LEICESTER CITY HEALTH AND WELLBEING BOARD
23rd November 2023

Subject:	Primary Care Capacity Planning over winter period
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EXECUTIVE SUMMARY:

Following the publication of the Delivery plan for recovering access to primary care in May 2023, integrated care boards (ICBs) are required to develop system-level access improvement plans for primary care.

The purpose of this report is to provide Health & Wellbeing Board with an overview of the NHSE Primary Care Recovery Plan (PCARP) and the commitments to patients therein, and provide assurance to Board that, through the development and implementation of LLR ICB's "System-level Access Improvement Plan", (SLAIP), during winter and beyond, we will deliver on these commitments for the people of LLR by: -

- Tackling the 8 am rush - make it easier and quicker for patients to get the help they need from Primary Care
- Enabling "Continuity of Care"
- Reducing Bureaucracy

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

RECEIVE this report that describes:

- the key components of the LLR System-level Access Improvement Plan and outlines how the ICB intends to deliver its key actions and priorities that supports Winter period.

Primary Care Capacity Planning over winter period

Background

1. General Practice, like many parts of the NHS, is under tremendous pressure – nationally one in five people report they did not get through or get a reply when they last attempted to contact their practice. The Fuller Stocktake stated, "there are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it". The Fuller Stocktake also provides valuable insights on the preferences of people waiting for and choosing appointments:

   People waiting for an appointment with their GP prioritise different things. Some need to be seen straightaway while others are happy to get an appointment in a week's time. Some people – often, but certainly not always, patients with more chronic long-term conditions – need or want continuity of care, while others are happy to be seen by any appropriate clinician, as long as they can be seen quickly. Equally, for some patients it is important to be seen face to face while others want faster, more convenient ways of accessing treatment and there is emerging evidence of a growing appetite (even before COVID-19) for patients to access care digitally.

2. The NHSE "Delivery Plan for Recovering Access to Primary Care" (NHSE May 2023) has two central ambitions:

   a) **To tackle the 8am rush** and reduce the number of people struggling to contact their practice. Patients should no longer be asked to call back another day to book an appointment, and we will invest in general practice to enable this.

   b) **For patients to know** on the day they contact their practice how their request will be managed.

      i. If their need is clinically urgent it should be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.
      ii. If their need is not urgent, but it requires a telephone or face-to-face appointment, this should be scheduled within two weeks.
      iii. Where appropriate, patients will be signposted to self-care or other local services (e.g., community pharmacy or self-referral services).

3. The Recovery Plan seeks to support recovery by focusing on four areas:
   i. **Empower patients** to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy.
   ii. **Implement Modern General Practice** Access to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment. The 2023/24 contract requires practices to assess patient requests on the day.
   iii. **Build capacity** to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.
   iv. **Cut bureaucracy** and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence

requests so practices have more time to meet the clinical needs of their patients.

Why do we need a Recovery Plan in LLR?

The "National Problem" – Pressures in Primary Care and the Problems for Patients – and what it means in LLR

4. In 2022/23:
    - LLR general practices provided **360,807** more appointments than in 2022
    - On average, 75% of LLR practices recovered to their 19/20 appts levels
    - Overall, LLR practices exceeded LLR target of 70% of available appointments being "Face to Face" – monthly average 74%
    - Overall, LLR practices exceeded LLR target of 75/1000 practice population clinical contacts – monthly average 93%

5. However, we know "access"- getting through to a practices, and then being "seen" in a "timely manner" - are major concerns for our LLR population.

6. Like many parts of the NHS, general practice is under intense pressure. Where demand is greater than capacity it means general practice cannot always be effective, and patient experience and access are negatively impacted. It also means that stresses appear in other parts of the health system as patients seek alternative routes to get NHS care. One key driver of growth in demand is the ageing population. Most of those over 70 live with one or more long-term condition and have five times more GP appointments on average than teenagers.

7. Nationally, overall general practice staffing is 27% higher and the number of staff delivering direct patient care is 44% higher than March 2019. However, nationally, the pandemic has changed the nature of demand. Patient contacts with general practices are estimated to have grown faster than demographic pressures, at between 20% and 40% since pre-pandemic, in part as COVID-19 backlogs have increased workload.

8. Practice surveys conducted by NHSE suggest that administrative tasks outside a consultation, measured by entries to medical records, are up 50% since 2019. Locally, and nationally, Practices report that they have never been as busy. Nationally, over the same period, NHSE reports that the growth in the number of GPs has lagged behind that of total practice staff employed.

9. Importantly, the pressure in general practice is felt strongly by these experienced GPs, who today are managing larger practices, with more patients, and supervising more doctors in GP training, more practice staff, and more clinical roles, yet remain critical to assessing the on-the-day urgent clinical need.

10. Overall growth in the LLR Primary Care workforce is at 0.9%, which is below expectation. However, separately both City and County, (including Rutland), have seen growth. County largely outgrew City in 22/23. Based on plans submitted by the LLR Primary Care Networks to NHSEI, increase in practice

staff through the “Additional Roles Reimbursement Scheme”, (ARRS), is on plan in LLR and has seen substantial growth in all staff groups.

11. Our LLR SLAIP describes the workforce strategies and initiatives – recruitment, retention, and development - through which we will optimise our most valuable workforce resource. A particular focus for Leicester City will be on the level of Social Prescriber Link Worker, (one of the ARRS roles key to enabling effective clinical navigation and sign-posting).

12. The national picture is that as demand rises, many practices are struggling to meet all the needs of their patients. Difficulties with access were also highlighted in the DHSC pulse-check survey, (December 2022), where one in five of the public said they either did not get through or get a reply when they last tried to contact their practice.

13. Good access is central to general practice being effective at meeting the reasonable needs of patients. As demand rises, the number of calls is challenging for reception staff. For those practices still on analogue lines, patients find repeated engaged tones frustrating. Retaining staff in this environment can be difficult.

14. The recently released General Practice Experience Survey, (GPES), results has allowed us to compare LLR practices performance on the Care Quality Commission (CQC) NHS GP Practice Indicators for 2023 to national performance.

15. Nationally and within the LLR ICS, performance on all indicators was lower in 2022 than in 2021. However, in 2023, average performance in LLR improved in 7 out of the 11 indicators (and 6 out of 11 nationally).

16. As in 2021 and 2022, in 2023 the worst scoring questions relate to access to GP services – GPES Q1 – *Ease of getting through to…,* LLR 2023 score down 3.29%, LLR practice score variation 11% - 97%: GPES Q2 – *How helpful was the receptionist…*, LLR 2023 score up, but LLR practice score variation 52% - 99%.

17. This is followed by *Overall experience of GP practice*…, LLR 2023 score down 0.54%, LLR practice score variation 33% - 96%.

18. Improvement initiatives will focus on addressing this variation, learning from “high” scoring practices/PCNs, and supporting “lower” scoring practices/PCNs to design, implement, and sustain improvements.

19. The results show some “positives” to <u>learn from and build on</u>:
    - The majority of respondents had positive perceptions of their care and felt their needs were met during their last GP appointment.
    - Confidence and trust in healthcare professionals is high (93%) among respondents.
    - 90% of respondents feel their needs were met during their last GP appointment.
    - 90% of respondents feel they are involved in decisions about their care and treatment.

20. GPES 2023 also provided useful insights into “online” usage in LLR:

- Both nationally and in LLR, respondents reported an increase in booking appointments, ordering repeat prescriptions, and accessing medical records online from 2022 – 2023.
- In 2021, 22 and 23, the most used online service was ordering repeat prescriptions (in 2023, 33% both nationally and in LLR).
- In 2023, the second most used online service, nationally and in LLR, was booking appointments online (23% of patients nationally and 18% of patients in LLR).

21. We have ranked top, middle, and bottom performing practices for each indicator to identify examples of good and poor performance and to get a deeper sense of performance across the system for each indicator.

22. Our 2023 GPES data will be, shared with practices and PCNs and data can be aggregated to PCN level to further nuance and support the implementation of the PCN Capacity and Access Improvement Payment plans - a key and integral component of our LLR SLAIP - to drive improvement in the experience of accessing general practice and general practice services.

23. Addressing variation in experience will continue through existing Access, Resilience, and Quality committees and processes.

What is in our System-Level Access Improvement Plan (SLAIP)

24. Although titled as a plan for recovering access to Primary Care, successful delivery of the **Delivery Plan for Recovering Access to Primary Care** will require concerted and not insignificant response and action from nearly all ICS Partners and ICB Teams in LLR.

25. To enable and assure this system level response, LLR ICB has developed and implemented an approach to delivery based around 3 central aims. These are: -
    - To tackle the 8 am rush - make it easier and quicker for patients to get the help they need from Primary Care
    - To enable “Continuity of Care”
    - To reduce Bureaucracy

26. These LLR aims reflect and will in turn be enabled by the four key commitments of the Primary Care Access Recovery Plan, (PCARP): -
    - Empowering Patients
    - Implementing “Modern General Practice Access”
    - Building Capacity
    - Cutting Bureaucracy

27. This relationship, and the delivery areas within our SLAIP are shown in *Figure 1 – LLR System-level Access and Improvement Plan* – below: -

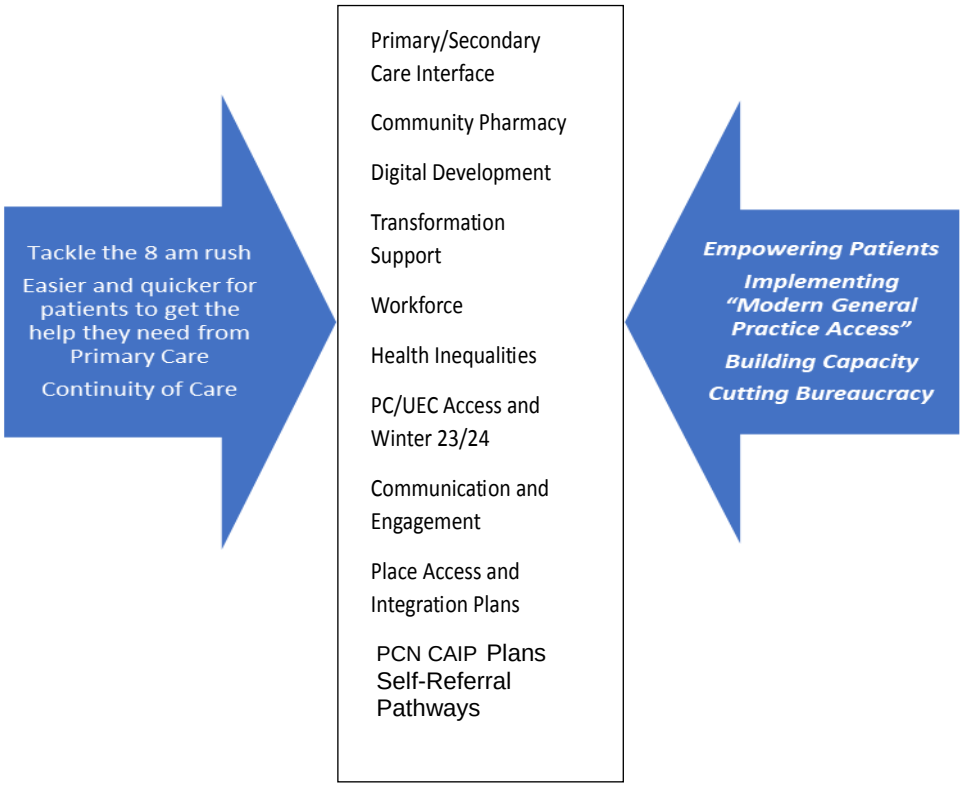


Figure 1 – LLR System-level Access Improvement Plan

Primary-secondary Care Interface

28. In the NHS, there's a growing demand amidst limited resources. To optimise patient journeys and experiences, it's crucial for healthcare professionals in primary and secondary care to collaborate effectively. However, the complex systems, varying IT systems, cultures, and priorities often hinder seamless communication and interconnection. The advent of Integrated Care Systems (ICS) represents a shared vision, where organisations partner to plan and deliver unified healthcare services for local communities. This includes delivering patient care within ICS and progressively across multiple ICS.

29. The true success lies in transitioning from 'I' to 'we.' It's not about adding to the burden on services or shifting bottlenecks within the care continuum. Instead, it's about working collectively across the primary-secondary care interface to provide the best care at the right time and place for each patient when they need it most. Patient-centred care, delivered at the right time and by the appropriate professionals, is fundamental. Effective communication is vital in interface working, as many issues stem from suboptimal communication practices. Given the pressures of workloads, waiting lists, service delays, and patient demands, healthcare professionals operate at maximum capacity. It's easy to be absorbed in one's own pressures and overlook colleagues facing their unique challenges. Improved patient outcomes and experiences are the goals. This approach not only reduces medical errors but also curtails healthcare costs and enhances overall efficiency in service delivery. It benefits patients and ensures the healthcare system's sustainability and effectiveness.

30. This approach is closely linked to the challenges outlined in our Primary Care Strategy and aligns with the themes designed to address these challenges. A significant aspect of the access challenge stems from the increasing workload, particularly for seasoned GPs, which risks overwhelming them and leaving less time available for patients. The pressure originates from the escalating number of patient contacts, which practices report to have surged by 20% to 40% since the pre-pandemic period.

Primary-secondary Care Interface -Progress so far within LLR:

31. TCS(Transferring Care Safely) established since 2016. We were one of the first nationally to set up a group to resolve ongoing interface issues.

32. C2C policy which reflects previous principles and has evolved i.e., initially consultant to consultant now clinician to clinician.

33. TCS Handbook created in 2017 with the purpose of offering comprehensive guidelines to healthcare providers regarding the best practices for effective interface collaboration.

34. **New Interface document for LLR (2023)** embedding the 10 principles to improve effective communication and behaviours. The document provides a detailed framework and principles for seamless communication, coordination, and cooperation across different levels of care. It serves as a valuable tool for healthcare professionals striving to improve the quality of care and patient outcomes by fostering better collaboration among various providers across LLR (*signed off by SE on 22/9)*

35. Pathway revisions, fit note policies, 2ww changes and various other issues as highlighted through TCS.

36. There are opportunities to reduce this workload by:
    i. improving the primary-secondary care interface
    ii. building on the “Bureaucracy Busting Concordat”

37. The existing system-level LLR Transferring Care Safely Group (TCS) is taking the lead on this and has reached a consensus on the primary areas of focus for delivery partners in the upcoming 6-9 months. These are shown in the table below:

Delivery Partner	Focus Actions
University Hospitals, Leicester	Embedding and improving the approach to providing Medical Fit Notes on discharge. Further embedding the use of Consultant Connect across the organisation. Delivery of an options appraisal for the development of a centralised contact point for those on the waiting list.
Leicestershire Partnership Trust	Provide easy access to the GP team for secondary care clinicians via non-public phone numbers and shared email mailboxes. Make 'fit note' more accessible on inpatient wards and in outpatient clinics and produce guidance for secondary care clinicians on their use. Standardise outpatient clinical letters where possible (placing particular emphasis on concise GP recommendations)
Primary Care	Prereferral work - This is mainly to look at pathways where investigations are being requested above and beyond what should be done in Primary Care (based on NICE guidance). Ensuring referrals have got all the relevant information needed. “Advice & Guidance” to get converted to referrals if deemed necessary if all the relevant information is available Build on consultant connect-currently few practices signed up, to ensure more practices sign up to allow good communication between primary and secondary care.

Community Pharmacy - Common Conditions Service and Community Pharmacy Consultation Service

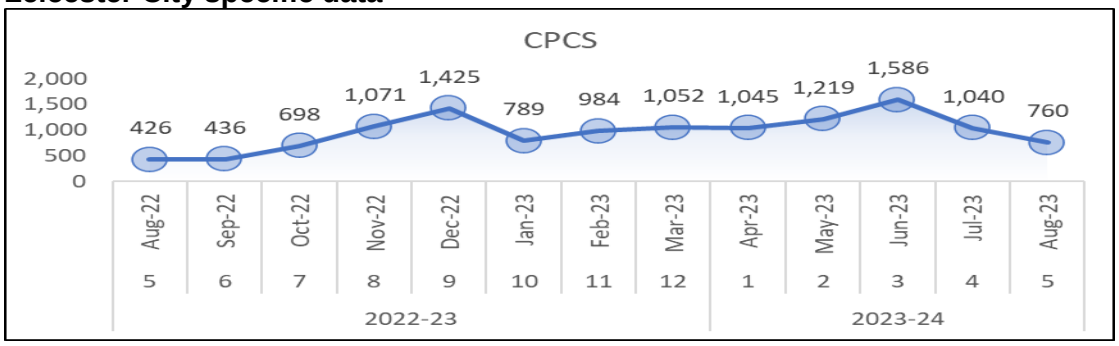
38. One of the key priorities identified within our Primary Care strategy to deliver our LLR vision is to redesign care pathways. The role Community Pharmacies have in this space is crucial.

39. As per PCARP, the ICB will support the transitioning of pharmacies participating in the regional extended care services to the proposed common conditions service where the two services overlap. We will work with our community pharmacy network and system stakeholders, including Community Pharmacy Leicestershire & Rutland to drive engagement and participation with the common conditions service, with the ambition that over 50% of the network are actively participating within 6 months of launch.

40. We will build on work already underway with regards to the Community Pharmacist Consultation Service to promote community pharmacy capacity as a viable and reliable option for patients with wider stakeholders including general practice and primary care networks.

41. Working with national colleagues we are developing an interactive map showing the services available from local pharmacies. We are still in the testing stage, but it is envisaged that this tool will help other primary care colleagues, particularly GP patient services teams and care navigators, identify pharmacies that patients can be referred to thus freeing up practice capacity and providing quicker, needs appropriate access to care in the most appropriate setting.

Leicester City specific data

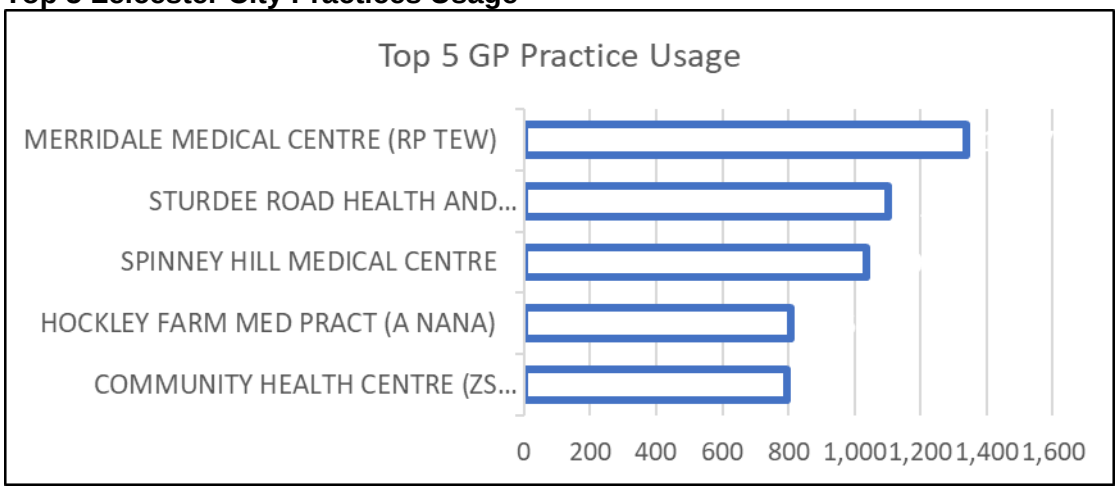


Community Pharmacy - Blood Pressure and Oral Contraceptive services

42. Targeted support has been provided to several practices and PCNs to engage with local community pharmacies to integrate the community pharmacy blood pressure checks service. We continue to see growth in referrals and pharmacy identified checks for both one off clinic checks and ambulatory blood pressure monitoring (ABPM). The LPC are working with contractors to increase confidence on the use of ABPM machines and are trialling in innovative IT platform to send data back directly into GP practices.

43. Whilst national level negotiations continue, in LLR there has been significant interest from contractors in providing the service, and several neighbourhood level meetings are planned. The latest month we have data for is June - 12 contractors have delivered a total of 63 consultations.

Top 5 Leicester City Practices Usage



	Month	Activity
2022-23	August 2022	426
	September 2022	436
	October 2022	698
	November 22	1,071
	December 2022	1,425
	January 2023	789
	February 2023	984
	March 2023	1,052
2023-24	April 2023	1,045
	May 2023	1,219
	June 2023	1,586
	July 2023	1,040
	August 2023	760
	Grand Total	**12,531**

Digital Development

44. Another of our priorities within the Primary Care Strategy is the "Digital First" approach. This includes enabling and promoting digital innovation and a "digital by default" approach to the design and delivery of care, including patient and staff education, whilst ensuring digital inclusion and avoiding un-intended digital discrimination.

45. Revised guidance for delivering the recovery plan was received from NHSE mid-September 2023, with 3 revisions specific to our digital development:

I. **Cloud-based telephony** – National support to enable 1,000 practices to transition to digital telephony by December 2023. Expectation is that all remaining analogue practices move to digital telephony by March 2024. We will be actively monitoring progress, working alongside the national procurement hub, and following further national guidance and support expected soon, we will review the quality of cloud-based telephony already in place with a view to improve this where necessary.

a. In LLR, 102 practices already have digital telephony platforms. Twenty, 20, LLR practices, supported by national funding, are in the process of migrating to a Cloud Based Telephony system. Five, 5, LLR practices are also migrating independently of national support. We will work with those practices that have not yet described their plan to migrate.

II. **NHS App** – Data shows that all our LLR practices have patients registered to use the NHS App and have patients making and cancelling appointments and ordering repeat prescriptions via the NHS App. The same data shows significant variation in relative levels between practices, and across the year within practices. We will work with practices to understand this variation and support the sharing of learning and best practice to address.

We will continue to leverage the core functions of the NHS App, to empower patients and enable them to self-serve to address appropriate. We will liaise with practices to ensure that each practice has a plan for each patient to receive prospective record access, (unless exceptions apply), from 31 October.

III. **Digital pathways framework** – Whilst national level engagement with the market continues, and the timeline for the launch of the framework is confirmed, we will work with practices to fully understand the contracting position for their online consultation, messaging and booking solutions currently in use. We expect to receive guidance and information on what to expect from the framework from our Regional Team so we can begin preparatory work.

Primary Care Transformation and Transformation Support

General Practice Improvement Programme (GPiP)

46. This national programme includes Universal, Intermediate, Intensive and Local levels of support. Programmes focuses on implementing 'modern general practice' operating models and introduces the Support Level Framework (SLF) tool.

City practices that have signed up for the different 'phases' of GPIP

Phase A

Practice Name	C Code	PCN	Offer type
Beaumont Lodge Medical Practice	C82094	Millennium	Intensive
Bowling Green Street Surgery	Y02686	Leicester Central	Intensive
Heron GP Practice	Y02469	Leicester Central	Intensive

Phase B

Practice Name	C Code	PCN	Offer type
Highfield Surgery	C82116	Leicester City PCN	Intermediate
Heron GP Practice	Y02469	Leicester Central	Intensive

Phase C

Practice Name	C Code	PCN	Offer type
East Leicester Medical Practice	c82063	Salutem PCN	Intensive
Fosse Medical Centre	C82086	Millennium	Intermediate
Willows Health	Y00137	Aegis	Intermediate

Phase D
None

Phase E
Currently available for sign-ups

Workforce

47. One of the key enablers, outlined within the Primary Care Strategy to achieve the needed transformation, is our workforce. The performance of any health and care system ultimately depends on its people.

48. We have described the LLR workforce position earlier in the report, and we are committed to addressing workforce issues through retaining our existing workforce whilst supporting, optimising new roles, and making LLR an attractive place to train and work.

49. Reflecting the NHSE "People Plan", and the expectations of PCARP, the ICB's Workforce Team has developed robust plans in place to support and build the workforce. Please see Appendix 2 – *LLR PCARP Workforce Plan Summary* – for examples of the initiatives to be actioned.

Health Inequalities

50. Improving Health Equity by identifying and addressing health inequalities is one of the ICS's key pledges within its "Five Year Joint Plan", and "tackling inequalities in outcomes, experiences, and access" is one of the plans quintuple aims.

51. This is under-pinned and enabled by our "Life Course" and "Population Health Management" approaches that run through the LLR Primary Care Strategy and all our operational and delivery plans.

52. In their CAIP Plan development and submissions, LLR PCNs have been asked how they will identify and address health inequalities in their strategies for improving patient experience and access. This will build on the work and plans our PCNs have undertaken as part of the Network DES Contract – to develop a "Tackling Health Inequalities Plan", and "Personalised Care Plans" for patients identified through risk stratification.

53. Quality and Equality Impact Assessments will be undertaken - as standard practice and process – for any service change proposals within the emerging Place Based Access and Integration Plans.

PCN Capacity and Access Improvement Payment (CAIP) Plans

54. All Leicester City PCNs submitted plans to the ICB as per the national deadline, and all 10 plans were accepted by the ICB. It is expected that these plan will be iterative and there will be opportunities, formal and informal, throughout the year to guide and support further development and implementation. Our proposed process to allocate CAIP funding to our PCNs is described later in the paper.

55. Whilst all 10 PCNs have described how they will address/achieve the core CAIP requirements, a number of themes emerged from the submitted plans. (*LLR CAIP Plan Themes* below). These have been shared with all PCNs to share ideas and spread innovation.

Leicester City Place "CAIP" Plan Themes

Ideas shared	Themes from Plans
• Addressing 8am rush • Empowering pts – Modern General Practice options (NHS App, Online Consultation, CPCS, use of ARRS, etc) • Active Signposting Training • Use of CBT triangulation data • Maintain project / delivery plan to monitor progress • Collaboration with partners and voluntary organisations to deliver the plan • Linked to the H&W / Place Plans	• Collaboration with PPGs • Promoting ARRS, CPCS services • T&D of staff; Active Signposting • Update website – online consultation / booking • Segmentation of population • Triangulation of CBT / Online consultation • Integrated working with partners / voluntary organisation • Website review and redesign / social media and use of QR codes

Winter 2023/2024 – Adult and Paediatric ARI Hubs – LLR Response

Primary Care/Urgent and Emergency Care Access and Winter 23/24

56. Although not an explicit "NHSE requirement" for our SLAIP, we are including how we intend to enhance system wide access and capacity to manage winter surge demand from Acute Respiratory Infections, (ARIs), identified as one of the "High Impact Actions" for Winter 23/24.

57. NHS England and UK Health Security Agency (UKHSA) reports from 2020-2022 show that acute respiratory infections are among the most common reasons for emergency attendance and admission. Scenarios for COVID-19, combined with those for flu, suggest that even in optimistic scenarios, high numbers of appointments and beds will be needed for respiratory patients during Winter.

58. Primary care, secondary care, and NHS111 will need to work together to prevent large numbers of children and older patients with breathing difficulties from being triaged with the outcome of an emergency ambulance, as many of these patients do not need to be admitted and can be looked after in the community.

59. In the NHSE Winter Letter published in July 2023, Acute Respiratory Infection Hubs are listed as one of the ten high-impact interventions for Winter 2023/2024. They should "support consistent roll-out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures."

LAST YEAR – WINTER 2022/2023

60. By the end of Winter 2022/23, we had 8 ARI hubs, one of which was paediatrics only, and the others were for both paeds and adults. The hubs saw an additional 4341 adults between January and the end of March. Around 1.6% were sent to ED/A&E after assessment.

61. 61% of adults were discharged home, which might indicate that the majority of these people could have been managed by pharmacy/111/CNH or over the phone instead of having a face-to-face ARI appointment.

62. This was also evident in the presenting conditions and diagnoses. However, all our data is free text (due to implementation speed), so it can't be relied upon fully. And we didn't have robust patient triage in place.

63. Additionally, many patients were seen for more chronic presentations of the allowed criteria, for example, coughs lasting longer than 4 weeks or sinus problems over several months.

64. When compared to other systems, our average price per available appointment was quite expensive: £73. And because only 72% of our appointments were utilised, the average cost per utilised appointment was £102.

CAPACITY & DEMAND

65. We cannot know the adult ARI demand over a given winter – at the moment, our primary care data doesn't allow us to know how many people will get an acute respiratory infection and want to be seen.

66. However, using the data we have, there is an undeniable surge in acute respiratory infections in LLR, as well as an increase in related emergency admissions and A&E attendances between October and February.

67. Nationally, it is understood that 73% of ED attendees are discharged on the same day of arrival. (GIRFT – Emergency Medicine) For LLR, between April 2022 and March 2023, 58% of those patients coded with a complaint of "airway/breathing" in A&E were not admitted. In many cases, it would be more appropriate for these patients to be seen in the community.

68. There are generally two types of adult patients who will require a service to manage their acute respiratory infection:
    - Patients with no known respiratory conditions who get an ARI and need low-level care, reassurance and perhaps some medicine such as over-the-counter products or antibiotics.
      Some of these patients might legitimately require urgent treatment from secondary care services, which is appropriate.
    - Patients with known respiratory conditions who are more at risk from getting an ARI and are more likely to have adverse effects, more likely leading to treatment from secondary care services and are at risk of a longer length of stay.

PROPOSAL

63 **For Cohort 1**, who don't require secondary care treatment, there are additional services/improvements in the system which have/will be set up to manage this kind of demand. They are:
- Maximising Community Pharmacy use (including CPCS) – *suitable complaints include coughs, flu symptoms, sore throat, blocked or runny nose, earache, etc.*
- Minor Injuries and Minor Illness Unit (MIaMI)
- Better access to GP services through Enhanced Access and the Capacity & Access Improvement Plans (CAIP)
- Redirecting appropriate patients from ED to Type 3 Urgent Treatment Centres such as Oadby/Merlyn Vaz.
- Increase walk-in capacity at UTCs instead of booked appointments. See ARI patients as a priority.
- Increase use of NHS App – advice and reassurance.
- Growth of 111 and Clinical Navigation Hub, including retired clinicians – As part of LLR Delivery Plan to recover UEC services, May 2023
- Targeted immunisation programmes such as flu/COVID – increasing uptake will reduce the incidence of ARI.

64 Based on our estimated data on ARI Hubs from last year, the majority of the surge in ARI demand for cohort 1 (who do not require urgent secondary care treatment) will be captured by one or more of these services.

65 All of these services are designed to meet our objective: to support the ARI demand in primary care and ED and ease system pressures.

66 There is already a tremendous amount of work happening to improve or implement these services ready for this Winter, and it is proposed that we don't add any more services to an already busy and complicated system.

67 However, all these services will be continually monitored through the UEC programme and the associated dashboard.

68 Finally, the ICB comms and engagement teams are implementing a targeted communications plan to ensure that patients know where to go and what to do over Winter. This is called “Get in the Know.”

69 **For Cohort 2**, more work is needed to help our known respiratory patients in case of ARI. There are two types of interventions:

- Proactively monitoring appropriate patients to spot signs of deterioration earlier, likely using technology. This can also be known as ‘remote monitoring.’
- Proactively optimising known respiratory patients so that in case of exacerbation or ARI, they and their clinicians are more prepared, de-escalation will be quicker, and in case of a hospital stay, length of stay may be reduced. This will also help to support flow through UHL, including pressures on the front door.

69. There is already a service in place to remotely monitor some COPD patients. Spirit Health provide the technology, and the platform is called Clinitouch Vie. It would be beneficial to expand this kind of “telehealth”; however, there isn’t currently any additional funding to do this. A review of this service is now underway to evaluate its effectiveness, and we can ensure it is maximised, even without any additional funding.

70. The Integrated Respiratory team will continue to work proactively with general practices and PCNs to optimise care for specifically for patients with respiratory conditions.

End