICS development leads, and facilitated by Bernie Brooks and Tim Whitworth of The Leadership Centre.

What is an Integrated Care System?

In 2016, NHS organisations and local councils came together to form 44 sustainability and transformation partnerships (STPs) covering the whole of England, and set out their proposals to improve health and care for patients. The STP for LLR is known as Better Care Together (BCT).

According to NHS England: "In some areas, these partnerships have evolved to form an integrated care system (ICS), a new type of even closer collaboration. In an ICS, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. Local services can provide better and more joined-up care for patients when different organisations work together in this way. For staff, improved collaboration can help to make it easier to work with colleagues from other organisations. And systems can better understand data about local people's health, allowing them to provide care that is tailored to individual needs.

"By working alongside councils, and drawing on the expertise of others such as local charities and community groups, the NHS can help people to live healthier lives for longer, and to stay out of hospital when they do not need to be there. In return, integrated care system leaders gain greater freedoms to manage the operational and financial performance of services in their area."

Aims of the development session

Aims for the session were to:

- Deepen the conversations across BCT and the system, developing mutual trust and respect for each other and thereby reinvigorating the work of the SLT
- Continue to build a mature system and increase the pace of change in order to form a functioning ICS in 2020-21
- Address some of the difficult conversations in radically transforming the local system in order to meet place-based needs that are matched by resources
- Develop plans to draw in and engage with a broader stakeholder group.

Summary of the development session discussions

"How do you see you and your organisation in an LLR integrated system for care and well-being in three-to-five years' time?"

A range of views were offered in answer to this question with answers predictably varying between the organisations represented.

Clinical Commissioning Groups (CCGs) focused naturally on some of the commissioning complexities of establishing a new health and care system. Issues included the development of place-based commissioning, commissioning for quality and outcomes, managing variation in the quality of services across different providers, and ensuring the continuity of care being delivered across local authority and STP boundaries.

Providers (Leicestershire Partnership, DHU Health Care and East Midlands Ambulance Service representatives) discussed how patient information could best be shared and patient hand-offs reduced. They looked at how provider alliances may be developed and resources best managed. University Hospitals of Leicester provided views on what the optimum provider size might be and the need for joint accountability and leadership in order to deliver the plan.

Local authorities were seeking more information on what an ICS might mean, both for health and local government, and its potential benefits, noting the need for increased member engagement. There was a desire for health funding to flow across the whole system, following the patient and outcomes, but there was a concern whether contracting arrangements would change to allow this. It was felt that the ICS may provide an opportunity for market development in the health and care sector.

Healthwatch considered how primary care networks could be used to develop integrated teams, making best use of resource in primary and community care, helping develop new roles and reducing current gaps in capacity.

"What will you give to, want to get and expect (particularly from other stakeholders) from participating in a fully integrated health and care system?"

In the open discussion session, a number of potential benefits from establishing an ICS were highlighted. These included the potential to share intelligence across commissioners and providers, place a greater focus on the prevention of ill health and injury, and better channel resources to meet patient need. The challenge of ensuring patient and public involvement at every level of the system was highlighted. There was also a question about exactly who would be responsible for making sure all this happens.

CCGs could envisage a future where there would be improved outcomes, better value for money services, and more satisfied patients. It was thought an ICS might be able to provide greater flexibility and the ability to innovate, as well as reducing bureaucracy.

Provider organisations considered issues such as the sustainability and longevity of services and the need for a system-wide workforce plan that would underpin future health and care. It was considered that an ICS would create the conditions which could 'unblock and unlock' – making it easier to do the right thing. It would allow the sharing of business information, sharing of resources, such as beds, occupational therapists and physiotherapists, and the sharing of functions for the benefit of the whole system. It was hoped that ultimately this would all lead to better decision making.

Local authorities were seeking clarification on issues such as accountability and scrutiny. They could see the opportunities for greater personalisation of care through use of such approaches like personal health budgets. It was also thought that an ICS and greater collaboration could be a strategic way of tackling the challenges of delivering adult social care.

There were many useful contributions from Healthwatch representatives. It was seen that the development of an ICS would require strong and systematic public and patient engagement, prioritising the use of co-design approaches. Healthwatch representatives said now was the right time to develop those relationships and solutions and that the public and patients had to be continually involved.

"How will we move to making integration a reality? What are the key functions that will be undertaken at system, place and neighbourhood? Who will take a leadership role in this?"

The notion of 'place' was assessed as being difficult and complex. Some argued that 'neighbourhood' and 'place' were the same thing, others that neighbourhood factors would influence place. The idea of place also has an inherent geographical consideration – varying across city, county and the primary care networks. There was agreement that place in LLR was City, Leicestershire County and Rutland.

It was questioned how commissioners and providers best work together at the place level. Different organisations had of course different perspectives with an acknowledgement that local authorities have a wider responsibility beyond social care, taking into account departments for transport, education, planning and the environment. It was argued that there is a need for a clear set of place priorities which would help to engage local authority members.

Place had the potential to re-distribute resources including staffing. Attendees said there was an opportunity within a place-approach to put more emphasis on prevention of ill health and injury.

There was a view that services within place should be designed from the bottom-up, so that services could then be scaled up to meet the needs of the wider system. In terms of leadership, it was stated that there were roles and responsibilities for local authority and health commissioners, providers, primary care networks, health and wellbeing boards, and citizens. All leaders were encouraged not to try to define functions from above but to address the issues that need solving.

There was a view that the ambition should be to deliver as much as possible at neighbourhood level. Throughout all this, it was stressed that efforts were needed to explain to local people about the benefits that could be obtained from taking this neighbourhood/place approach.

Next steps

The conversations about developing an ICS will be progressed this year with some next steps highlighted as:

- Developing more awareness among local authority elected members and the city and county health portfolio holders about the desire to create an ICS and how to make this real.

- Undertaking more research to understand more about what the LLR pound includes (and excludes) before establishing an agreed single control total (budget) for the area.
- Deciding on the mechanisms on how to design and deliver the changes and how leaders in the system and the organisations would be held to account.
- Carrying out more work on agreeing the joint outcomes.

Next steps contd.

- Testing the changes at both a neighbourhood and place level.
- Building a provider network, recognising the increasingly complex mix of providers across the system.
- Progressing plans through focusing on a particular project or patient pathway such as nursing, aligning therapy services, or mental health.
- Developing an ICS communications plan which would help broadcast consistent and clear messages to stakeholders and the public about the planned changes to how the local health and care system would work, how this would affect patients, and how there would be moves to establish joint commissioning.
- Establishing a single integrated business intelligence function to help produce a single truth about the needs of the population and how these are being met.
- Continuing with an organisational development approach for the system that includes primary care networks, building up capacity, and considering the needs of regulators.
- Progressing the establishment of a partnership group to encourage engagement and conversations across a diverse group of individuals and organisations, with the group considering their chairing arrangement.
- Building on the May 16 session and creating a bigger event in the autumn, widening the conversations to include more stakeholders including primary care networks.

Glossary of acronyms

Better Care Together – BCT

Integrated Care System - ICS

Leicester, Leicestershire and Rutland – LLR

Quality, Innovation, Productivity and Prevention - QIPP

System Leadership Team - SLT