LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 23 NOVEMBER 2023

Time: 9:30 am

Location:
MEETING ROOM G.01, GROUND FLOOR, CITY HALL,
115 CHARLES STREET, LEICESTER, LE1 1FZ

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

For Monitoring Officer

NOTE:

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http://www.leicester.public-i.tv/core/portal/webcasts

MEMBERS OF THE BOARD

Councillors:

Councillor Sarah Russell, Deputy City Mayor, Social Care, Health and Community Safety (Chair)

Councillor Adam Clarke, Deputy City Mayor, Climate, Economy and Culture

Councillor Elly Cutkelvin, Deputy City Mayor, Housing and Neighbourhoods

Councillor Vi Dempster, Assistant City Mayor, Education, Libraries and Community Centres

1Vacancy

City Council Officers:

Martin Samuels, Strategic Director of Social Care and Education

Rob Howard, Director Public Health

Dr Katherine Packham, Public Health Consultant

1 Vacancy

NHS Representatives:

Jean Knight, Deputy Chief Executive, Leicestershire Partnership NHS Trust

Richard Mitchell, Chief Executive, University Hospitals of Leicester NHS Trust

Oliver Newbould, Director of Strategic Transformation, NHS England and NHS Improvement

Dr Avi Prasad, Place Board Clinical Lead, Integrated Care Board

David Sissling, Independent Chair of Leicester, Leicestershire and Rutland Integrated Care System

Rachna Vyas, Chief Operating Officer, Leicester, Leicestershire and Rutland Integrated Care Board

Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Group

Healthwatch / Other Representatives:

Benjamin Bee, Area Manager Community Risk, Leicestershire Fire and Rescue Service

Harsha Kotecha, Chair, Healthwatch Advisory Board, Leicester and Leicestershire

Kevan Liles, Chief Executive, Voluntary Action Leicester

Rupert Matthews, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Kevin Routledge, Strategic Sports Alliance Group

Sue Tilley, Head of Leicester, Leicestershire Enterprise Partnership

Barney Thorne, Mental Health Manager, Local Policing Directorate, Leicestershire Police

1 vacancy

STANDING INVITEES: (Non-Voting Board Members)

Cathy Ellis – Chair of Leicestershire Partnership NHS Trust

Professor Andrew Fry – College Director of Research, Leicester University

Susannah Ashton, Divisional Manager for Leicester, Leicestershire and Rutland, East Midlands Ambulance Service

John MacDonald, Chair of University Hospitals of Leicester NHS Trust

Professor Bertha Ochieng – Integrated Health and Social Care, De Montfort University

Information for members of the public

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- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Jacob Mann**, Democratic Support on (0116) 454 6356 or email jacob.mann@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

If the emergency alarm sounds, you must evacuate the building immediately by the nearest available fire exit and proceed to area outside the Ramada Encore Hotel on Charles Street as directed by Democratic Services staff. Further instructions will then be given.

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed at the meeting.

3. MINUTES OF THE PREVIOUS MEETING **Item 3 (Pages 1 - 10)**

The Minutes of the previous meeting of the Board held on 21 September 2023 are attached and the Board is asked to confirm them as a correct record.

4. UHL/ICB WINTER PLANNING AND PRIMARY CARE CAPACITY **Item 4 (Pages 11 - 88)**

Jon Melbourne (Chief Operating Officer, University Hospitals Leicester) and Rachna Vyas (Chief Operating Officer, Integrated Care System) will present and outline the ICB/NHS winter plan and priorities for the 2023/24 winter period. Mayur Patel (Head of Transformation, LLR Integrated Care Board) and Nisha Patel (Head of Transformation, LLR Integrated Care Board) will present an overview of Primary Care Capacity Planning over the winter period.

5. WINTER VACCINATIONS AND IMMUNISATIONS PROGRAMME **Item 5 (Pages 89 - 106)**

Kay Darby (Deputy Director Vaccinations and Immunisations, Leicester, Leicestershire and Rutland Integrated Care Board) will present an overview of the winter vaccinations and immunisations programme across the Leicester population for adults and children and young people.

6. SOCIAL CARE WINTER PREPAREDNESS

Item 6
(Pages 107 - 114)

Kate Galoppi, (Director of Adult Social Care and Commissioning, Leicester City Council), Mark Abbot (Head of Service, Social Work, Leicester City Council), and Jagjit Singh-Bains (Head of Independent Living, Leicester City Council) will present a summary of the actions in place locally to support a resilient social care system that is able to provide people and their carers with appropriate support this winter.

7. PUBLIC HEALTH INITIATIVES AND WINTER PLANS

Item 7
(Pages 115 - 148)

Gurjinder Bans (Public Health Programme Manager, Leicester City Council) and Kate Huszar (Public Health Programme Manager, Leicester City Council) will share a presentation to outline programmes and initiatives to address critical winter issues.

8. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

9. DATES OF FUTURE MEETINGS

To note that meetings have been arranged for the following dates in 2023/2024 which were submitted to the Annual Council in May 2023. Please add these dates to your diaries. Diary appointments will be sent to Board Members.

Thursday 18 January 2024 – 9.30am
Thursday 22 February 2024 – 9.30am
Thursday 18 April 2024 – 9.30am

Meetings of the Board are scheduled to be held in Meeting Rooms G01 and 2 at City Hall unless stated otherwise on the agenda for the meeting.

10. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 21 SEPTEMBER 2023 at 9:30 am

Present:

Councillor Sarah Russell (Chair)	Deputy City Mayor, Social Care, Health, and Community Safety
Councillor Elly Cutkelvin	Deputy City Mayor – Housing & Neighbourhoods
Ben Bee	Area Manager – Community Risk, Leicestershire Fire & Rescue
Rob Howard	Director of Public Health, Leicester City Council
Jean Knight	Deputy Chief Executive, Leicestershire Partnership NHS Trust
Helen Mather	City Place Lead
Rani Mahal	Deputy Police and Crime Commissioner, Leicester, Leicestershire, and Rutland
Ruw Abeyratne	Director of Health Equality & Inclusion, University Hospitals of Leicester NHS Trust (UHL)
Dr Avi Prassad	Clinical Place Leader, Leicester, Leicestershire, and Rutland Integrated Care Board
Kevin Routledge	Strategic Sports Alliance Group
Rachna Vyas	Chief Operating Officer, LLR Integrated Care Board (ICB)
Martin Samuels	Strategic Director of Social Care and Education, Leicester City Council
Sue Tilly	Head of the Leicester and Leicestershire Enterprise Partnership
Barry Thorne	Mental Health Partnership Manager, Leicestershire Police

In Attendance

Councillor Geoff Whittle	Chair of Health Scrutiny, Leicester City Council
Chris Burgin	Director of Housing, Leicester City Council
Jo Atkinson	Consultant in Public Health, Leicester City Council
Andrea Thorne	Public Health Project Manager, Leicester City Council
Alison Williams	Public Health Admin, Leicester City Council (minute taker)

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16. APOLOGIES FOR ABSENCE

Apologies were received from:

- Councillor Vi Dempster - Assistant City Mayor
- Andy Williams - Chief Executive, LLR Integrated Care Board
- Susannah Ashton – Divisional Manager for LLR, East Midlands Ambulance NHS Trust
- David Sissling - Independent Chair, Leicester, Leicestershire, and Rutland Integrated Care Board
- Richard Mitchell – Chief Executive, University Hospitals of Leicester NHS Trust (UHL)

17. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business to be discussed at the meeting. No such declarations were received.

18. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 29 June 2023 be confirmed as a correct record.

19. LEICESTER JOINT HEALTH, CARE AND WELLBEING STRATEGY DELIVERY PLAN QUARTERLY UPDATE

Dr Katherine Packham (Consultant in Public Health, Leicester City Council) presented a highlight report summarising key progress against actions to address the six priorities selected for initial focus outlined within the Joint Health, Care and Wellbeing Strategy. The update covered the six-months from February to July 2023 inclusive. Some of the work being undertaken, around children/young people and mental health work in the Public Health team, was not fully captured in the current Plan. Each strand of the workstream was discussed in turn. Only one risk was noted – see Healthy Aging section below.

- Healthy Start; *priority "to mitigate against impacts of poverty on children and young people".* Progress includes:-
    - Anti-poverty grants had been issued (particularly around food insecurity).
    - "Lets Get Resourceful" was evolving into longer term resilience-building projects.
    - The fuel poverty programme (Public Health in collaboration with National Energy Action) continued.
    - A Task & Finish Group was meeting to look at the experiences of BAME women accessing services. An event would be held to raise awareness of equity for maternity care.
- Healthy Places; *priority "to improve access to primary & community health and care services".* Progress includes:-

    - Better links were being developed with social prescribers, the Primary Care Networks and digital services; this would help address the five priorities for the workstream.
    - Uptake of Health Checks by those with learning disabilities had improved.
- Healthy Minds; *priorities based on improving access to Mental Health services".* Progress includes:-
    - A new advice service commenced May 2023.
    - Mental Health Support Teams in schools had increased.
    - The "Crisis Cafes" had been rebranded to "Mental Health Cafes" – and there were now eleven of these.
    - The "IAPT" service had been rebranded as "NHS Talking Therapies".
    - The Dementia Strategy consultation was closing on 22.9.23 – and members were asked to share the link widely.
- Healthy Lives; *priority to "increase detection of heart disease, lung disease and cancer in adults".* Progress includes:-
    - The hypertension pilot scheme was being evaluated.
    - Significant work had progressed on cancer pathways – including year two rollout for the "FIT" pathway.
- Healthy Aging; *priority "age comfortably and confidently through a person-centres programme to support self-care, build on strengths and reduce frailty*". Progress includes:-
    - Expansion of MyChoice directory.
    - Building up assets around loneliness.
    - Appointment of a Project Lead for Reablement (with respect to hospital discharges).
    - A risk was noted; the £500k allocated for increased reablement will be insufficient to make transformative change.
- Communications and engagement activity continued via joint working between the ICB and the Local Authority (and particularly through facilitation by the Community Wellbeing Champions).

Comments and questions from the Board:-

- The Chair proposed a future Development Session of the Board to discuss ways to demonstrate and evidence impact. This was agreed by Members, with a suggestion to invite academic colleagues.
- The Chair felt that the Dementia Strategy consultation was a prime example of information that helps understand the community – and as such should be a link that was shared across all partners represented at the Board.
- Dr Packham confirmed that there were Communications Leads in the membership of the Delivery Action Plan Steering Group but acknowledged the Chair's suggestion that a distinct Comms Group could be useful.
- The Chair felt that vaccine uptake promotion needed to be in every school and club newsletter – and perhaps in sporting match-day programmes.
- Primary Care and LPT leads collaborated to find the previously missing cohort of learning disabled who had not had their NHS Health Check.

As a result, this year 1500 were contacted and only one of those did not then come forward for their check.

- The NHS Galleri cancer research trial utilised local Councillors and the Primary Care Networks to successfully engage more participants from lower socio-economic groups.
- There had been a large increase in uptake of Talking Therapies this year following community engagement. As a result of the engagement, the services now went out to the people rather than expecting the people to come to the service.
- The Chair noted that elected members were keen to champion health and wellbeing challenges – and welcomed any tools that can be used to help with this.
- The Member of the Board representing United Leicester noted that the clubs had previously established a health and wellbeing module placed on all their websites. Sustainability of the module was proving a challenge post-pandemic.
- A Joint Charter was signed by the City Mayor, the Universities, County Council and Rutland Council around fifteen months ago. As a result cross-cutting groups were set up – but the "Health and Wellbeing in Sport" group struggled with sustainability.
- A recent Health Needs Assessment showed that there was poor oral health in Leicester, and that access to NHS dentistry was a significant challenge. It was requested that Officers bring a presentation to a future Board meeting to plan what actions can be taken.

RESOLVED:

1. That the Board thanks Officers for the presentation and asks them to take Members comments into account.
2. That more detail on any of the projects mentioned in the report can be directed to Dr Packham.
3. That the Board members will share the link to the Dementia Strategy consultation (which closes 22.9.23).
4. That Officers will bring the refreshed Dementia Strategy to a future Board meeting.
5. That there will be a future Development Session of the Board to discuss ways to demonstrate and evidence impact.
6. That Members will make the most of communications networks to share health and wellbeing messages across Leicester, Leicestershire and Rutland.
7. That Officers will bring a report on oral health to a future Board meeting – to enable discussion about possible actions to improve oral health and access to NHS dentistry.
8. That Officers bring a report, to a future meeting, on the energy advice work of Public Health and National Energy Action.

20. CURE EVALUATION

Jo Atkinson (Consultant in Public Health, Leicester City Council) and Andrea Thorne (Public Health Project manager, Leicester City Council) gave a slide-desk presentation, to accompany the document in the agenda pack, on the evaluation of the CURE programme since its implementation. The CURE programme was a tobacco dependency treatment service within Acute hospital settings, mental health inpatient settings (within LPT) and maternity hospital settings – but this evaluation was only about the Acute inpatient arm of the service delivered within University Hospitals of Leicester NHS Trust (UHL). It was noted that:

- The service launched gradually due to the Covid-19 pandemic.
- Thanks were noted to the small project team under Andrea Thorne, and to partners/leads in UHL, ICB and Leicestershire Partnership Trust (LPT).
- Smoking was the leading cause of premature preventable deaths – and this programme was part of the NHS Long Term Plan to address that.
- Smoking prevalence in Leicester adults was reported as 12.8% in 2021.
- The NHS Long Term Plan had a target for all inpatients being offered support to stop smoking by 2023/4.
- East Midlands Tobacco Alliance funding helped with the set-up costs for the first phase in Glenfield Hospital in April 2021. The Leicester Royal Hospital came on board in Summer 2022, and finally Leicester General Hospital in April 2023.
- The pathway was described as:-
    - Admission to hospital
    - A Making Every Contact Count (MECC) assessment being completed by UHL staff.
    - A smoking status in the MECC assessment generates an automatic referral to the Tobacco Dependency Advisers (TDAs) within CURE.
    - A TDAs see the patient at their bedside and offers support.
    - Nicotine Replacement Therapy was prescribed.
    - On leaving the hospital the patient was offered continued support for a further 12+ weeks within the community Local Authority smoking cessation teams (City or County as appropriate).
- The focus of the paper in the agenda pack was the evaluation conducted in collaboration with Dr Shilpa Sisodia (Public Health Registrar at the time of the project) using the RE-AIM methodology*.
- *RE-AIM stood for Reach, Effectiveness, Adoption, Implementation and Maintenance.
- REACH;
    - 3615 clients were referred between October 2022 and February 2023. There was an average referral rate of 700-800 per month.
    - At the time of the evaluation 31% of the referrals were seen at bedside; this was low due to staff sickness at that time. By April 2023 this had improved to 40% and is currently sitting at 50%. 100% will never be achievable as the staff only work Monday to Friday 9am-5pm – but the team are aiming for 60%. The pilot in Glenfield Hospital achieved 73%.

    - 53% of the clients were from Quintiles 1 and 2 – and this indicated the project was reaching the most deprived cohort.
- Effectiveness;
    - 65% of those supported maintained a quit at four weeks; this was higher than the community rates (55-60%) and may have been due to the personalised support by the TDAs.
    - 75% received pharmacotherapy.
    - 84% of those seen at bedside accepted the offer of a transfer to the community smoking cessation services.
- Adoption; adoption was highest in Glenfield Hospital (*possible reasons are listed in the report in the agenda pack).*
- Implementation;
    - The biggest key challenge/barrier was the number of different IT systems involved (two for UHL, one for City Community, one for County Community and one for Pharmacies). A Data Working Group was set up to tackle this – and a new over-arching and simplified system was set to commence from January 2024. This would stop the current need for the team to be manually inputting onto a spreadsheet on a daily basis. Thanks were noted to Saadia from the LLR STP Digital Innovations Hub for her assistance around the IT challenge.
    - Another barrier/challenge was the pharmacology provision – and a Medicines Management Steering Group was established to address issues. Special mention went to Jo Priestly (UHL Pharmacist).
    - Another barrier was the governance structures involved; the LTP funding comes into the Integrated Care Board, the team were employed by the City Council but based in UHL offices using Honorary contracts.
    - Another barrier was the lack of uncertainty around recurrent funding.
    - Other facilitators were the seed funding (see above), clinical leadership, joint working and the national mandate.
- Feedback from interviews had suggested the following areas for improvement:-
    - Greater patient/public involvement
    - See more clients (whilst noting the increasing costs of NRT without the corresponding increase to the budget).
- Recommendations were noted as:-
    - Staff make better use of translation services. This had improved since the recommendation was made.
    - Speed up the time it took for a patient to receive NRT. The national target was two hours. Quality improvement work had seen this target getting closer.
    - Finalise one IT system to make efficiencies (see above for details).
    - Make the MECC assessment a mandatory field (this was being progressed).
    - Continue to evaluate and monitor impact on prevalence rates and deaths in the longer term.

- In addition to the recommendations above (which are all being worked on), other next steps were noted as:-
    - More quality improvement projects.
    - Have conversations regarding LTP funding.
    - Influence a cultural change to get tobacco dependence treated as a disease.

Comments and questions from the Board:-

- Members of the Board thanked everyone involved - and noted that this was a project which shows true partnership working.
- Members of the Board commented that it would be helpful for return-on-investment data to be gathered, as longer-term economic analysis would allow the project to be prioritised for extension/expansion in the future.
- Members of the Board asked to see projection data on equity, lifestyle, generational and financial impacts.
- A Member of the Board asked why the CMG MECC Assessment was not listed in the report.
- A Member of the Board asked whether external assistance would be useful to make links with the Community Pharmacists. Jo Atkinson explained that there was a Community Pharmacy arm to CURE – and there was a separate Task Group working on this. Progress had been slow to date – but the ICB had just employed a Project Manager to increase engagement with Pharmacies.
- Members of the Board suggested that the new Occupational Health Lead within UHL could help reach the UHL workforce and expand resources. In addition, information about the project could be shared more publicly through UHL Senior Leadership Pathways.

RESOLVED:

1. That the Board thanks Officers for the report.
2. That the UHL representative present will speak with Andrea Thorne about making better links with the new Occupational Health Lead in UHL.
3. That UHL leads will share the information about the project through Senior Leadership Pathways.
4. That the Board would welcome sight of further analysis and return-on-investment data.

21. MEETING THE NEEDS OF COMPLEX PEOPLE

Chris Burgin (Director of Housing, Leicester City Council) presented a slide-deck update on the progress which had been made towards addressing the significant health and service challenges which are faced by complex tenants since bringing this issue to the Health & Wellbeing Board in January 2023. It was noted that:

- Previous presentation to the Board on 26.1.23 had resulted in the setting up of a Joint Agency Working Group. This has now met three times and

Chris Burgin, as Chair, had been impressed by the collective intelligence and passion of the members.

- The group used the Changing Futures platform to co-ordinate a system-change and embed the new practices. Each output of the Action Plan had a named lead.
- When the group met initially there were some clients that were not known to all members – so a data trawl was undertaken to collect information to use to register the cohort through Changing Futures. This allowed these clients to be supported on an intensive basis.
- Public Health had undertaken a Joint Service Needs Assessment (JSNA) which was almost completed; this will give added evidence and intelligence to enable further development of an Action Plan and strengthening of pathways.
- Mark Pierce (ICB) had been heading an investigation into why outpatients do not attend appointments.
- Wayne Henderson at Inclusion Healthcare had been leading on the primary care aspects of the workstream.
- It was envisaged that the JSNA will indicate the need for non-general housing – and may show that the 20,000 current Council homes are not suitable for certain people with complex needs. There was an appetite for mental health/drugs/alcohol support to be included as part of the housing offer to those tenants.
- Public Health were leading on a piece of work to prevent people from becoming homeless via early prevention alongside partners.
- The Board were thanked for setting this work in motion – and thanks were passed on to everyone who involved in the Working Groups.

Comments and questions from the Board:-

- The Chair asked that some case studies be brought to the Board to better demonstrate the impact of this work on individuals and the system as a whole. One example had been an individual, who previously attended A&E twice a week, who was now registered with a GP and only attended the practice once a month.
- Councillor Cutkelvin noted that the Housing service was required to become more agile when the pandemic struck – and at that same time there was a rise in single men entering the service. The service found that there were antisocial issues, however, when these men were moved on from the temporary accommodation.
- Councillor Cutkelvin noted that she attended national forums where “Housing First” and “Psychological Informed Environments” were discussed.
- Councillor Cutkelvin felt that Services should work to reduce barriers and encourage self-care – and this could include things such as dentistry and haircuts. She asked that all partners around the table input into agile wrap-around services to achieve this.
- That the Action Plan could make more use of peers and lived experience.
- That the work undertaken helped people to live well in a house – and this lessened the burden on the services represented by the Board.

- It was noted that Police were part of Changing Futures but had not engaged in the three meetings to date; there were links, however, to the Street Lifestyle Group which did have Police representation. Members felt that there were strong city centre links but less so moving outwards.

RESOLVED:

1. That the Board thanks Officers for the report and asked that comments from the meeting are taken into account.
2. That case studies be brought back to the Board on a future occasion.
3. That the Board offers continued support to the workstream due to its impact on people and services.
4. That the Board looks forward to receiving the JSNA when completed.
5. That the Police representative will speak with Chris Burgin outside the meeting to discuss the comments noted above.

22. HEALTHWATCH ANNUAL REPORT

As Kevin Allen-Khimani and Harsha Kotecha had both sent apologies – this item was deferred.

23. BETTER CARE FUND

The amended document was noted by the Board (the Capacity & Demand figures in Tab 4 have been amended since the version published with the June 2023 Health & Wellbeing Board papers).

24. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions from members of the public had been received.

25. DATES OF FUTURE MEETINGS

The Board noted that future meetings of the Board would be held on the following dates:-

Thursday 23 November 2023 – 9.30am
Thursday 18 January 2024 – 9 30 am
Thursday 22 February 2024 – 9.30am
Thursday 18 April 20234– 9.30 am

Meetings of the Board were scheduled to be held in Meeting Rooms G01 and 2 at City Hall unless stated otherwise on the agenda for the meeting.

26. ANY OTHER URGENT BUSINESS

There being no other business the meeting closed at 10.59 am.

LEICESTER CITY HEALTH AND WELLBEING BOARD
23rd November 2023

Subject:	Winter Planning Update
Presented to the Health and Wellbeing Board by:	Jon Melbourne, Chief Operating Officer, UHL Rachna Vyas, Chief Operating Officer, ICS
Author:	Sarah Taylor, Deputy Chief Operating Officer, UHL / Interim Director of Urgent and Emergency Care

EXECUTIVE SUMMARY:

Purpose of report

1. The purpose of this report is to summarise planning to manage Winter pressures across LLR in 2023/ 2024 and provide an update on the COVID-19 and flu vaccination programme for the eligible population resident within Leicester, Leicestershire and Rutland

Policy Framework and Previous Decisions

2. At the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting on 10 August 2023 the Board approved the Winter Plan for 2023/24. The Leicester, Leicestershire & Rutland Integrated Care System - Delivery plan for recovering urgent and emergency care services is appended to this report.

Background

2. Winter planning is an annual responsibility of health and social care organisations, in order to cope with the anticipated increase in demand for care as a result of weather conditions and seasonal illnesses.

3. Across the health and social care system, winter planning is co-ordinated to ensure that there are robust arrangements to cope with demand and surges in activity, and that agencies are working together to manage pressures to ensure that residents continue to receive safe and appropriate care.

4. Urgent and emergency services have been through the most testing time in NHS history with a perfect storm of pressures impacting the whole health and care system but causing the most visible problems at the 'front doors' of our services such as General Practices, 111 services and Emergency Departments.

5. Nationally staff prepared extensively for winter, putting in place thousands more same-day appointments, thousands more beds, more call handlers, 24/7 care control rooms and respiratory hubs, and often working at the limits of their endurance.

6. Despite their best efforts, increasing length of stay, alongside the demands of flu and COVID peaking together, has seen hospital occupancy reach record levels. This means patient 'flow' through hospitals has been slower.

7. In the last 12 months, LLR has made significant progress in its Urgent and Emergency Care performance, including a sustained improvement in ambulance handover times – with over 90% less time lost to ambulance handover delays when compared to 2022.

Winter Plan for 2023/24

8. Sustaining the improvement of the last 12 months will require focus in five areas:

9. Increase capacity, to help deal with increasing pressures on Leicester hospitals which see 19 in 20 beds currently occupied.

- Dedicated revenue and capital for additional capacity at Glenfield and 52 (25 new) community beds as part of the permanent bed base for next winter/spring.
- New ambulances will be available across the East Midlands, the majority of which will be on the road by next winter.
- 'Same day' emergency care services will be in place across the LRI and the Glenfield hospital, so patients avoid unnecessary overnight stays.
- Grow the workforce, as increasing capacity requires more staff who feel supported.
- More clinicians will be available for 111 online and urgent call services to offer support, advice, diagnosis and, if necessary, referral. From this April we will launch a new targeted campaign to encourage retired clinicians, and those nearing retirement, to work in 111 rather than leaving the NHS altogether.
- We will grow the workforce with more flexible ways of working and increase the number of Emergency Medical Technicians next year to respond to incidents and support paramedics.

10. Speed up discharge from hospitals, to help reduce the numbers of beds occupied by patients ready to be discharged.

- At the Autumn Statement 2022, the government made available up to £2.8 billion in 2023/24 and £4.7 billion in 2024/25 of additional funding to put the adult social care system on a stronger financial footing. Locally this includes Adult Social Care funding of £4.77M to increase the Better Care Fund in 2023/24, and the new Adult Social Care Market Sustainability & Improvement Fund of £9.65M.
- We will further enhance our integrated care hub for our bed base ahead of next winter. This will support faster discharge to the right setting, so that people do not stay in hospital longer than necessary.
- We will continue to embed new approaches to step-down care, so for example, people who need physiotherapy can access care as they are being discharged

from hospital before they need to be assessed by their local authority for long-term care needs.

- New discharge information will be published, with new data collected from this April.

11. Expand new services in the community, as up to 20% of emergency admissions can be avoided with the right care in place.
    - Ahead of next winter we will offer more joined-up care for older people living with frailty; this includes ensuring 100% of our patients able to access urgent community response within 2 hours, 80% of our frail patients having clear, accessible and proactive care plans and falls services will cover the whole LLR footprint – meaning the right people help you get the care you need, without needing an admission to hospital if it's not necessary.

    - Greater use of 'virtual wards', which allow people to be safely monitored from the comfort of their own home, will be achieved by an extra 199 beds to provide 236 beds in total by this autumn.

12. Help people access the right care first time, as 111 should be the first port of call and reduce the need for people to go to A&E.
    - By April 2024, urgent mental health support through NHS 111 will be universally available.

    - From this April, new data will allow the public to easily see and compare the performance of their local services.

    - We will also tackle unwarranted variation in performance in the most challenged local systems.

    - We will continue to embed our clinically led programme to reduce unwarranted variation, working with our 20 practices where we note the highest levels of variation. Intensive support will be in place for those neighbourhood areas struggling the most.

13. To support the recovery of urgent and emergency care services, the LLR system has committed to targeted funding in both acute services and the wider system. This includes:

    - £14.3M of dedicated funding to support capacity in urgent and emergency services, building on the national funding used over winter 2022/23 to support an increase our overall capacity.
    - £4.7M of additional social care discharge funding over 2023/24 (with 2024/25 to be confirmed), building on the £500 million Adult Social Care Discharge Fund and £200M funding for step-down care during winter 2022/23, to be pooled into the Better Care Fund and used flexibly on the interventions that best help discharge patients to the most appropriate location for them – part of social care investment of up to £7.5 billion over the next two years.

Progress with Winter Plan to date

Given the way we collate, process and publish data, a verbal update on progress against plan will be given at the meeting.

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Delivery plan for recovering urgent and emergency care services

Leicester, Leicestershire & Rutland Integrated Care System

Final v4.0 / 31 July 2023

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Appendix A – UEC Partnership Terms of Reference

Appendix B – LLR Delivery Plan 2023/24

Our commitment to the public in publishing this plan is to improve waiting times and patient experience. We will:

Increase capacity, to help deal with increasing pressures on Leicester hospitals which see 19 in 20 beds currently occupied.

1. Dedicated revenue and capital for additional capacity at Glenfield and 52 (25 new) community beds as part of the permanent bed base for next winter/spring.
2. New ambulances will be available across the East Midlands, the majority of which will be on the road by next winter.
3. 'Same day' emergency care services will be in place across the LRI and the Glenfield hospital, so patients avoid unnecessary overnight stays.

Grow the workforce, as increasing capacity requires more staff who feel supported.

4. More clinicians will be available for 111 online and urgent call services to offer support, advice, diagnosis and, if necessary, referral. From this April we will launch a new targeted campaign to encourage retired clinicians, and those nearing retirement, to work in 111 rather than leaving the NHS altogether.
5. We will grow the workforce with more flexible ways of working and increase the number of Emergency Medical Technicians next year to respond to incidents and support paramedics.

Speed up discharge from hospitals, to help reduce the numbers of beds occupied by patients ready to be discharged.

6. At the Autumn Statement 2022, the government made available up to £2.8 billion in 2023/24 and £4.7 billion in 2024/25 of additional funding to put the adult social care system on a stronger financial footing. Locally this includes Adult Social Care funding of £4.77M to increase the Better Care Fund in 2023/24, and the new Adult Social Care Market Sustainability & Improvement Fund of £9.65M.
7. We will further enhance our integrated care hub for our bed base ahead of next winter. This will support faster discharge to the right setting, so that people do not stay in hospital longer than necessary.
8. We will continue to embed new approaches to step-down care, so for example, people who need physiotherapy can access care as they are being discharged from hospital before they need to be assessed by their local authority for long-term care needs.
9. New discharge information will be published, with new data collected from this April.

Expand new services in the community, as up to 20% of emergency admissions can be avoided with the right care in place.

10. Ahead of next winter we will offer more joined-up care for older people living with frailty; this includes ensuring 100% of our patients able to access urgent community response within 2 hours, 80% of our frail patients having clear, accessible and proactive care plans and falls services will cover the whole LLR footprint – meaning the right people help you get the care you need, without needing an admission to hospital if it's not necessary.

11. Greater use of 'virtual wards', which allow people to be safely monitored from the comfort of their own home, will be achieved by an extra 199 beds to provide 236 beds in total by this autumn.

    Help people access the right care first time, as 111 should be the first port of call and reduce the need for people to go to A&E.
12. By April 2024, urgent mental health support through NHS 111 will be universally available.
13. From this April, new data will allow the public to easily see and compare the performance of their local services.

    We will also tackle unwarranted variation in performance in the most challenged local systems.
14. We will continue to embed our clinically led programme to reduce unwarranted variation, working with our 20 practices where we note the highest levels of variation. Intensive support will be in place for those neighbourhood areas struggling the most.

Executive summary

Urgent and emergency services have been through the most testing time in NHS history with a perfect storm of pressures impacting the whole health and care system but causing the most visible problems at the 'front doors' of our services such as General Practices, 111 services and Emergency Departments.

Nationally staff prepared extensively for winter, putting in place thousands more same-day appointments, thousands more beds, more call handlers, 24/7 care control rooms and respiratory hubs, and often working at the limits of their endurance.

Despite their best efforts, increasing length of stay, alongside the demands of flu and COVID peaking together, has seen hospital occupancy reach record levels. This means patient 'flow' through hospitals has been slower.

As a result, patients are having to spend longer in A&E and waiting longer for ambulances. Hospitals are fuller than pre-pandemic, with 19 out of 20 beds at UHL beds (occupancy in Apr 2023 is 94%) occupied; up to 200 beds occupied by an LLR patients who are clinically ready to leave UHL, LPT or an out of area bed each day in April 2023 and the number of the most serious ambulance call-outs has been at times up by 12.9% on pre-pandemic levels. These pressures have also taken their toll on our staff, who have had to work in an increasingly tough environment.

The challenge is not just in ambulances or emergency departments, and so neither are the solutions. Recovery will require different types of providers working together and joining up care better for patients, led by local systems and backed by additional investment. We also know this is not unique

to Leicester with many similar challenges faced by regions and nations across the UK and across the world.

To support recovery, this plan sets out our ambitions, including:

- Patients being seen more quickly in our emergency department: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.

- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

These ambitions would represent one of the fastest and longest sustained improvements in emergency waiting times in the local NHS's history. Meeting these ambitions provides a focus for recovery, but they will not be enough on their own. Successive analysis has demonstrated the importance of looking at multiple metrics to support better outcomes for patients. We will therefore begin to publish more data on time spent in A&E, including 12 hour waits from time of arrival, and we are working with social care partners on a better measure of discharge to ensure we are measuring the whole patient journey in hospital. Performance against these metrics will fluctuate in response to COVID and other viral illness, as well as the usual seasonal pressures.

But even before the pandemic, pressure on urgent and emergency care had been growing, with changes in demographics and new types of care available, meaning the need for services has been growing every year. And looking forward, our growing and ageing population will see this continue.

We also need to reform and provide a genuinely better experience for patients. Our plan builds on the investment and evidence-based actions taken during winter 2022/23 to increase capacity and resilience, by taking steps to embed what works for patients while also creating space for people to innovate. It also builds on the experience during COVID, which brought out the best in our local NHS and care services – with new services scaled quickly, genuine innovation focused on improving patient care, and better working across different types of care provider centered on the needs of patients.

Through partnerships between acute, community and mental health providers, primary care, social care and the voluntary sector, our ambition is to create a sustainable system that provides more, and better, care in people's homes, gets ambulances to people more quickly when they need them, sees people faster when they go to hospital and helps people safely leave hospital having received the care they need.

This plan sets out how the NHS and partners across Leicester, Leicestershire & Rutland will make this a reality and continue to transform patient care at scale.

Meeting this challenge will require sustained focus on five areas:

- **Increasing capacity** – investing in more hospital beds and ambulances, but also making better use of existing capacity by improving flow.

- **Growing the workforce** – increasing the size of the workforce and supporting staff to work flexibly for patients.

- **Improving discharge** – working jointly with all system partners to strengthen discharge processes, backed up by more investment in step-up, step-down and social care, and with a new metric based on when patients are ready for discharge, with the data published ahead of winter. Work closely with providers to increase P0 discharges and reduce lost and delayed discharges.
- **Expanding and better joining up health and care outside hospital** – stepping up capacity in out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, including to avoid unnecessary admissions to hospital.

- **Making it easier to access the right care** – ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

To support the recovery of urgent and emergency care services, the LLR system has committed to targeted funding in both acute services and the wider system. This includes:

- £14.3M of dedicated funding to support capacity in urgent and emergency services, building on the national funding used over winter 2022/23 to support an increase our overall capacity.

- £4.7M of additional social care discharge funding over 2023/24 (with 2024/25 to be confirmed), building on the £500 million Adult Social Care Discharge Fund and £200M funding for step-down care during winter 2022/23, to be pooled into the Better Care Fund and used flexibly on the interventions that best help discharge patients to the most appropriate location for them – part of social care investment of up to £7.5 billion over the next two years.

Delivery will require prioritisation at a system level, but also local flexibility within each place. There will not be a one size fits all solution, and local places, working with social care and other partners continue to develop local plans reflecting local needs across LLR.

Why we need a UEC Recovery Plan

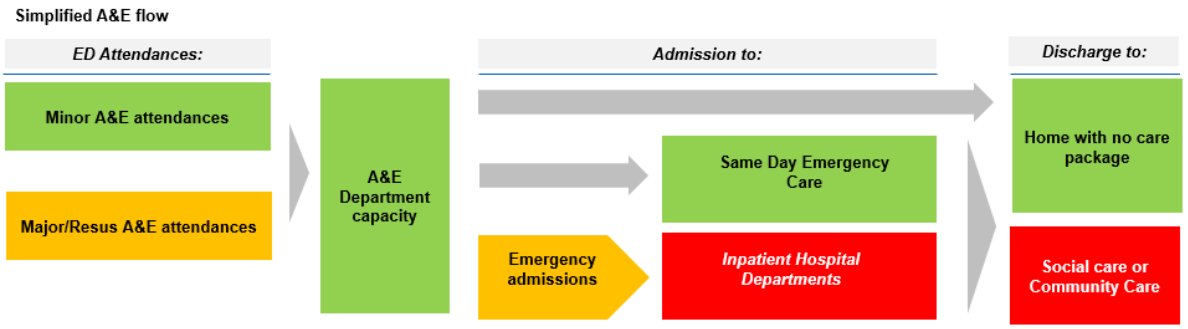
A. Why are we seeing pressures on Urgent and Emergency Care?

Current pressures

COVID is having a lasting impact on NHS services. Throughout 2022 there were never less than 3,800 people in England in hospital with COVID on any given day, with more than 9,000 on average across the year. This means not just more patients, but also knock-on impacts on the length of time patients are in hospital and more beds closed for infection control.

Occupancy levels for general and acute hospital beds have risen in recent years and have been persistently high over 2022, with around 94% of beds at Leicester Hospitals and 92% (LPT) of beds at Leicestershire Partnership Trust filled on average. High bed occupancy is a key driver of worsening A&E performance, which in turn has a direct impact on ambulance 'handover' and response times. This is because when hospitals are fuller it is harder to find free beds for patients that need to be admitted from the emergency department, which means it is harder to bring new patients into the emergency department.

The figure below provides a simplified picture of A&E patient flow, highlighting the current constraints in hospital.



As set out in the diagram, the key driver for performance is high occupancy, with difficulty discharging patients, both internal and external factors, resulting in increased length of stay and knock-on difficulties admitting people as inpatients to hospital departments.

From April 2021 to October 2022, average length of stay in Leicester Hospitals increased by 5% (from 12% to 17%) compared to the national increase of 18%. The UHL average length of stay for emergency admissions was 9.6 days in the rolling six months up to March 2023 compared to the peer median of 10.3 days and provider median of 10.6 days in the same time period.

There were an average of 742 patients with >7day LOS at UHL each day in February 2023. Long length of stay has also significantly increased in mental health inpatient care, reflecting increased acuity and

challenges around discharge, with 20% of all people staying for more than 60 days. Increasing length of stay is driven by several factors including:

- Increasing complexity of care with patients having more comorbidities, in part linked to COVID.
- Delayed discharge: while the majority of people are treated and discharged within 48 hours of an emergency admission, for some discharge is more challenging. There are around 200 UHL, LPT and OOA beds occupied by LLR patients who are clinically ready to leave (April 2023) compared to 195 each day in April 2022 (an increase of 2.5%). Nationally, there have been up to 14,000 inpatients who do not clinically need to be in hospital, increasing by more than 10% over the last year – accounting for around 13% of occupied beds. This challenge exists across all settings, including mental health.

As set out in the diagram, the number of attendances is not the thing primarily driving performance, but they do create additional pressure. Following a reduction in activity at the start of the pandemic as fewer people came forward for care, demand has been consistently rising. Attendances have recently been just above pre- pandemic levels: Nationally, December was the busiest month on record for emergency departments in England with nearly 2.3 million attendances, 18,000 higher than the previous high. Locally, we saw 22,657 A&E attendances at UHL in Dec 22 compared with 22,536 in Dec 19. The ambulance service also responded to 18% more category 1 calls nationally in December compared to a 12.9% increase seen locally. We have continued to see admissions from COVID as well as other respiratory illnesses, with more than 350,000 COVID admissions since this time last year nationally, with 5,388 of these within LLR.

Taken together, even though there are more beds open now than immediately before the pandemic, occupancy remains very high, reducing patient 'flow' through hospitals and creating longer delays for patients at the front door and in the community. That said, evidence-based interventions put into place as part of our local winter planning have shown positive impact:

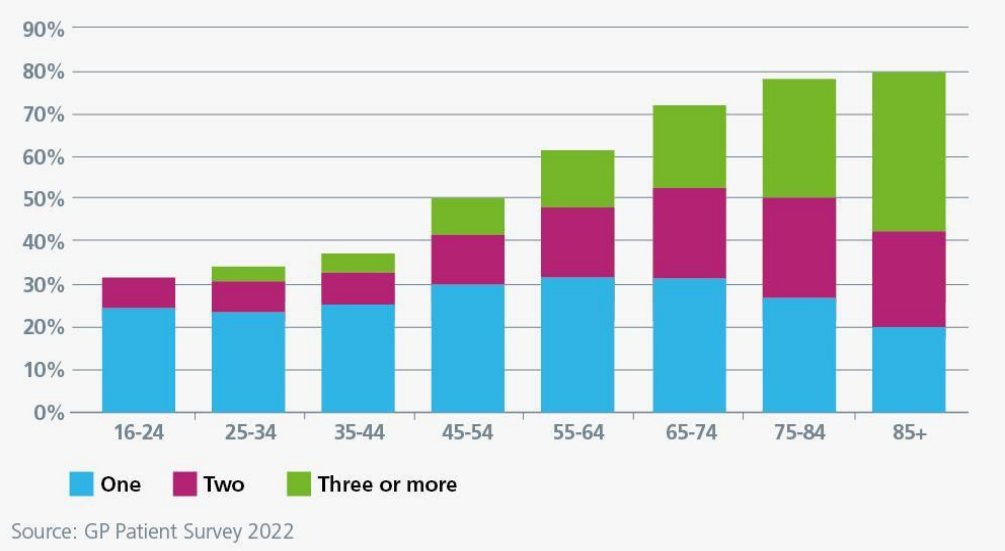
- Attendances at our Emergency Department have stabilized since the introduction of patient streaming with an average of 26 patients streamed into booked community slots instead
- Our community based Acute Respiratory Hubs have seen 8,971 patients in the period December 2022 to March 2023.
- Our General Practices have provided 12% more appointments during winter 2022/23 than in winter 2019/20.
- The numbers of complex patients (Pathways 1-3) awaiting a discharge plan has fallen from 228 (31/12/2022) to 192 (26/04/2023) over winter, despite over 192 additional bedded or non-bedded services being open.
- Since the revised ambulance assessment process at the Leicester Royal has been in place, ambulance handovers delays over 60mins have reduced from 38% in Dec 22 to 6% in Feb 23, with an average clinical handover of just over 30 mins in March 2023.

However, we know constrained UEC performance has a disproportionate impact on those who experience health inequalities. In 2021/22 NHS Digital reported that patients who live in the 10% most deprived areas (3.0 million people) were twice as likely to attend ED departments in England when compared to people living in the 10% least deprived areas (1.5 million people). Locally we know that for LLR, the 1.7% of patients living in most deprived areas have a 33% chance of an emergency admission in the next 12 months, compared with 1.3% of those living in least deprived. Our plans therefore must include action on equity and preventative services for these populations.

Longer term trends

The immediate challenges for UEC services come on top of longer-term trends. The need for health and care is continuing to increase as a consequence of population growth, ageing in the population and greater numbers of people living with long- term conditions. The number of people aged over 85 could increase by 55% over the next 15 years. More than 25% of the adult population in England now lives with two or more long-term conditions, increasing the likelihood of admission to hospital. [ii] In 2019, 33% of people over 18 were estimated to be living with complex multimorbidity, having doubled from 15% in 2004.[iii]

Proportion of age cohorts living with long-term conditions



Around 8% of people aged 50 or over are estimated to be frail, as high as 16% in parts of England.[iv] England is not the only country facing these challenges, countries across Europe are seeing rising levels of multimorbidity.

A growing and ageing population, with rising morbidity means that the need for UEC services rises every year:

- Demand for NHS 111 has continually increased, with annual growth of 6% a year in 111 calls received in the five years before the pandemic.

- Pre-pandemic ambulance services have faced the challenge of 4% increase in demand year on year.
- A&E including emergency departments and urgent treatment centres have seen rising demand in terms of acuity, with faster growth rates for older age people. Demand for major emergency departments has risen gradually but consistently since 2003.
- In 2019 there were 25.6 million A&E attendances (2.1 million a month), 20% more than in 2011. Emergency admissions grew by 28% over the same period to 6.5 million nationally. For UHL there has been an increase of 24.1% for A&E attendances from 205,561 in 2011/12 to 255,106 in 2019/20. For admissions there has been an increase of 31.1% from 76,348 in 2011/12 to 100,128 in 2019/20
- There are constraints and waits in social care, for service users to receive assessments and reviews in the community. The delay creates a risk of individuals moving into unplanned services as their needs are not addressed in a timely way.

The need for UEC mental health services is also growing. Community-based crisis services have seen a sustained increase in referrals since before the pandemic. Long waits for people with mental health needs in A&E are increasing, and people with mental health needs often report poor experiences relating to long waits. LPT are trialing some dedicated crisis inpatient beds, for people who need a short stay to stabilise their mental health and are quickly discharged back into the community for ongoing support.

B. What we will deliver for patients and the public

Our vision for UEC is for patients to have access to the right care, in the right place, at the right time. Our hospitals will be appropriate for some seriously ill patients but are often not the best place for many people whose needs are better met in a different way. Delivering this ambition will mean supporting more strengths-based, patient-centred, personalised care, accessed closer to, or at, home – but also more integrated services.

We will take the opportunity of new and existing technologies to enable people to access care in different ways and support staff in the NHS to deliver better care. New digital technologies provide the opportunity to change the way in which services are provided, but also transform the way in which people access services. We will support patients to manage their own health as they build on their knowledge and skills to improve their confidence.

We recognise that patients want better communication on time spent in A&E, want a better understanding of how to access the right care to avoid multiple handovers between services, and want greater continuity of care so that they do not have to repeat their story as they go through the system.

We will ensure that services reflect the needs of different groups of people, including all age groups, people with mental health issues and dementia and people with learning disability and autism. The

plan takes proactive steps to tackle known inequalities, particularly for groups who are disproportionate users of UEC services.

The plan sets out how we will achieve headline ambitions of patients spending less time in emergency departments, and ambulances getting to patients more quickly. While these ambitions provide an immediate focus, they are only part of the patient journey. We will also need to ensure focus across the pathway, including on long waits in emergency departments, on discharge and access to proactive care in our general practices, as we deliver this plan.

Achieving these ambitions in the next two years will be challenging. However, local partners are committed to this plan and the partnership approach needed to drive sustainable transformation. We recognise that delivering this vision will not happen overnight but we also recognise we are not starting from scratch. We will learn from and adapt our collective experience from winter 2022/23 and scale up the things we know will enable transformative change.

We know that urgent and emergency care is part of a more integrated health and care system; therefore, this plan will align fully with the principles of the Fuller Stocktake report as well as our planned improvements in access to general practice across the LLR footprint in line with the Access Improvement Plans our Primary care Networks are developing.

Meeting this challenge will require sustained focus on the five areas in the rest of the document:

1. Increasing capacity
2. Growing the workforce
3. Improving discharge
4. Expanding care outside hospital
5. Making it easier to access the right care

These actions consider the views of a wide range of stakeholders, from our clinicians and practitioners across the LLR footprint to our patients and our communities. It draws on a diverse range of opinion and experience, as well as views of patients and users, with each intervention being evidence-based and locally piloted.

1. Increasing urgent and emergency care capacity

We will need to increase the number of beds and ambulances if we want to reduce time spent in A&E and ensure hospitals are not as full. We will also work to make the most of the capacity we do have, with better processes and faster spread of best practice. We will increase capacity and reduce waiting times through:

A. Additional hospital bed capacity
B. Increasing ambulance capacity
C. Improving processes and productivity

A. Additional hospital bed capacity

Ambition:
There is a well-established link between high bed occupancy rates in hospitals and worse A&E performance.[vi] When hospitals are busy, it becomes more difficult to ensure patients get the care they need and can lead to longer time spent in A&E. Worsening A&E performance in turn has a direct impact on ambulance handovers and response times. We therefore need to reduce the current bed occupancy, which over 2022/23 has consistently been above 95%, back towards the 92% level which is safer and more efficient as it improves flow through hospitals.

Hospitals have tended to have higher occupancy levels in England compared to other countries, despite historically lower lengths of stay. The need for acute care will continue to increase over the coming years, and ongoing levels of COVID are creating additional pressures on hospital capacity. While we will act across all parts of health and care, increasing the number of staffed hospital beds to lower our occupancy levels ahead of next winter will be a fundamental part of the plan.

Through the additional funding for winter 2022/23 and through the year, Leicester Hospitals and Leicestershire Partnership Trust have already increased the number of staffed hospital beds by 79:

Ashton	24
Ward 22	16
Pre-Transfer Hub	12
Coalville W4	27

This increase in capacity is to be maintained for 2023/24 and we will also put in place further physical beds ahead of next winter

How we will deliver:
Compared to the originally planned levels of beds in 2022/23, there will be at least 52 additional staffed beds in 2023/24.

This additional bed capacity needs to be in the places that will deliver the greatest benefit to patients - based on our local demand and capacity modelling, we will put into place the following (subject to receipt of capital funding):

- Additional beds in UHL by Q4 2023/24.
- 52 additional beds (25 new) at LPT by Q3 2023/24.

We will work in partnership to ensure that the new beds are put in place as sustainably as possible, to reduce the impact of surge periods on other services, including theatres and research facilities.

B. Increasing ambulance capacity

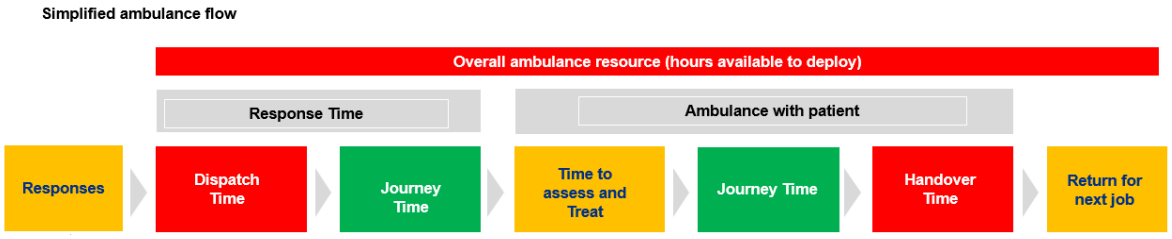
Ambition:

One of the main causes of longer waits for ambulances is delays handing patients over from the ambulance crew to hospital staff because the emergency department is full. On average more than 187 hours a day were lost to handover delays in December 2022 across LLR. Whilst this has reduced to an average of 32 hours per day in February 2023 since the introduction of an expanded ambulance assessment area at the LRI, this is still time when ambulances could be back on the road.

Therefore, on its own, reducing A&E waiting times will lead to an improvement in ambulance responses as flow improves out of, and therefore in to, emergency departments.

However, analysis of ambulance response times indicates that handover delays are not the only cause of slower ambulance response times. We have seen increases in sickness and other staff absence. We have also seen the complexity of ambulance crews' work increase meaning each incident is taking longer: the number of the most serious ambulance callouts has, at times, increased by one third since before the pandemic and there has been a long-term increase in the time ambulances are spending at the scene as crews provide more care directly with the patient. Therefore, additional ambulance capacity, not just additional beds, is needed to meet next year's 30-minute ambition for Category 2 ambulance response times.

The simplified ambulance flow diagram below shows the importance of handover times to ambulance performance, and the wider range of factors involved.



As well as increasing capacity, we need to ensure that ambulance services focus on emergency incidents and where ambulance services can add most value. In some cases, it may be more appropriate for other services, including urgent community response or mental health crisis teams, to respond to patients on scene.

How we will deliver:

To respond to these pressures, grow the fleet and better support the workforce, NHS England will ask ambulance services and lead commissioners to determine, by March 2023, their capacity plans

for 2023/24 and identify gaps. As part of that process ambulance services will look at ways to reduce sickness absence and how additional support could be given to staff.

This additional capacity will be largely delivered through more crew hours on the road, but we will also release capacity through better health and wellbeing for staff meaning a reduction in sickness absence, productivity gains, and through better links between the ambulance service and community services.

New ambulances will be available during 2023/24 across the East Midlands footprint, with the majority expected to be available ahead of winter, as part of ongoing improvement and replacement of our fleet.

The LLR system will work with East Midlands Ambulance Service and related partners such as DHU Healthcare to increase capacity and ensure patients receive the most appropriate care, including:

- **Single point of access for paramedics**: To ensure consistent and rapid access to clinical advice and alternative services, and to reduce unnecessary conveyance, we will implement a single point of access for paramedics. Single points of access provide a single, simple route for referrals to hospitals. They are staffed by qualified clinicians, able to ensure patients get referred to the most appropriate service for their needs.
- **Call assessment, triage and streaming via our unscheduled care hub:** By autumn 2023, we will work with EMAS to increase clinical assessment of calls in our Nottingham ambulance control and directly link this to our local Unscheduled care hub. This additional clinical input will ensure that the sickest patients are prioritised for ambulances and that patients who do not need a face-to-face response can be transferred quickly to services more appropriate for their needs via the UCH. This will include urgent community response, urgent treatment centres, same day emergency care (SDEC), mental health services, social care and primary care.
- **Forecasting:** We will work with EMAS improve forecasting of call demand and further develop the 'Intelligent Routing Platform' to manage the distribution of calls throughout England when individual services are under pressure and therefore reduce 999 call answering delays.

Right place, right time, right care: Navigating mental health pathways

Partners across health and care have developed a multi-agency approach to supporting patients with urgent mental health needs.

Mental health professionals have been embedded in the LLR unscheduled care hub since November 2022. A mental health dispatch pathway has been developed so that all appropriate 999 mental health calls, whether they are police/fire or ambulance calls, are routed into the mental health

professional in the hub. This allows partnership working across health and care to determine the most appropriate response for the patient and supports the 999 service.

This has meant more people with mental health needs have their needs met over the phone or are conveyed to more appropriate services. By February 2023, approximately 72% of calls directly handled by the mental health desk could be managed over the phone, without the need for ambulance dispatch. Patient and carer feedback has been excellent, with notable positive feedback from both ambulance and teams working in the hub as well.

C. Improving processes and standardising care

Ambition:
We know from patients how important it is to have a smooth experience in hospital, and to not experience too many unnecessary delays in situations like waiting for your test results or moving to a different part of the hospital. There is still significant variation between processes in hospitals, showing an opportunity to learn from where things are being done best and have a less confusing experience for patients. As we increase capacity, we will use existing capacity as effectively as possible by standardising processes so that patients get the right care at the right time, including when moving between organisations.

We will reduce variation in care when patients arrive at A&E, ensuring greater consistency in direct referrals to specialist care, and access to same day emergency care (SDEC) so patients avoid unnecessary overnight stays. We will also standardise the first 72 hours in hospital so that patients are assessed, get any required scans, and start their treatment as soon as possible.

We will continue to make effective use of our 'system control centre' (SCCs). These pioneering centres use data to respond to emerging challenges and bring together experts from across the system to make better, real-time decisions. They will continue to ensure the highest quality of care possible for the LLR population by balancing the clinical risk within and across acute, community, mental health, primary care, and social care services.

We will also work towards implementing new response time standards for people requiring urgent and emergency mental healthcare in both A&E and in the community, to ensure timely access to the most appropriate, high-quality support.

How we will deliver:
By April 2023, we will adopt and adapt the new improvement programme to support standardisation of care, working with clinical leadership to set out common principles for providers, including developing professional networks to support peer- to-peer learning and challenge, leadership and

best practice. This programme will be supported by national 'improvement collaboratives' as a mechanism for systematically adopting good practice.

Same day emergency care (SDEC) means shorter stays for patients and fewer unnecessary delays to leaving hospital. Current pressures often mean hospitals need to use their same day emergency care staff and space for other emergency care. We will spread best practice to ensure greater resilience ahead of next winter so that Leicester Hospitals provide appropriate SDEC seven days a week with a minimum opening of 12 hours per day, including for medical and surgical services as outlined in the 'SAMEDAY' strategy. Other SDEC services opening hours are designed to meet patient need.

We will work in partnership with our Primary Care Networks to design and deliver acute frailty services and SDEC, both of which will support reducing avoidable admissions and provide smoother care for patients, using the new frailty Commissioning for Quality and Innovation (CQUIN) incentive to support delivery of frailty services and link funding to quality improvement.

Paediatric early warning systems provide a consistent way of recognising deterioration in a child's clinical status, enabling early intervention and referral to alternative services if needed. We will implement the standardised paediatric early warning system for our inpatient settings by June 2023, which will be expanded into A&E, community, ambulance and primary care services, to deliver a cross-system approach.

We will provide streamlined pathways for mental health patients who need to remain in acute settings until their care can be transferred, with particular reference to better working with children and young people's mental health services, working-age adults and older adults, including people with dementia.

This will be supported by access to 24/7 liaison mental health teams (or other age- appropriate equivalent for children and young people) that are resourced to be able to meet urgent and emergency mental health needs in both A&E and on the wards, within one hour and 24 hours respectively.

We will fully embed year-round, our system control centre (SCCs) ensuring that it is appropriately resourced with autonomous clinical decision making across the system. The SCC will enable us to work with local authorities and other partners to ensure capacity, including in care providers, is used effectively and that the NHS provides support where needed.

We will implement digital tools that support decision making in near real time, including an electronic bed management system. We will work with NHS England as they continue to develop and roll out the A&E Admissions Forecasting Tool.

2. Increase workforce size and flexibility

Ambition:
NHS staff have faced immense pressures in recent years during the pandemic, and recovery will impose new ones. The COVID pandemic showed the remarkable flexibility of our staff to step into new roles, but it has also led to fatigue. While leaver rates reduced at the height of the pandemic, we know there are critical staff shortages across LLR, with a combined NHS Provider vacancy rate of 12.1% (excluding primary care). GPs and nurses in Leicester City have also seen a declining trend. Staff shortages have been an increasing issue since Covid-19 and exacerbated by winter pressures, surge conditions and industrial action.

Staff in post are under enormous pressure and experiencing high stress levels, due to this situation - this is borne out by the latest Pulse Survey, whereby 21.7% of respondents reported feeling negative, due to a high workload, competing demands, and being overworked. The net result is a high turnover of staff and an increase in sickness/absence, due in part to low morale, burnout, and psychological issues.

LLR has a variety of initiatives in place to address some of the above issues:

LLR is an Exemplar for the NHS England Retention Programme and a short to medium term plan is in place to mitigate some of the above issues, this includes for example: promotion and expansion of non-pay benefits and cost of living support available, development of a retention metrics dashboard, supporting improved understanding of the workforce and monitor change and improvements.

LLR has a well-established Care Workstream, delivered by LLR Academy, which include national and regional health and wellbeing programmes.

The LLR Academy also delivers Quality Improvement programmes, including the development of an LLR-wide QI Network, and Inclusive Culture and Leadership programmes.

Delivering the ambitions in the plan will require not just an increase in workforce, but also a change in the way that people work and opportunities for people, including recently retired clinicians, to return to work. We know that the scaling of out of hospital care requires rapid expansion of the community workforce and the development of more flexible and integrated teams. Key priorities are transforming primary and community care pathways, to reduce emergency attendances, hospital admission, including training community nurse in urgent and emergency care. Within our primary care workforce strategy is a focus on integrated teams, wrapped around a population and ensuring the combined skills of an MDT approach across health and are, will ensure the person is seen by the right time, right intervention, in the right place and by the right person.

LLR has a well-established apprenticeship programme, which will be expanding into targeted parts of the system, to ensure we are developing a future workforce pipeline. We also host an excellent Work Experience Portal, which can be used by existing health and care staff, those wishing to start a career in the NHS or Social Care and employers and education organisations looking for placements or to recruit staff.

How we will deliver:
While all areas of the NHS workforce are under pressure, we know that there are specific areas of the UEC workforce which we need to expand. Key priorities include the following:

Development of 'One Workforce' – a sustainable, long term, system-wide, integrated solution (strategic priority), through partnership working and co-production-based on complete health and care pathways (e.g, Home First, Discharge). Charnwood Pilot: Heart Failure Collaborative Intermediate Care Model-streamlining hospital discharge to community and social care provision, with rapid assessment within 48 hours post-discharge, supporting the principle of Right care, Right time, Right Place- will be implemented post-pilot. Charnwood MDT training taken place to enhance the skills and wellbeing of the team, thereby supporting portfolio and career pathways, leading to improved retention of those staff)

- **Paramedics** – Paramedics /Trainee Paramedics have consistently grown since March 2022. Ongoing recruitment of Primary Care ARRS roles, including Paramedics, continue to ensure that projected paramedic workforce gaps are mitigated through undergraduate student intakes, apprenticeships, and a focused retention improvement plan, to be developed in partnership with East Midlands Ambulance Service (EMAS) as part of the current strategic planning approach.

  Longer term planning for workforce growth in this area will be achieved through collaborating with Health Education Institutions and medical schools to ensure our approach to multi-year education and training investment planning is aligned to the health population needs and sit as part of the future workforce requirements.

- **Advanced practice** – we will continue to increase the numbers of advanced practitioners in priority areas including in emergency care. Advanced practice enables clinicians to take on expanded roles, supports the standardisation of same day emergency care and helps make the most effective use of multi-disciplinary teams.

- **Mental health** – we will continue to expand the mental health workforce within UEC and mental health services. Continued progress towards our local ambition of 75 peer support workers (further 20 planned in 23/24). Progression of peer support workers into further career roles has commenced and been encouraged (increasing reflection of local users).

We will continue to develop the workforce mix in community services, including physiotherapists, occupational therapists, speech and language therapists and dieticians to support people to participate in daily living. We will continue the development of advanced and consultant roles alongside the development of a strong and well-trained therapy and rehabilitation support and associate practitioner workforce.

As well as growing the workforce, we will support staff to work more flexibly. Flexible temporary workforce is an area of focus across LLR organisations, offering opportunities for retaining staff currently in post, flexing their skills across into areas of service need. We are well-skilled in doing this across LLR, with recent examples noted in the implementation of LLR Workforce Bureau, bank staff model, Care Homes Mutual Aid, facilitated by the LLR Workforce Sharing Agreement and development of the Digital Staff Passport.

For our work to scale virtual wards, we will work with NHS England to develop a national workforce recruitment capacity and capability plan. 7 out of 11 virtual wards have been mobilized (in addition to existing COVID & COPD VWs) with 100 beds open so far. This integrated workforce model is positively impacting the ability to discharge patients safely. These models have proven attractive to applicants and provided opportunities for advanced care practitioners.

Our 5-year workforce plan with a key component of Emergency Flow expansion - for example the staffing of 3 additional wards at Glenfield, over 2 years staffed through a mix of temporary and substantive workforce. Ongoing successful recruitment of international nurses-1100 recruited since 2017 and healthcare support workers. Additional workforce will be recruited to the Transit Hubs which will contribute to safe staffing over the ED floor as currently staff are redeployed to cover gaps in the transit hubs. Four separate hubs will be created at Glenfield and the LRI sites undertaking functions such as cohorting and discharge. The multi-organisational practices of discharge hubs are being enabled by innovative workforce practices to enable the sharing of staff across organisational boundaries.

Example: LLR Virtual wards

Workforce across a range of disciplines remains a significant challenge for the LLR system and this has had an impact to enhance the Virtual Wards Model.

Geriatrician capacity is limited and therefore alternative roles as GPs with special interest (GPwSI), consultant ACPs, and senior nurse roles have been implemented for the frailty Virtual Ward. 2 x Advanced care Practitioners have been recruited for the Frailty Virtual Ward and these models have been attractive to applicants and provided more opportunities for alternative role and skill mix within the team.

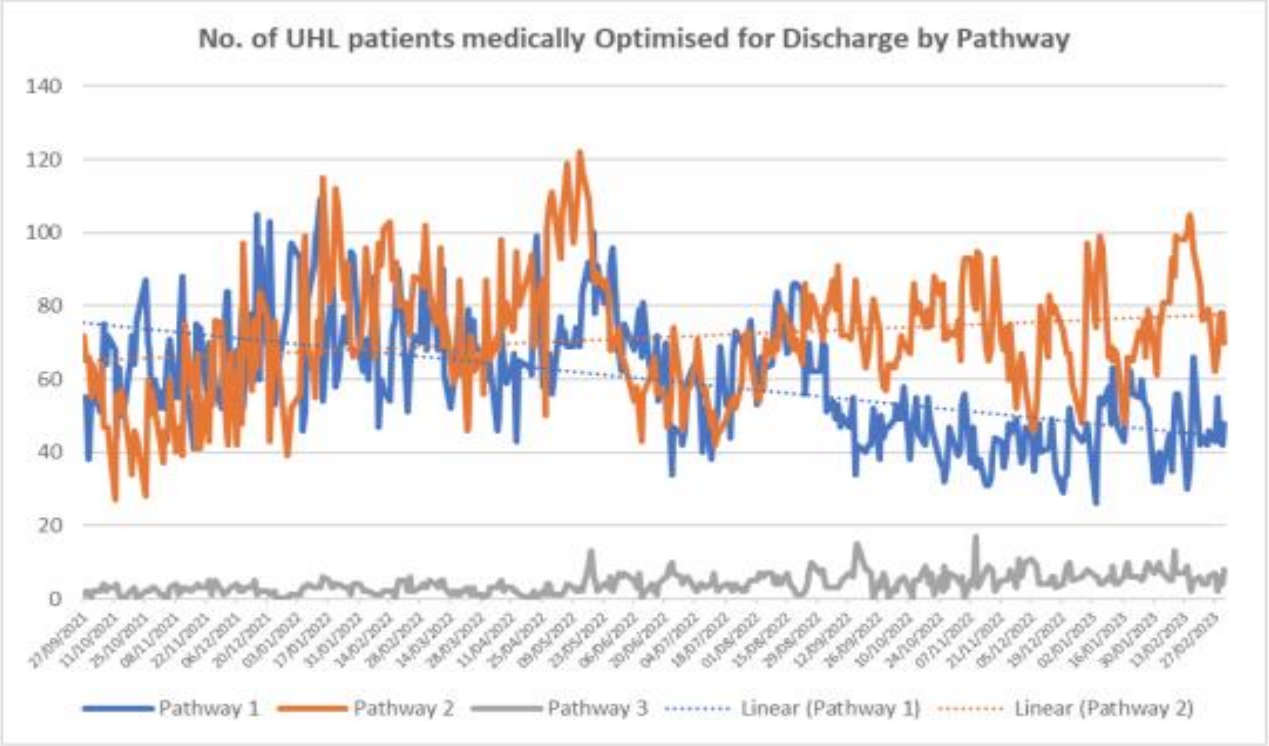
3. Improving discharge

Although having more hospital beds and more staff will help, it is also important to make sure patients are not in hospital for longer than necessary. We know that long stays in hospital are not good for patients or their independence and can lead to poorer health and economic outcomes.

Whilst discharge delays increased significantly over the pandemic, we have seen a significant and sustained improvement locally.

That said, there is much more to be done; we know both delays in discharge processes and shortages of capacity in social care and community care are making it more challenging to discharge patients from hospitals and mental health services. There are currently around 192 patients (including all UHL, LPT and out of area) patients remaining in hospital who no longer need to be there. On average, around 24% of patients with delayed discharges are awaiting the start of home-based care, 16% are awaiting residential or nursing home placements and 24% are waiting to begin intermediate care.

In order to deliver the 92% occupancy UHL has a bed gap of circa 350 beds. The bed bridge model closes the UHL gap by 248 beds by March 2025.



(Data taken from LLR Discharge Hub data Summery February 2023)

Current Discharge Status

	Total pts MOFD on S1	Patients with a planned discharge for today	Patients with a future plan	Patients awaiting an outcome
UHL	140	21	3	116
LPT	39	3	1	35
OOA	13	3	2	8
Total	**192**	**27**	**6**	**159**

(Data taken from S1 Sitrep 26.04.2023)

To improve discharge there must therefore be a sustainable increase in capacity in step-down services ('intermediate care') and social care, especially domiciliary care, and an improvement in discharge processes within hospitals and between hospitals, community services, local authorities and social care.

We will therefore improve discharge by:

A. improving joint discharge processes
B. scaling up intermediate care
C. scaling up social care services.

A. Improving joint discharge processes

Ambition:
As well as increasing capacity and improving the pathway within hospitals, we need to ensure that people are not in hospital unless they need to be and to improve the experience of patients when they leave hospital.

Discharge planning should begin when patients are admitted to hospital to ensure that people can get home or to a more appropriate setting as soon as possible, with services in place if needed.

We will work in collaboration with social care partners to ensure appropriate processes are in place to facilitate prompt discharge in NHS settings, including in community and mental health trusts. These processes should include early access to senior decision-makers to ensure patients get specialist advice sooner, removing avoidable delay.

We will work with our local government partners and the social care sector to ensure an integrated approach to building capacity, so that patients have rapid and reliable access to the joined-up health and care services they need when leaving hospital.

How we will deliver:

We will continue our implementation of the best practice interventions set out in the '100-day discharge challenge' across NHS settings. We have seen good progress so far, with the number of hospital process-related delays reducing by 25% since this approach was rolled out. This has now been extended to community and mental health settings.

The average daily P1-3 allocations for UHL, with detail of the discharges that did not occur:

	May	June	July	August	September	October	November	December	January	February	Trend
Average Number of discharge plans provided to UHL Mon to Fri	46	49	44	44	49	46	49	51	51	48	
Average Number of discharge plans provided to UHL Sat and Sun (Inc. Bank Holidays)	21	24	23	25	23	25	28	26	26	20	
Average Number of UHL patients with a same day plan becoming unwell	3	3	3	2	3	4	5	4	4	3	
Average Number of UHL patients experiencing a delayed discharge	8.5	11	11	10	13	11	11	12	8	6	

Systematic discharge planning between health and social care should start from the point of admission by identifying patients with complex discharge needs, setting an expected date of discharge, and working with families and carers to plan discharges. Everyone admitted to an inpatient bed should, on admission, have an estimated discharge date. Systems for discharge planning and delivery need to ensure timely transfers of care throughout the week, including evenings and weekend. IDT to work with UHL and LPT to reduce daily lost discharges.

Since COVID we have had a virtual discharge hub in place. We are now working towards implementing a 'care transfer' hub through an Integrated Discharge Team (IDT) to ensure that patients who do not need a hospital bed are discharged in a safe and timely way, either to their home or to a place in which long-term care decisions can best be made with rehabilitation and recovery support. The IDT will ensure:

- Clear plans for delivery, across all partner organisations, including agreed outcomes and data sharing arrangements.
- In reach support across Front Door wards
- A shared process to work with patients, their families and carers, and all professionals from admission, with all staff in the IDT sharing responsibility for delivering safe and timely discharge. The IDT will be focused on the most complex discharges and working to ensure that any assessments for long-term care are not completed in an acute setting.
- Strong and shared leadership at all levels, with clear accountabilities and responsibilities. We know this works best where there is a clearly identified senior leader accountable for flow across all partner organisations.
- A multidisciplinary staff mix, including social workers, case managers and clinical staff co-located in the IDT, who are empowered to make autonomous and accountable decisions that are respected across all partner organisations.
- Real-time evidence and insight into capacity and demand management planning across the local health and social care system.

Right place, right time, right care: LLR Integrated Discharge Hub

LLR's integrated discharge hub delivers an integrated service across seven days with a commitment from health and social care partners to cover 8am to 8pm, seven days a week.

Plan

- Reintroduce IDT on site from March 2023
- Increase IDT ward and board round attendance
- Increase voluntary services presence on wards from April 2023
- Ward therapist to be trusted assessors for ASC reablement services – commenced March 2023
- Ward therapist to act as trusted assessors for patients requiring low level ASC support, reducing triage time -planned June 2023
- UHL Discharge Specialist Team to review patients face 2 face and recommend short term care on behalf of MLSCU reducing triage time/delays -planned June 2023
- Increase usage of reablement pathways to support appropriate reduction of maintenance packages of care
- Increase pathway awareness with discharge teams and wards staff to encourage timely discharge
- Regular development and education sessions for IDT staff
- IDT to focus and reduce number of lost discharges daily
- Supporting consistent utilisation of criteria led discharge

B. Scaling up intermediate care

Ambition:

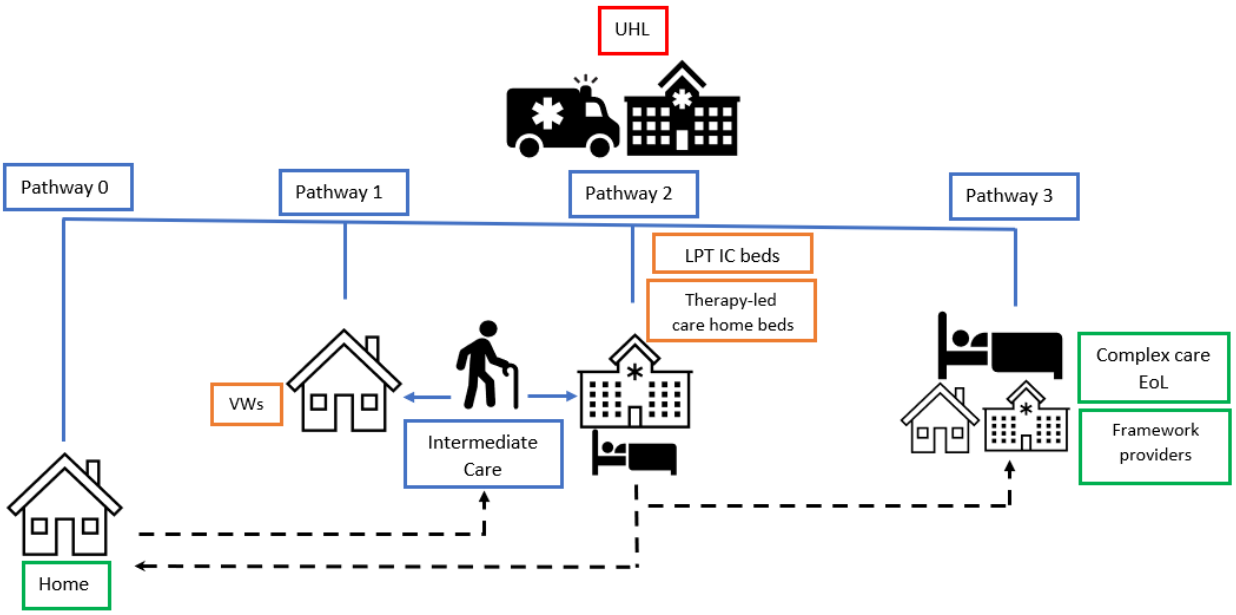
NHS England has begun a programme of work to develop and pilot a new approach to intermediate care, working with local authorities and voluntary and community partners. This expansion of 'step-down' care is designed to help people move from hospital into more appropriate settings for their needs, with the right wrap-around support for their rehab and reablement. This needs to be accompanied by growing the workforce, to ensure that we can deliver more care packages and good flow through community beds where required.

As an example, for people who need physiotherapy to regain their muscle strength, assessments of any longer-term care needs would take place after this initial recovery period and could take place in the person's own home.

Chapter 4 'Expanding care outside hospital' further details action to bolster 'step up' care (designed to help prevent hospital and emergency admissions) and 'step down' care (supporting timely and appropriate discharge).

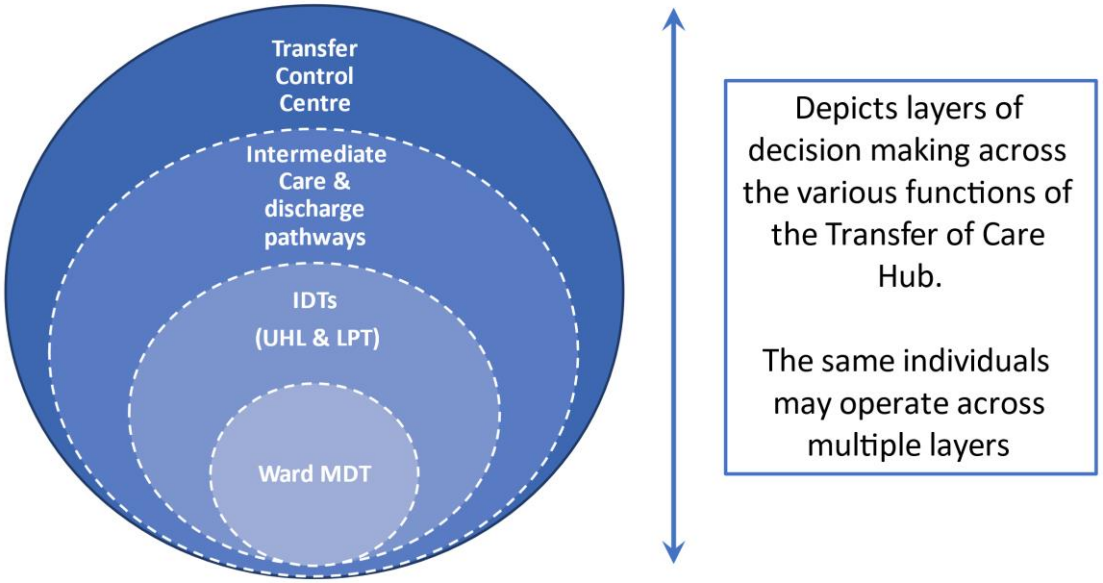
How we will deliver:

The LLR vision is to adopt a consistent Home First approach, underpinned by intermediate care, that ensures people are supported to remain independent, in their usual place of residence, for as long as possible.



The vision will be achieved through the establishment of a refreshed 'transfer of care' hub with four distinct functions:

1. Ward-based MDT: patient facing clinical decision-making; implement C-LD
2. Integrated Discharge team: focus on complex discharges – F2F reviews
3. IC and discharge pathways: ensure right care, right place, right time.
4. Transfer Control Centre: Discharge BI and operational coordination across the system



Development of this model will be coordinated through the Intermediate Care Delivery Group and will focus on the following:

1. Retain focus on reducing unwarranted variation in P0 discharges across 7 days.
2. Aspire to have no more that 20% of patients placed in spot-purchased residential P2 placements by November 2023.
3. Ensure consistent data collection of people discharged into long-term maintenance home care packages (P3) across LLR.
4. Revisit, with the support of Newton Europe, LLR demand and capacity modelling to right size P1 ensuring all patients discharged home are assessed for home-based intermediate care (intake model).
5. The LLR Intermediate Care Delivery Group undertake focused work for LPT beds to become the predominent destination for P2 discharges/transfers.
6. Continue to work with strategic workforce colleagues to facilitate recruitment of sufficient reablement and rehabilitation capacity in community settings.
7. Refocus MDT/IDT discharge support to LPT to mitigate risk of increased MOFD and ensure good flow.

8. LPT bed demand and capacity modelling to determine capacity required for a step-down intermediate care model. Once this model is in place, explore options for step-up.

C. Scaling up social care services

Ambition:

Alongside these improvements to discharge processes and intermediate care, local government, the NHS and the social care sector will work together to improve access to social care, with a particular focus on domiciliary care, supported by the Better Care Fund, additional social care funding and the government's reforms to adult social care.

How we will deliver:

At the Autumn Statement 2022, the government made available up to £2.8 billion in 2023/24 and £4.7 billion in 2024/25 of additional funding to put the adult social care system on a stronger financial footing. This will support an increase in capacity and improve the quality of and access to care for many of the most vulnerable in society.

Locally, the funding includes:

- Adult Social Care Discharge funding of £2.26m for Leicester City Council, £2.48m for Leicestershire County Council and £0.03m for Rutland Council. This will increase the 'Better Care Fund' in 2023/24 to build additional adult social care and community-based reablement capacity to reduce hospital discharge delays through delivering sustainable improvements to services for individuals.
- the new Adult Social Care Market Sustainability and Improvement Fund of £3.68m for Leicester City Council, £5.65m for Leicestershire County Council, and £0.32m for Rutland Council to make improvements to target areas of activity including
    - Increasing fee rates paid to adult social care providers in local areas
    - Increasing adult social care workforce capacity and retention
    - Reducing adult social care waiting times

The government is also allowing local authorities to increase the adult social care precept up to 2% per year in 2023/24 and 2024/25.

4. Expanding care outside hospital

The challenge of recovering urgent and emergency services also presents an opportunity. For decades we have known that many patients can receive better, safer, more convenient care outside hospital. We have seen in the pandemic the NHS's ability to design and expand new types of care and provide better care in people's homes. We know that backing those models that have been shown to work can give a better experience for patients and avoid unnecessary admissions and improve discharge. We will do this by:

A. expanding and better joining up new types of care outside hospital
B. expanding virtual wards.

A. Expanding and better joining up new types of care outside hospital

Ambition:

People's care needs can often be best met outside hospital. We know that up to 20% of emergency admissions are potentially avoidable with the right care in place. Care closer to, or at, home without the need for hospital admission is not only often more convenient for patients, but through timely access can help to avoid the deconditioning and prolonged recovery that can accompany a hospital stay.

Personalised care approaches such as supporting self-management, shared decision-making and one-off personal health budgets, alongside providing patients with the right information and support to make decisions, can enable them to manage their own care and avoid the need for hospital care for longer.

Community health services, including therapy services, help keep people well at home and in community settings close to home, and support people to live independently. When community services are delivered in combination with personalised care, they can reduce pressures on hospitals and emergency services by supporting patients at home and in the community, as well as provide them with greater choice and control, leading to improved patient experience and outcomes.

Falls are the number one single reason why older people are taking to the emergency department, and around 30% of people 65 and over will fall at least once a year.[ix] Care outside hospital is of particular importance for older people living with frailty, who are much more likely than younger people to be admitted to hospital, and likely to have a longer stay when they are admitted. Through better joint working and sharing of information between services we can help improve care for people who fall or are living with frailty.

Continued focus on mental health crisis prevention and a joined-up community response will ensure people are accessing the best service for their needs in a timely way, reducing avoidable admissions to hospital.

Making use of new technology and better collaboration, including between ambulance services and community care, will enable care that would often currently be delivered in a hospital to be delivered closer to people's homes. For example, the use of 'NHS @home' approaches can support people to recover, keep well and manage their health and wellbeing at home, and help reduce the need for hospital care due to supported condition management at home.

Adult social care plays a vital role in working with health services to provide the community support that prevents unnecessary admissions. Working in partnership with acute and community health services, the voluntary and community sector and care providers, our local authorities will continue to promote wellbeing and prevent unnecessary hospital admissions.

How we will deliver:
Many people can be best supported by a quick response from services in their community. Urgent community response (UCR) teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, people who urgently need care can get fast access to a range of health and social care professionals within two hours. Locally, these services are well embedded at place level, and regular exceed national standards.

Ahead of next winter, our aim will be to improve use of UCR including consistently meeting or exceeding reaching 80% of patients referred within two hours, with a service that operates for at least 12 hours a day in each of our three place footprints.

The population has aged and has increasingly complex conditions, and so we will make sure services are better joined up – with healthcare that works for patients.

We will immediately scale up falls and frailty services based on our learning from winter 2022/23, and help these services be better joined up with ambulances and existing UCR services so they can work together to provide a network of support for patients. Our UCR services will work in partnership with the Unscheduled Care Hub to implement a step up model into care and with the Integrated Discharge hub to provide speedy access to step down care – all designed to prevent or minimize stays in our acute bedded services where appropriate.

We will also roll out adult and paediatric Acute Respiratory Infection (ARI) Hubs to provide timely access to same day urgent assessment, preventing hospital attendance and ambulance conveyances through Winter 2023/24. Our ambition is that a longer-term community-based model of care is

established, integrated across primary, secondary and community care, and will be a key point of referral for, or to, virtual wards.

We will continue the transformation of community mental health services and build on the recent expansion of community-based crisis services to ensure that our patients have a range of open-access age-appropriate services which meet local population needs, alongside 24/7 Crisis Resolution and Home Treatment provision.

We will continue to roll out High Intensity User Services, adopt good practice in supporting patients who are experiencing homelessness or rough sleeping, and embedding family support workers in A&E settings to provide additional support to children and families presenting with non-urgent issues.

High frequency users of services can also be supported to tackle social and practical issues that affect their health and wellbeing through working with social prescribing link workers, who can link them to a range of community assets depending on their needs and preferences. This may include help to stay active, make social connections, and manage their health conditions.

Right place, right time, right care: Pre-transfer clinical discussion and assessment service
Our Pre-Transfer Clinical Discussion & Assessment service joins up hospital-based secondary care expertise and a dedicated GP-led assessment service, linked to the urgent community response pathway. This provides an integrated service that aims to keep people with frailty safe and well at home, avoid hospital admission if possible, and provide a seamless transition to secondary care if it becomes necessary.

Our EMAS crews are able to contact the PTCDA service whilst with the patient at their home, followed by a triage consultation with Consultant Geriatrician or GP input. The most suitable outcome for the patient is agreed, for example inclusion on a virtual ward for observation and monitoring and/or further face-to-face assessment by a consultant or community advanced clinical practitioners.

So far, this has led to an 80% reduction in ambulances conveying frail patients to ED (from care homes in particular) and gives frail older adults an alternative to hospital admission. Where necessary, patients are then stepped up into further care as required, care plans and ReSPECT plans are updated and shared with carers and /or family and the patient's GP is informed of any changes.

B. Expand virtual wards

Ambition:

One example of better, more convenient care for patients is hospital care at home through 'virtual wards', which are bridging the gap between hospitals and patients' homes. Virtual wards combine technology and face-to-face provision to allow hospital-level care including diagnostics and treatment, using many of the same staff that work in hospitals. In some cases, virtual wards can replace the need for admission, and in others facilitate people being able to safely leave hospital sooner.

Virtual wards enable patients to remain in their own home supported by family or carers to recover more quickly in a more comfortable environment. The evidence base for virtual wards is growing, with clinical evidence to show that virtual wards are a safe and efficient alternative to NHS bedded care, particularly for patients living with frailty.

Our ambition is to scale up capacity ahead of next winter to 236 virtual ward beds with a longer-term ambition of reaching 40-50 virtual wards per 100,000 people. As well as continuing to increase capacity, we need to increase utilisation of virtual wards to 80% by September 23 so we make more of the capacity we already have.

How we will deliver:
Through winter 2022/23, we have rolled out 8 virtual ward pathways with 110 beds through investment in community provision for conditions including respiratory conditions, palliative and EoL and heart failure.

We will have 11 virtual wards by July 2023 and will aim to increase utilisation to 80% by September 23 across a broader range of conditions, with less variation and so more people can receive high-quality care from their own home.

We will increase utilisation of virtual wards from around 50% to 80% by September 2023. We will work with our local clinical and operational teams to ensure standardisation across their area to enable referrals, build patient engagement and benefit from economies of scale.

Implementation of a centralised hub to monitor and support patients to capture deterioration and offer treatment at its earliest point.

- Manage patients virtually who may otherwise need to be seen in ED
- Reduce unplanned admissions by detecting and dealing with deterioration early in disease trajectory
- Reduce length of stay on planned acute admissions, increasing throughput through both virtual and physical virtual wards.
- Reduce 90-day readmission rate by proactively monitoring for early decline
- Streamline patients into Virtual Wards for further diagnosis/treatment ensuring high utilisation of virtual wards expected from NHSE

Build on the Level 3 component (proactive care) to ensure maximum utilisation of Level 4 (Virtual wards)

This would include:

- Proactive monitoring for at risk admission groups
- Home First + model
- Tech Enhanced Living Service (e.g., in care homes)

We will support systems to build on the expansion of Home Treatment teams for people with acute health needs, with a focus on the quality of provision and therapeutic offer, underpinned by technology and data to better manage and plan care to avoid deterioration and unnecessary hospital admission.

5. Making it easier to access the right care

Ambition:
We need to ensure that the urgent and emergency care system is responsive to the needs of patients, and so people receive the right care in the right place, and in a timely way. NHS 111 is crucial to this, and we know that it can reduce demand on emergency care and be convenient for patients, especially with clinical input and oversight. But we also know that the percentage of 111 calls abandoned increased significantly during winter 2022/23 as pressures grew, and so we will need to provide more resilience to improve access for patients and reduce demand on UEC services.

Over the past ten years we have seen increased need for UEC services across all age groups and have heard in our engagement with patients that UEC services are complex to navigate.

We will make it easier for patients to access the care they need without feeling they have to go to A&E or call 999 and help make 111 online and calling 111 the first port of call so that patients can easily access the appropriate advice and be directed to the most effective care. The Fuller Stocktake recommendations, and the widespread commitment to them, provides an opportunity for services to integrate closely with all parts of primary care, so that people get the care they need, regardless of how they contact services.

Many patients will need clinical advice, and we know that can make a difference to patients, and so we are looking to better use clinicians in 111 for the patients who will benefit most. New technologies should help people to get clinical advice and be directed to the most effective care. Clinical advice to NHS 111 underpins our plan to assess and direct patients to the most appropriate point of care,

whether that be self-care, pharmacy, general practice, advice from a paediatrician, mental health crisis centre, an urgent treatment centre, or another setting.

How we will deliver:
Over the pandemic we have seen the advantages of 111 online and we will further expand it through its continued promotion and development. It will be further connected with other services to mean patients are better directed to the right place. We will work to integrate 111 online with the NHS App.

We know from our engagement the importance of 111 to families. We will expand advice offered through NHS.UK and NHS 111 online to provide dedicated paediatric advice and guidance for families to support decision making around care options.

We will roll out paediatric clinical assessment services to ensure specialist input for children and young people is embedded within 111.

NHS England will undertake an extensive review of 111 services, including intensive trials of '111 First' following lessons learnt in the 2019 pilot. It will test the models and their effectiveness at directing patients to the clinicians and services who can best meet their needs with the minimum possible delay. This review will be aligned with priorities for primary care, including for community pharmacy, the forthcoming GP access recovery plan and implementation of the Fuller Stocktake report. The review will also explore the potential to incorporate advancements in technology, including AI and machine learning, within 111 services and we will work with NHS England to tailor these for our local populations.

NHS England will work with ICBs to increase 111 clinical input where it will have most impact, including to confirm which care setting is best for the patient – providing better care for patients and reducing demand on emergency services. We will ensure the clinical assessment of a greater proportion of NHS 111 Category 3 or 4 ambulance dispositions by April 2024.

Right place, right time, right care: The LLR Unscheduled care hub

The LLR system has established a system-wide Clinical Assessment Service (CAS) to remotely assess EMAS and 111 calls.

The CAS is staffed by experienced clinicians including clinicians with experience in General Practice, Integrated Urgent Care, Paediatrics, Mental Health and Emergency Medicine who are able provide the most appropriate response and where necessary direct the patient to the best care for them.

As a result, they've seen real positive outcomes on patient care, including 94% of patients who would have received a Category 3/4 ambulance response being clinically assessed as able to have their care needs met elsewhere in the community. Both patients and clinicians feel its benefits, with 93% of patients extremely likely or likely to recommend to friends and family, and 97% of clinicians would recommend working within the CAS due to the multi-disciplinary approach, the ability to learn from others as well as welcoming more hybrid roles.

We will do more to support people to access mental health support. Urgent mental health support will be universally accessible by using NHS 111 and selecting 'option 2' by April 2024. We will continue with our plans to sustain and enhance our 24/7 CCAP service, providing open access, freephone urgent mental health support for all ages, accessible using NHS 111. This will be further supplemented by future provision of 24/7 crisis text lines, which we will integrate into our local open access crisis pathways. We plan to introduce a local Mental Health Response Vehicle service by January 2024, which will work closely with EMAS to reduce inappropriate conveyance to ED.

The Directory of Services enables referrals into the most appropriate urgent care service from 111 and 999, supporting better management of patients. A platform rebuild will make it easier for staff in the NHS to direct people to the appropriate services and supports faster innovation of new services.

Some patients that come to emergency departments would get better, quicker care if they are navigated to an Urgent Treatment Centre. Locally, our clinicians have designed and implemented a consistent approach for patients who walk into the Emergency Department, which supports our patients to be seen in the most appropriate setting. Approximately 60 patients a day are being streamed to a booked appointment at a local UTC, with non-urgent patients also booked into out of hours or next-day services where appropriate. We will grow this offer through 23/24. Patients requiring minor injury or minor illness treatment will also have the option to go through to the MIaMI (Minor Illness and Minor Injury) unit for treatment, which supports our on-site UTC provision.

Right place, right time, right care: Streaming into community-based services

Streaming non-urgent patients from LRI ED to a booked appointment has been established as BAU from November 2022 at an average of 804/month from December 2022 to March 2023 with a trajectory to extend as additional sites mobilise. The profiling for introduction on a phased plan is detailed below.

Total Capacity for ED re-direction / increased acuity at Oadby	UHL/111 avg capacity (Nov 22 - Mar 23)	UHL avg capacity (Apr 23 - Jun 23)	UHL avg capacity (Jul 23 - Sep 23)	UHL/111 avg capacity (Oct 23 - Mar 24)	Un-utilised daily capacity 22/23 (yr avg)	CPCS enabled - GP referrals to CPCS (yr avg)
Oadby UTC	59	24	24	83		
Merlyn Vaz UTC	n/a	0	6	11	11	0
Merlyn Vaz OoH	9	12 (Jun 2023)	12	20	18	2
City Hub Westcotes	n/a	15	15	40	22	18
City Hub Saffron	n/a	n/a	Discussion required	10	4	6
City Hub Belgrave	n/a	n/a	Discussion required	14	7	7
TOTALS	**68**	**51** (was 77)	**57** (was 119)	**178**	**62**	**33**

- UCC and Extended Access Hub services will receive booked appointments from NHS111, UHL LRI ED Front Door or GP practice clinical triage recorded in the medical record.
- Capacity can be flexed across the wider system to minimise the number of unused appointments daily.
- Noting that streaming involves more than one contact point, it does support patient education on choice at their next time of need.

We will improve streaming from ED, urgent care services and NHS111 into Community Pharmacy services:

- CPCS baseline participation – 217/229 LLR community pharmacies
- CPCS activity baseline - 14,961 (LLR 2022/23)
  - 9,479 (Leicester City)
  - 5,482 (County & Rutland)
- CPCS trajectory – activity growth of 1% by March 2024

6. Delivering this plan

We will deliver this plan by putting in place the fundamentals that are essential to successful local delivery: a clinically led plan, accountability at every level, genuine transparency, on- the-ground support, and mechanisms to spread good practice and innovation.

A. Accountability at all levels

]

Delivery of the UEC recovery plan will reflect the new NHS operating framework, with alignment through the national, regional and local level, including DHSC and local authorities to ensure full involvement of social care. The LLR Integrated care board will be accountable for delivery across health, able to draw together different partners and provide a cross-system view of the interventions required for delivery.

The LLR ICB will be accountable for the relevant metrics outlined in the Operational Plan, through the services that we commission, recognising links to all parts of the system that have an impact on UEC.

Through each place-based governance structure, the LLR ICB and our local authorities will work with our provider partners to undertake systematic capacity and demand planning, with the aim of understanding the expected levels of need for social care and intermediate care services across LLR and develop shared plans to meet this need.

Local delivery

The delivery of this plan will sit with the LLR UEC Partnership and Richard Mitchell, Chief Executive of Leicester Hospitals will be the Senior Responsible Officer. The executive lead for this plan is Rachna Vyas, Chief Operating Officer of the LLR ICB.

The partnership will delivery all facets of value associated with this plan – performance improvements, equity, quality, financial improvements and resource utilization and partnerships. Advice / actions from colleagues from across the health and care system will be sought as needed.

Delivery of local plans will be also monitored by regional and national teams, providing oversight, support and intervention as appropriate to ensure delivery of the plans.

Appendix A contains the UEC Partnership Terms of Reference.

Appendix B contains the activity planning and budgets schedule.

B. Transparency

Transparent, high-quality data are important for improvement, providing insight across the whole journey but also identifying unwarranted variation.

To ensure greater transparency, more data will be made available to the public. This will be published by the LLR Integrated Care Board area by April 2023, and new metrics to monitor the effectiveness of discharge will be put in place. We will publish data on 12-hour delays from time of arrival in A&E from April, to support prioritisation of long waits as part of delivery. The public will be able to more easily see and compare the performance of their local services.

We will use data to help manage periods of high demand and increased pressure across systems and enable urgent system action. 'Faster data flows' will bring together data in a way that will reduce burdens on providers, and allow a more granular understanding of patient flow to support improvement.

C. Tiered intervention

Through national and regional teams, we will continue to work with NHS England to support and challenge ourselves to deliver this plan.

Building on experience from elective recovery and improvement in ambulance handovers, NHS England is developing three tiers of intervention, to be in place by April 2023:

- **Tier one: intensive support** – for systems off-target on delivery, support including on-the-ground planning, analytical and delivery capacity, "buddying" with leading systems and executive leadership.
- **Tier two: light touch** – for systems largely on-track, support including regional reviews and deep-dives to diagnose challenges and drive improvement.
- **Tier three: core offer** – universal support offer for systems on track, including specialty guidance, peer review and sharing of best practice.

The LLR ICB has been confirmed as Tier Three. We will work with NHS England through this approach; as with existing tiering arrangements these tiers will be reviewed frequently, and tiers will be publicly available information.

D. Reducing unwarranted variation

We will continue to embed a complementary, clinically and professionally led programme to reduce unwarranted variation. This programme will increase standardisation of what works across different areas of urgent and emergency care.

This programme will be supported by a stronger approach to improvement collaborative development. Building on the approaches of the Acute Winter Collaborative and Discharge "100 Day Challenge", subject-specific improvement collaboratives will be established to co-develop across systems and share emerging good practice, drawing on teams of experts.

E. Supporting innovation

We know that evidence is needed where innovative care is being developed. Through the national collaborative, we will work with regional and national teams to showcase where an approach is being trialed and work together to understand the benefits of scaling for spread and adoption.

Early priority areas for further exploration include models of remote clinical assessment including rehabilitation expertise, intermediate care models and virtual wards.

Vaccinations and Immunisations

Autumn / winter 2023/24 vaccination campaign: Eligible cohorts

The Joint Committee for Vaccination and Immunisation (JCVI) has agreed the 2023 seasonal vaccination programme. The groups to be offered vaccinations are:

Cohort	COVID Booster	Flu
Residents in older adult care homes & their staff	Yes	Yes
Adults aged 65 years & over (note: all those that turn 65 by 31 March 2024 are eligible for both COVID & flu vax)	Yes	Yes
6 months to 64 years in clinical at risk group i.e. asthma, serious mental illness, epilepsy, learning disability, etc	Yes	Yes
Frontline health and social care workers	Yes	Yes
Household contacts of immunosuppressed patients (contacts aged 12 to 64 years)	Yes	Yes
Carers aged 16 to 64 years (registered / unregistered)	Yes	Yes
Pregnant women	Yes	Yes
2 and 3-year-olds (turn 3 years by 31/08/23)	No	Yes
Children and young people (reception to year 11)	No	Yes
Working aged adults in long-stay residential care homes and their staff	Yes	Yes

Campaign timing

To maximise and extend protection during the winter and through the period of greatest risk in December 2023 and early January 2024, health systems will follow a campaign timeline:

Flu

2 and 3-year-olds, school age children (reception to age 11) and children in clinical risk groups to start from 1st September 2023

Ideally delivery will be completed by 15th December, however some groups i.e. pregnant women, will continue to be offered a vaccination up to the end of March 2024.

COVID-19 & flu

- Start date 2nd October – Care Homes for flu and COVID-19
- Start date 7th October – all cohorts for flu and COVID-19

- National booking system will open for the public from 2nd October for appointments from 7th October 2023
- End date 15th December, although some inequalities work will continue to end January 2024. Short 10-week campaign
- Care homes a priority – aiming to complete visits to all within first 4 weeks of campaign.

Vaccination campaign

The Vaccination campaign for 2023/24 in Leicester, Leicestershire and Rutland (LLR) will comprise:

- Encouraging greater co-administration of COVID-19 and flu
- Tackling health inequalities and areas of low uptake as a priority, using a variety of initiatives i.e. mobile vaccination units, super vaccinators, supporting events/activities i.e. Steady Steps (activity programme)
- Delivering plans that are informed by needs of local communities and co-developed with local partners, i.e. local authorities, community, voluntary and social enterprises

Not all GPs will be offering COVID-19 and flu vaccinations, however, additional community pharmacies are being recruited via an 'expression of interest' process, to ensure there is sufficient coverage across LLR. Gaps in provision will be covered by mobile vaccination units/teams.

We currently await confirmation of vaccine types for autumn/winter 2023/24.

New model for vaccine supply will automatically replenish provider's vaccine stock on a 3-day cycle.

Tackling health inequality

To tackle health inequality, we will implement:

- Roving health care unit available for:
    - out-reach, hyper local vaccination opportunities and health care inequality Making Every Contact Count (ECC) initiatives.
    - additional health and care capacity i.e. unit located in surgery car park or as close as possible to a surgery.
- Assistance with promoting additional and out-reach clinics, including:
    - texting patients, via NHS and partners networks.
    - promoting health and care opportunities via social media i.e. Facebook, etc.
    - telephoning eligible patients and booking them directly into clinics.
    - additional vaccinating staff to assist with capacity.

Improving MMR (measles, mumps and rubella) uptake to eliminate measles

Measles is a highly contagious disease caused by a virus. It spreads easily when an infected person breathes, coughs or sneezes. It can cause severe disease, complications and even death.

Measles can affect anyone but is most common in children. Being vaccinated is the best way to prevent getting sick with measles or spreading it to other people. The vaccine is safe and helps the body fight off the virus.

We are working to improve MMR uptake by:

- Working with primary care to promote a global offer for MMR across LLR
- Promoting a vaccination offer to be targeted to communities and vulnerable population groups, known for low vaccination uptake.
- Working with stakeholders to scale up accessible, convenient offers i.e. promoting to university students and delivering offer on campus.
- Promoting to local families to promote the 'check and confirm' vaccination status of their children.
- Working with VCSE organisations to advocate the importance of vaccination/immunisation and codesigning accessible delivery channels, i.e. dedicated vaccination clinic offered within alternative community setting.
- Frontline health and care staff encouraged to check and confirm vaccination status with mop-up clinics to be offered via occupational health teams.

LEICESTER CITY HEALTH AND WELLBEING BOARD
23rd November 2023

Subject:	Primary Care Capacity Planning over winter period
Presented to the Health and Wellbeing Board by:	Mayur Patel, Head of Transformation, ICB Nisha Patel, Head of Transformation, ICB
Author:	Mayur Patel, Head of Transformation, ICB Nisha Patel, Head of Transformation, ICB

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: -

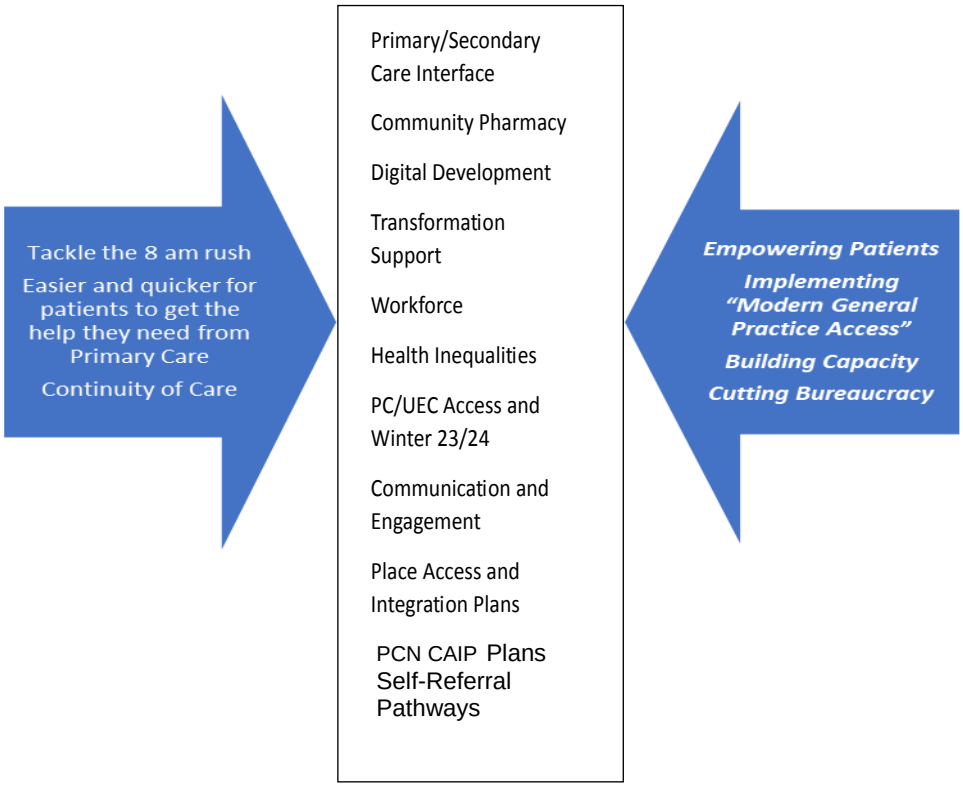


Figure 1 – LLR System-level Access Improvement Plan

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

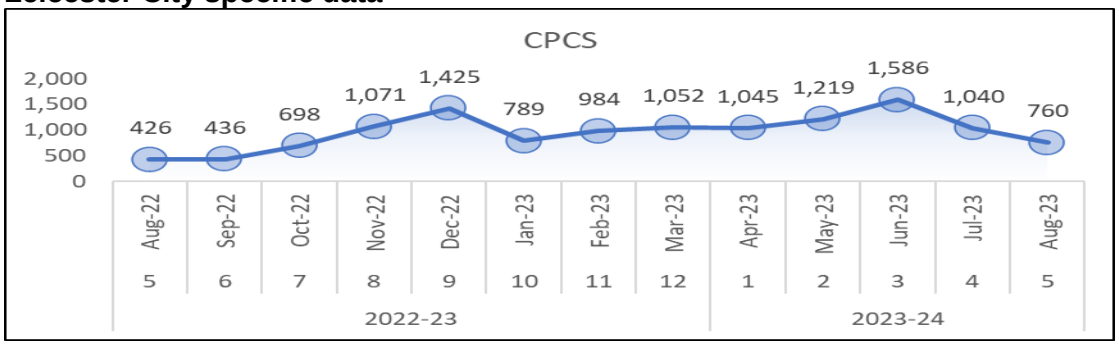
38. One of the key priorities identified within our Primary Care strategy to deliver our LLR vision is to redesign care pathways. The role Community Pharmacies have in this space is crucial.

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

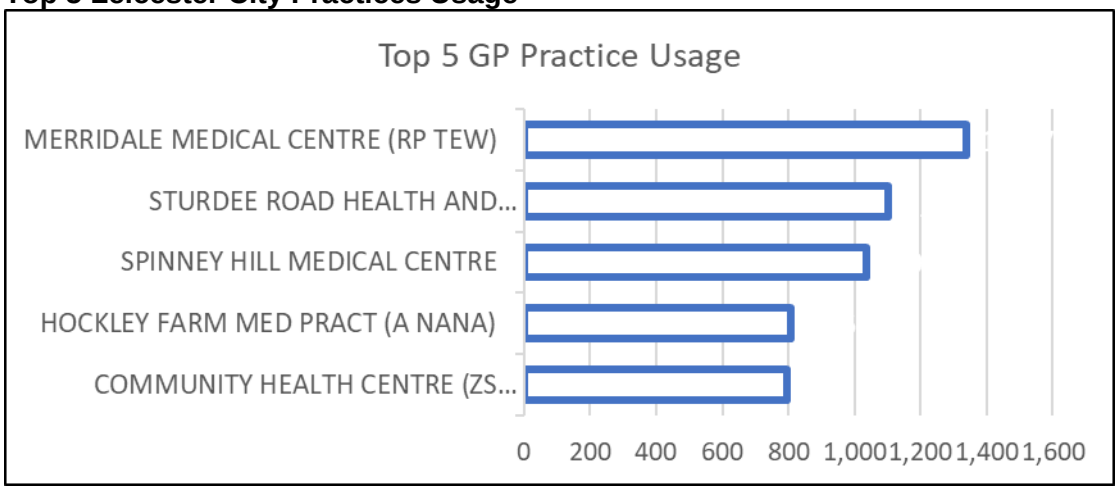


Community Pharmacy - Blood Pressure and Oral Contraceptive services

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

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Primary Care Update

Mayur Patel, Head of Transformation, LLR ICB
Nisha Patel, Head of Transformation, LLR ICB

City Health & Wellbeing Board: 23rd Nov 2023

Item 4

A proud partner in the:
Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Areas of Focus

- NHSE Delivery Plan for Recovering Access in Primary Care
- Development of System Level Access Improvement Plans (SLAIP) & our approach to implementation across LLR
- Winter Planning
- Comms & Engagement Plan

NHSE Delivery Plan for Recovering Access to Primary Care

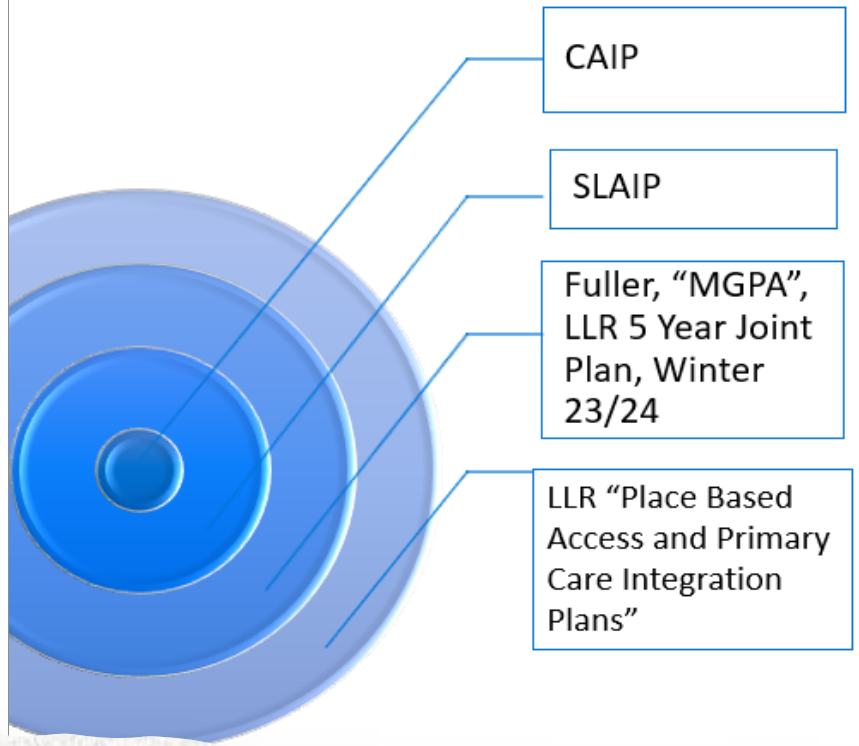
Key deliverables:

- ***Tackle the 8am rush***
- ***Easier and quicker for patients to get the help they need from Primary Care***
- ***Continuity of Care***
- ***Empowering Patients***
- ***Implementing "Modern General Practice Access"***
- ***Building Capacity***
- ***Cutting Bureaucracy***

Actions to achieve the above are underway and will support capacity challenges during Winter

COMPONENTS

ELEMENTS



"We want to build a new primary care system together, for everyone in LLR. Nurturing a safe, healthy, and caring community. Giving all our people the best start in life, supporting them to stay healthy and live longer, happier more fulfilling lives. We will use our collective capabilities and strong partnership working to provide high quality, sustainable, joined up care; ensuring greatest overall impact on health and wellbeing outcomes"

What are we going to do in LLR?

Tackle the 8 am rush

Easier and quicker for patients to get the help they need from Primary Care

Continuity of Care

- ✓ Primary/Secondary Care Interface
- ✓ Community Pharmacy
- ✓ Anti-microbial Resistance
- ✓ Digital Development
- ✓ Transformation Support
- ✓ Workforce
- ✓ Health Inequalities
- ✓ PC/UEC Access and Winter 23/24
- ✓ Communication and Engagement

Empowering Patients

Implementing "Modern General Practice Access"

Building Capacity

Cutting Bureaucracy

Primary and Secondary Care Interface

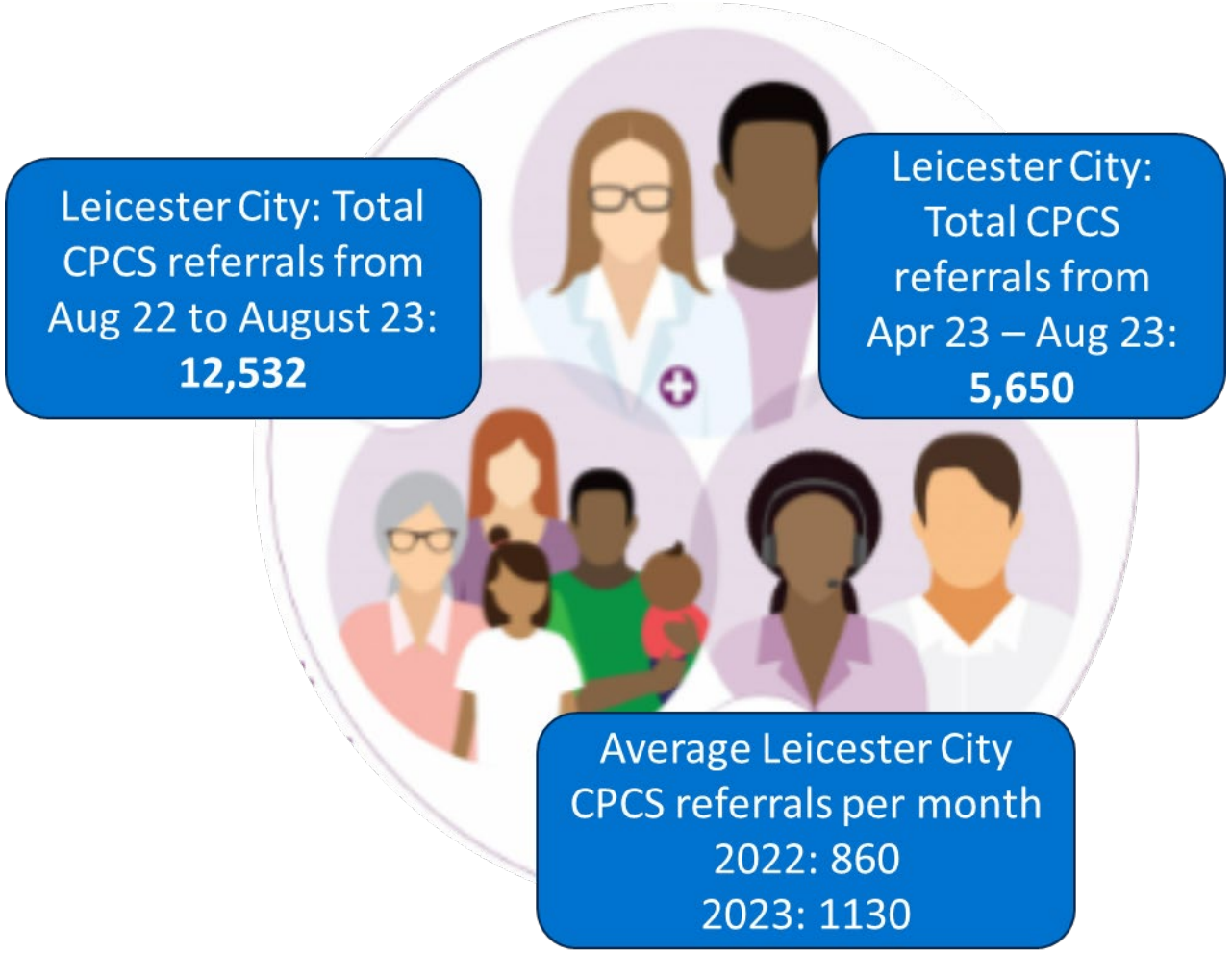
- Access challenge is a result of the rise in workload, particularly for experienced GPs, being overloaded and having less time available for patients.
- Pressure from the rising number of patient contacts, reported to have grown by 20% to 40% since pre-pandemic.
- *There are opportunities to reduce this workload by*:

1. improving the primary-secondary care interface
2. building on the Bureaucracy Busting Concordat

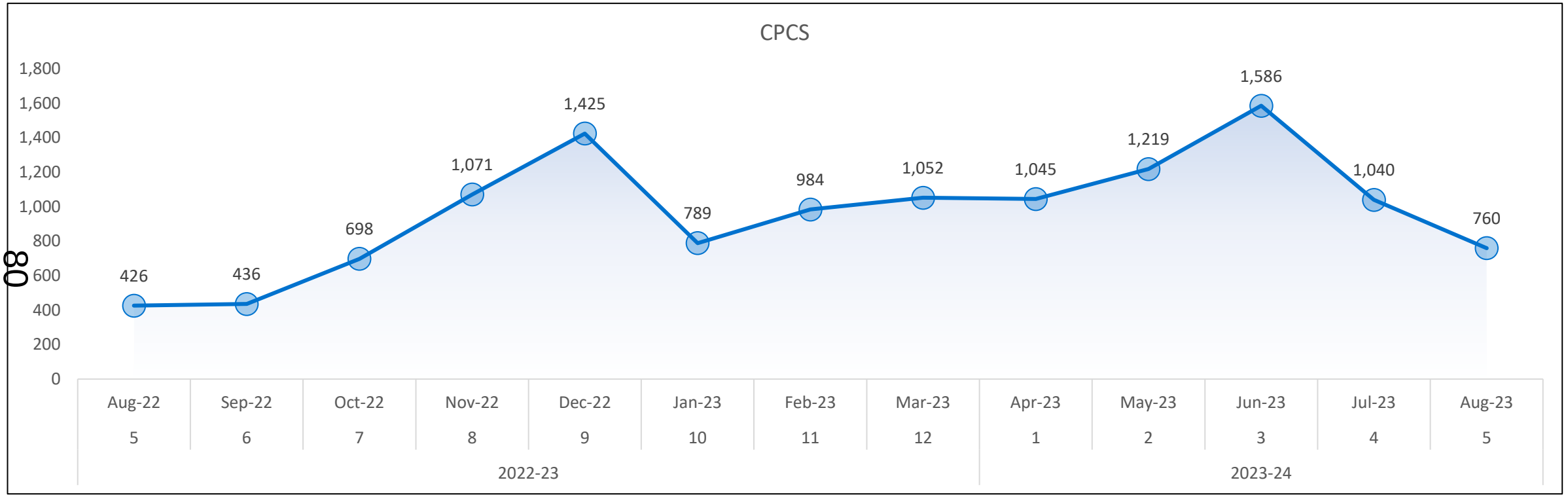
- The LLR Transferring Care Safely Group is taking the lead on this and has reached a consensus on the primary areas of focus for delivery partners in the upcoming 6-9 months. These are outlined in the paper.

Community Pharmacy Consultation Service (CPCS)

- The ICB supporting the transitioning of pharmacies participating in the regional extended care services to the proposed common conditions service where the two services overlap.
- The ICB working with community pharmacy network and system stakeholders 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.
- The ICB will continue to enable referrals to community pharmacy as part of the **Community Pharmacist Consultation Service (CPCS)**



CPCS Referrals in Leicester City



ICB continue to work in parentship with Leicestershire Pharmacy Committee (LPC), PCNs, Community Pharmacies to promote CPCS as an opportunity to improve access across Leicester City

Utilising the Support Level Framework (SLF)

Information based on:

- Planned Quality and Contracts visits
- Sign up for national GPIP programme
- Completion of Quality Assessment Template
- ‘Scores’ on Quality variation dashboard

32 practices (**including 4 from City**) identified for inclusion in a local proactive Support process for 23/24 - assurance/identify improvement opportunities and challenges:

- Priority 1 – 15 Practices: concerns on variation dashboard
- Priority 2 – 17 Practices: performing ‘well’ but general lack of engagement/assurance

Workforce – our “People Plan”

- Continuation of GP Fellowship
- Development of a Fellowship+ and mid/wise to support GPs to diversify, retain skillset and capacity
- Introduced IMG GP Ambassador and Fellowship Ambassador
- Relationship with Leicester Medical School / ST1, 2 and 3s to promote primary care in LLR
- Funding of Next Generation GP programme
- Continuation of GP Mentoring
- Outreach programmes with HEIs, colleges / schools / access to medical education and subsequent careers in primary care

- Development of practice nursing programme
- Practice nurse preceptorship – supports integration in primary care
- Support Practice Nurse recruitment
- Support for newly qualified nurses
- Support for PCNs with ARRS roles
- Continuation of ARRS and well established primary care roles
- Group video clinics for PCN teams

- Expansion of LLRTH designed ARRS/New to Primary Care Induction programme
- Increase clinical placements
- Funding placement provision in PC
- Non-clinical training programmes - rapid upskilling
- Continuation of interprofessional education sessions
- Annual Training Needs Analysis support
- Full engagement with the METIP planning to ensure future education, training and development capacity in PC workforce

Health Inequalities

- Improving Health Equity by identifying and addressing health inequalities is one of the ICS's key pledges within it's "Five Year Joint Plan", and "tackling inequalities in outcomes, experiences, and access" is one of the plans quintuple aims.
- This is underpinned and enabled by our Leicester City Health and Wellbeing Strategy **"Life Course"** and **"Population Health Management"** approaches that run through all our operational and delivery plans.
- Quality and Equality Impact Assessments are undertaken - as standard practice and process – for any service change proposals.

Health Inequality Plans Summary

The plans submitted by PCNs will focus on the following areas:

- Dementia / LD / Hypertension / Diabetes
- Women & menopause
- At risk of financial distress & depression
- Looked after children
- Childhood immunisation uptake
- CVD & HF with obesity
- COPD & vaccination uptake
- Mental health, low mood & anxiety
- Overall health & wellbeing
- PPN with unmet health needs
- Social isolation

Capacity and Access Improvement Plans Summary (CAIP)

The plans submitted by PCNs will focus on the following areas:

- Collaboration with PPGs
- Additional appointments with ARRS,
- Improve usage of CPCS services
- T&D of staff; Active Signposting
- Update website – online consultation / booking
- Segmentation of population
- Integrated working with partners / voluntary organisation
- Website review and redesign

PC/UEC Access and Winter 23/24

PLACE (BASED) ACCESS AND PRIMARY CARE INTEGRATION PLANS – PROGRESSING

to design – now - and implement – by 1st April 2025 – integrated general practice/primary care systems, processes, and or services that provide and sustain levels of ***same day access*** capacity, and ***continuity of care*** capacity in general practice, as determined by and to meet the needs of the local population(s), 7 days a week

ACUTE RESPIRATORY INFECTIONS (ARI Hubs)

Children - Acute Respiratory Infection Hubs: 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

Adults - 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

ARI service – To Commence in December

- ARI / Acute paediatric appointments will be available Monday to Friday from 4pm
- LLR will offer minimum of 10,000 additional appointments based on 15-minute consultations over a 10-week period, starting in December 2023.
- Each PCN will be required to confirm how many additional appointments will be offered each day, over and above the core contract and Enhanced Access. Each PCN will have a minimum number of appointments expected.
- For City Place, ARI service will offer a balance of appointments for children and adults that meets the needs of the population – including those with known respiratory illness and with any ARI.
- Prioritise those with respiratory illness
- Triage process implemented to signpost to other services where appropriate such as pharmacy
- Appointments accessible by 111

Communications and Engagement

- **Key** to restore trust in General Practice and for citizens to understand the changes driven by the Recovery Plan and "Modern General Practice Access"
- LLR ICB are committed to working with GP Practices, patients and the public to co-produce campaigns to ensure messaging is right to support delivery of the areas outlined and inform/educate our population.
- Our system will be guided and supported by national focus and materials and will use the learning from previous "campaigns" to ensure the message reaches all our local communities.
- National focus is on the changing Practice Team – the multi-disciplinary team and the ARRS roles – and empowering patients through the self-referral, community pharmacy, and NHS App opportunities.

LEICESTER CITY HEALTH AND WELLBEING BOARD
23 NOVEMBER 2023

Subject:	Vaccinations & Immunisations
Presented to the Health and Wellbeing Board by:	Kay Darby – Deputy Director Vaccinations & Immunisations, NHS LLR ICB Vaccinations Programme
Author:	Kay Darby

EXECUTIVE SUMMARY:

An overview of the performance of the 2023/34 Covid-19 and flu vaccination programme covering the City of Leicester

An update on the new approach to shingles vaccination

Measles

NHSE as commissioners and transition to systems by 2025/26.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: Note.

LLR City Provider Network for Autumn/Winter 2023/24 Vaccination Programme

- 17 Community pharmacies
- 6 Primary care networks representing 23 GP practices.

Programme Timings

This year's autumn flu and Covid-19 vaccine programmes started earlier than planned in England as a precautionary measure following the identification of a new Covid variant, BA.2.86, which was first detected in UK in August.

The Covid-19 vaccination programme was originally supposed to start on 2 October with care homes initially, however the start date was brought forward to September to align with the flu programme. Covid-19 vaccinations began on 11 September for those most at risk, including adult care home residents and people who are immunosuppressed.

From 18 September, other eligible patients were able to take up vaccination offers from their GP practice or could book a vaccination appointment via the National Booking System.

The Covid-19 vaccination programme is due to finish on 18 December 2023, whilst inequality work involving Covid-19 vaccinations can continue until 31 January 2024. The flu vaccination campaign is due to finish on 31 March 2024.

City Flu Vaccination Uptake by Cohort (figures correct at 1 November 2023)

Flu Cohorts	Eligible Population	Doses Administered	% Vaccinated
Over 65 years	54,257	33,264	61.31%
Care homes	1,436	1,104	76.88%
Children aged 2 & 3 years	8,769	1,856	21.17%
At risk	54,982	17,599	32.01%
Frontline HCSW (ESR)	10,275	2,262	22.01%
Frontline HCSW (self-declared)	7,474	1,301	17.41%
Frontline social care workers	5,125	595	11.61%
Household contact of IS patients	10,529	343	3.26%
Pregnant women	2,498	86	3.44%
Primary school	34,131	2,634	7.72%
Secondary school	23,379	2,064	3.24%
TOTAL	**212,855**	**63,108**	**29.65%**

*Leicestershire Partnership NHS Foundation Trust's School Aged Immunisation Service (SAIS) is providing flu vaccinations to children and young people across LLR in educational settings. The SAIS flu programme commenced with Leicester City primary schools on 25 September and include secondary schools, initial delivery to 25 schools. The programme is due to finish on 12 December with 102 additional schools due to be visited. Flu vaccinations were offered to children attending special educational needs schools on 25 September. Catch-up vaccination clinics to children that missed their initial flu vaccination offer will be offered. This offer will continue till to January/February based on vaccine availability.

SAIS is currently working to increase the engagement with parents and carers and children and young people, across all vaccination programmes in Leicester, Leicestershire and Rutland leading to a lower non-responder rate and increases in the vaccination uptake, with young people having vaccinations at the right timeframe, which offers them the best protection from various diseases.

As part of this SAIS have updated their offer to:

- Enable informed young people (age 12+) to participate in decision making through self-consent for vaccinations using existing Gillick competency framework.
- Clearly offer the nasal flu vaccine and alternative injectable flu vaccine.
- Create additional resources in different languages, including in video format.

SAIS also offer vaccinations for:

- 3-in-1 teenage booster and Meningitis ACWY vaccinations (starting year 9 and any outstanding till year 11)
- Human papillomavirus (HPV) vaccinations (starting year 9 and any outstanding till year 11)
- Measles, Mumps and Rubella (MMR) vaccinations for those under vaccinated (starting from year 8).

City Covid-19 Vaccination Uptake by Cohort (figures correct at 1 November 2023)

COVID-19 Cohorts	Eligible Population	Doses Administered	% Vaccinated
1. Care home residents	1,751	1,257	71.8%
2. Health care workers	20,292	3,678	18.1%
3. Social care workers	3,022	462	15.3%
4. 80+ years	11,605	6,627	57.1%
5. 75-79 years	9,519	5,355	56.3%
6. 70-74 years	12,801	6,268	49.0%
7. 65-69 years	16,363	6,261	38.3%
8. At risk	51,707	7,471	14.4%
9. 12-15 at risk	701	30	4.3%
10. 12-17 years – household contacts of immunosuppressed patients	912	5	0.5%
11. 5-11 years at risk	337	7	2.1%
12. 60-64 years	0	436	0.0%
13. 55-59 years	0	364	0.0%
14. 50-54 years	0	263	0.0%
15. 40-49 years	0	281	0.0%
16. 30-39 years	0	224	0.0%
17. 18-29 years	0	158	0.0%
18. 16-17 years	0	6	0.0%
19. 12-15 years	0	6	0.0%
20. 5-11 years	0	0	0.0%

TOTAL	**129,010**	**39,161**	**29.0%**

Care home residents: This cohort has been prioritised for vaccination due to their vulnerability and providers have been incentivised accordingly. By 3 November, all the city's care homes had been visited by vaccination teams. Revisits will continue until the programme end date.

Housebound patients: From a total population of 2,875 eligible patients, 1,373 vaccinations have been administered; 159 declined, leaving a further 1,343 visits to complete. (Figures correct at 1 November). Vaccinations will continue until the programme end date.

Covid vaccinations for children aged 5-11 years and in a clinical at-risk group: This cohort are being offered a vaccination within specialist clinics at UHL. Due to appropriate vaccination supply, these clinics only opened w/c 9 October. A further four satellite sites are due to open across LLR to provide convenience/ease of access to patients.

Inequalities Offers

- **6 months to 4 years at risk:** Vaccination invitations have been issued for UHL specialist clinics and GPs can refer eligible patients, who have not had an invitation.
- **Allergy pathway:** Patients previously referred via Prism/allergy service will already have access to the VidPrevtyn Beta vaccine via UHL specialist allergy vaccination clinic. New patients thought to have PEG allergy can be referred by GP via PRISM to allergy clinic for assessment. Patients who do not suffer anaphylaxis/allergy to PEG but who are clinically severely intolerant of mRNA vaccines may be eligible for VidPrevtyn Beta and GPs can refer their eligible patients
- **Learning disability patients:** This cohort of patients can obtain their vaccinations through regular scheduled clinics. However dedicated provision is being scoped to provide a specialist service with dedicated learning disability nurses in attendance; this includes a pop-up clinic in Loughborough, drive-by vaccinations in other areas and vaccinations at home for the most complex patient.
- **Mobile vaccination units:** To make Covid and flu vaccinations as accessible and convenient as possible, a mobile vaccination unit is deployed to target communities of low vaccination uptake four days per week. An overview of locations and vacations to date is detailed below:

Location	Dates	Total vaccinations given
British Islamic Medical Association health & wellbeing event	16 Sept	51
Beaumont Leys Market	19 & 20 Sept	76
Horizon Medical Practice car park	20 & 23 Sept & 30 Oct	220
Humberstone Gate	25 to 27 Sept	196
City Centre (outside Primark)	7 Oct	43
Peepul Centre health festival	12 Oct	5
Christ the King food bank	13 Oct	10
City Centre (outside Lloyds Bank)	14, 21 & 28 Oct	100

MMR / Measles Elimination Plan

LLR ICB has devised a measles elimination plan to outline a series of actions that are required to reduce the risk posed by measles. Since 2022 there has been an increase in measles cases both globally and in the UK. Measles and rubella can be eliminated, and congenital rubella infections prevented by achieving high uptake of the combined measles, mumps and rubella (MMR) vaccine in national childhood immunisation programmes. This plan aims to mitigate the risk of measles, by the ICB working collaboratively with other agencies, undertaking a series of initiatives to increase uptake & reduce health inequalities.

Since 2022, measles activity has been slowly increasing. To achieve & maintain measles elimination, the World Health Organisation recommends that a 95% uptake with two doses

of MMR by 5 years of age and by using all opportunities to catch up older children and adults who missed out when they were younger. Unfortunately, current UK performance for the second dose is sub-optimal at around 88%. Due to the national concern of increasing cases, this plan aims to address any current issues, plan future objectives and be proactive at tackling this challenge.

The objectives of the plan are:

Primary Objectives

1. Ambition to achieve and sustain ≥ 95% coverage with two doses of MMR vaccine in the routine childhood programme (5-years-old) by 2025

2. Ambition to achieve ≥ 95% coverage with two doses of MMR vaccine in older age cohorts through opportunistic and targeted catch-up (>5 years old) by 2025

3. Improvement in uptake in key priority groups eg students (the 'Wakefield cohort'), traveller communities, women of childbearing age, underserved communities and ethnicity groups with the lowest uptake, new entrants, etc.

Secondary Objectives

1. Provide leadership and public health expertise to address the decline in MMR vaccination
2. Bring together partners to develop a multi organisational approach to increasing MMR uptake
3. Develop engagement activities that seek to understand why some people are not taking the MMR vaccination offer
4. Develop a communications campaign that will raise awareness about the risks associated with measles and promote positive messages about the importance of vaccination uptake.
5. Develop innovative interventions that will support increased MMR vaccination uptake, tailored to the differing needs of the population
6. Respond to the potential change in age of delivery of MMR2 (likely from 2025 approximately) and work with stakeholders including GPs to identify potential issues and develop appropriate capacity and engagement plan.

City Measles Outbreak

At 3 November, there has been two confirmed and two unconfirmed cases of measles involving children and young people, from two separate and unrelated families living in the city. All the individuals attend different learning establishments in the city.

Working collaboratively with the UK Health Security Agency, NHS England (NHSE) and City public health, we are mobilising the following:

- Catch-up MMR vaccinations to be offered to unvaccinated/partially vaccinated students by LPT's school age vaccination service
- Additional MMR vaccination clinics to be provided by GP practices located within the Spinney Hills area and beyond. These will be supplemented by MMR vaccinations being offered by our mobile vaccination unit, which will target areas of low MMR vaccination uptake
- Promotion of the importance of MMR vaccination to the LLR population.

Vaccination Against Shingles (Herpes Zoster)
In 2010, the Joint Committee on Vaccination and Immunisation (JCVI) was asked by the Secretary of State for Health to review the available evidence relevant to the introduction of a universal vaccination programme to protect against shingles (Herpes Zoster).

The JCVI considered a range of issues including disease epidemiology, vaccine efficacy, vaccine safety and the cost effectiveness of introducing a routine shingles vaccination programme in the UK. Based on the findings of the cost-effectiveness analysis, the JCVI recommended a universal routine herpes zoster (shingles) vaccination programme using a single dose of the live Zostavax shingles vaccine for adults aged 70 with a catch-up programme for those aged 71 to 79 years. Individuals who reached their 80th birthday were not eligible for a shingles vaccination due to the reduced efficacy of Zostavax vaccine with increased age.

From September 2013, a single dose of Zostavax shingles vaccine was offered routinely to individuals aged 70 years (born on or after 1 September 1942) with a phased catch-up programme based on age as of 1 September that year. From August 2021 Shingrix vaccine was introduced as an alternative vaccine for immunocompromised individuals.

From September 2023 Shingrix has been offered to all severely immunosuppressed individuals from 50 years of age and to immunocompetent individuals from 60 years of age over a 10-year phased introduction.

Commissioning Responsibility for National Immunisation Programmes
Since 2013, immunisation services have been commissioned by NHSE. Staff from Public Health England (PHE) were also involved, up until their transfer to NHSE when PHE ceased to exist (October 2021).

NHSE commissioning responsibility for immunisation will formally transfer to ICBs in April 2025 (as per national policy). Work is ongoing around joint commissioning arrangements in the meantime. The current PH commissioning teams will transfer from NHSE to a lead ICB from April 2025.

There will be an East Midlands Team and a West Midlands Team. It is currently unclear whether the teams will cover screening and immunisation as now or whether these functions will be separated out. The East Midlands host will be Nottingham and Nottinghamshire

ICBs will take on more of the leadership of the immunisation function, driven in part by the much-awaited national immunisation strategy.

ENDS

NHS
Leicester, Leicestershire and Rutland

LLR Vaccination Programme Update

Health & Wellbeing Board

Kay Darby, Deputy Director, LLR ICB Vaccination Programme
Sarah Ward, Family Services Manager, School Aged Immunisation Service, Leicestershire Partnership Trust

23 November 2023

COVID-19 & flu vaccination uptake AW 2023/24

LLR AW 22/23 COVID-19 closing uptake: 61.33%

Location / COVID-19	Booster eligible population	Booster doses given to eligible population	% Booster doses given
LLR (03/11/23)	**415,969**	**184,211**	**44.3%**
Rutland (03/11/23)	17,661	9,581	54.2%
City (03/11/23)	127,910	37,990	29.7%
County (03/11/23)	270,372	136,637	50.5%

Location / Flu	Booster eligible population	Booster doses given to eligible population	% Booster doses given
LLR (03/11/23)	**633,302**	**259,005**	**40.9%**
Rutland (03/11/23)	24,736	12,882	52.8%
City (03/11/23)	218,055	63,889	29.3%
County (03/11/23)	389,714	177,133	45.6%

(Source: Foundry)

Flu vaccination offer AW 2023/24: CITY uptake

Flu Cohorts	Eligible Population	Doses Administered	Received a vaccine dose
Age 65+	54,257	33,264	61.31%
Care homes	1,436	1,104	76.88%
Children aged 2 & 3 years	8,769	1,856	21.17%
Flu at risk	54,982	17,599	32.01%
Frontline HCSW (ESR)	10,275	2,262	22.01%
Frontline HCSW (self-declared)	7,474	1,301	17.41%
Frontline social care workers	5,125	595	11.61%
Household contact of IS patient	10,529	343	3.26%
Pregnant women	2,498	86	3.44%
Primary school	34,131	2,634	7.72%
Secondary school	23,379	2,064	3.24%
Total	**212,855**	**63,108**	**29.65%**

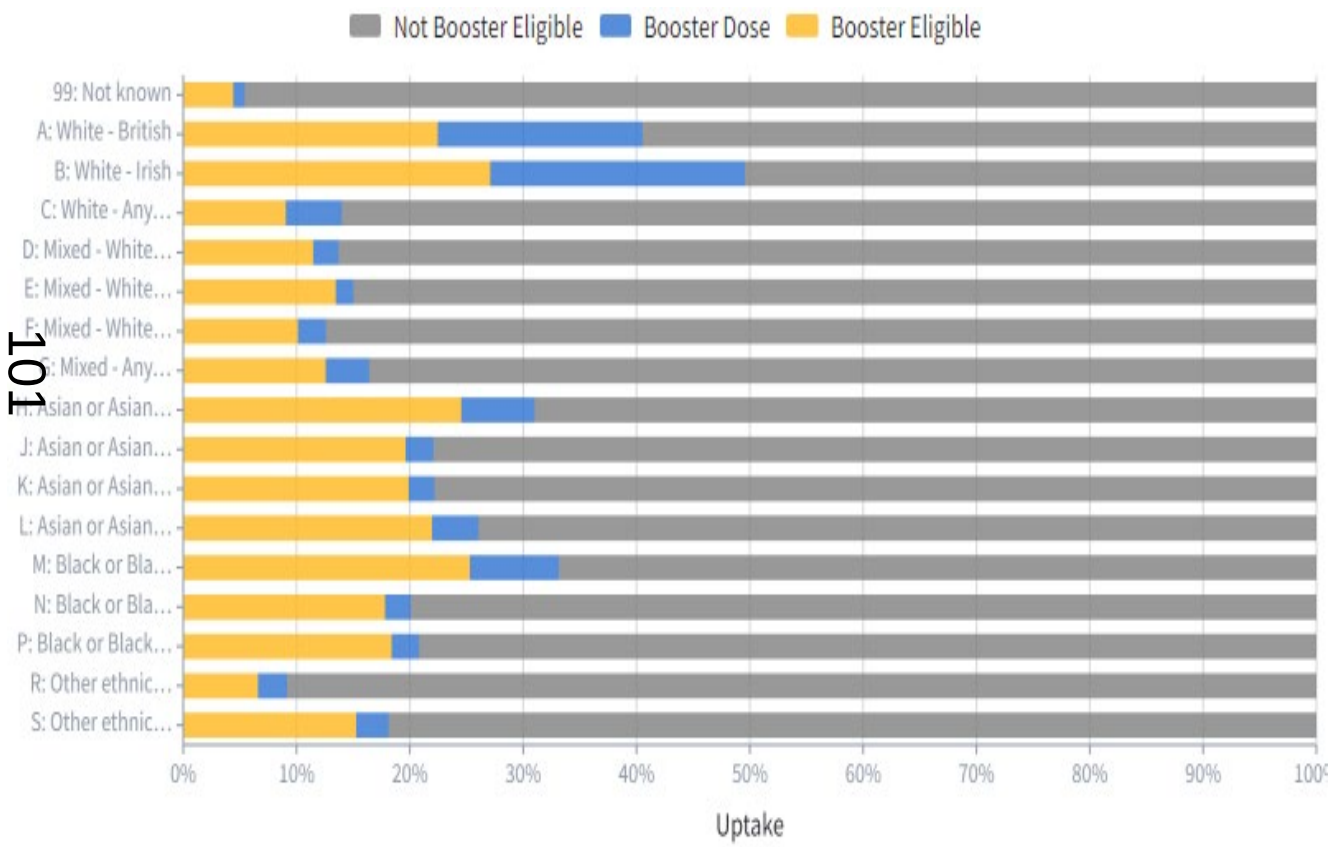
(Source: Foundry 1/11/2023)

COVID-19 vaccination offer AW 2023/24: City

(Source: Foundry 1/11/2023)

COVID-19 Cohorts	Eligible Population	Doses Administered	% Eligible Population Vaccinated
1. Care home residents	1,751	1,257	71.8%
2. Health care workers	20,292	3,678	18.1%
3. Social care workers	3,022	462	15.3%
4. 80+ years	11,605	6,627	57.1%
5. 75-79 years	9,519	5,355	56.3%
6. 70-74 years	12,801	6,268	49.0%
7. 65-69 years	16,363	6,261	38.3%
8. At risk	51,707	7,471	14.4%
9. 12-15 at risk	701	30	4.3%
10. 12-17 years – household contacts	912	5	0.5%
11. 5-11 at risk	337	7	2.1%
12. 60-64 years	0	436	0.0%
13. 55-59 years	0	364	0.0%
14. 50-54 years	0	263	0.0%
15. 40-49 years	0	281	0.0%
16. 30-39 years	0	224	0.0%
17. 18-29 years	0	158	0.0%
18. 16-17 years	0	6	0.0%
19. 12-15 years	0	6	0.0%
20. 5-11 years	0	0	0.0%

COVID-19 vaccination offer AW 2023/24: Total CITY by ethnicity

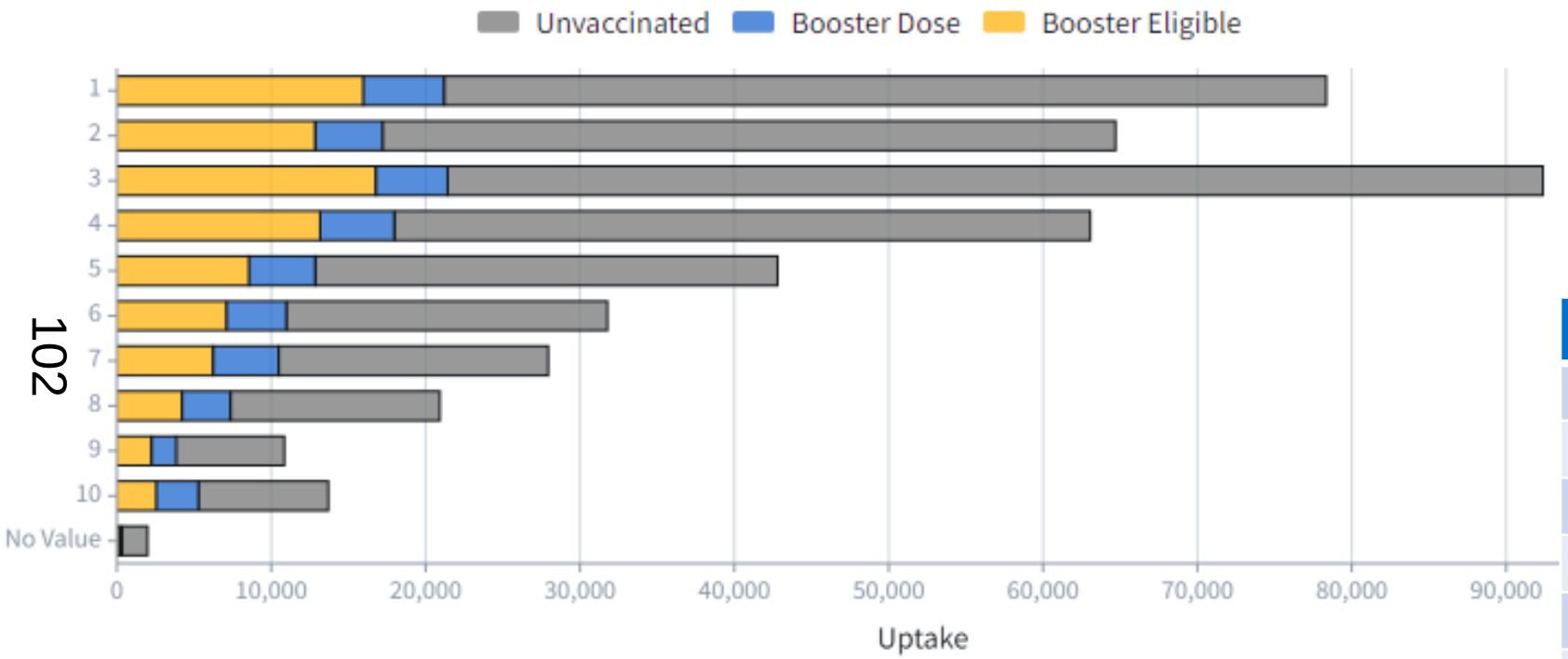


Ethnic Group	Vaccinated	Remaining
A. White – British	24,052	29,866
B. White – Irish	312	376
C. Any other White background	1,818	3,331
D. Mixed – White & Black Caribbean	82	422
E. Mixed – White & Black African	39	336
F. Mixed – White & Asian	79	324
G. Any other Mixed background	221	728
H. Asian or Asian British - Indian	9,146	34,527
J. Asian or Asian British – Pakistani	330	2,641
K. Asian or Asian British – Bangladeshi	138	1,213
L. Any other Asian background	1071	5,725
M. Black or Black British – Caribbean	334	1,076
N. Black or Black British – African	475	3,743
P. Any other Black background	171	1,305
R. Other ethnic groups – Chinese	131	336
S. Any other ethnic groups	581	3,116

(Source: Foundry 1/11/2023)

Lowest uptake ethnic groups indicated in red (less than 3% uptake)

COVID-19 vaccination offer AW 2023/24: CITY by deprivation



IMD decile	Vaccinated	% Vaccinated
1	5,239	6.69%
2	4,363	6.74%
3	4,662	5.05%
4	4,816	7.64%
5	4,302	10.05%
6	3,893	12.25%
7	4,255	15.23%
8	3,142	15.02%
9	1,608	14.82%
10	2,745	20.04%

(Source: Foundry 1/11/2023)

COVID-19 & flu vaccination offer: CITY mobile vaccination unit

Location	Dates	Total vaccinations given
British Islamic Medical Association health & wellbeing event	16 Sept	51
Beaumont Leys Market	19 & 20 Sept	76
Horizon Medical Practice car park	20 & 23 Sept & 30 Oct	220
Humberstone Gate	25 to 27 Sept	196
City Centre (outside Primark)	7 Oct	43
Peepul Centre health festival	12 Oct	5
Christ the King food bank	13 Oct	10
City Centre (outside Lloyds Bank)	14, 21 & 28 Oct	100

Updated programme to include

- Enable informed young people (age 12+) to participate in decision making through self-consent for vaccinations using Gillick competency.
- Clearly communicate alternative for the flu vaccine.

Nasal spray flu vaccine

Offers the best protection against flu. It is given as a spray squirted up each nostril. It's quick and painless.

For some children the nasal spray is not suitable for medical reasons. Our team will review the medical information submitted before offering the flu vaccine injection.

The nasal vaccine contains traces of a highly processed form of porcine gelatine.

Flu vaccine injection

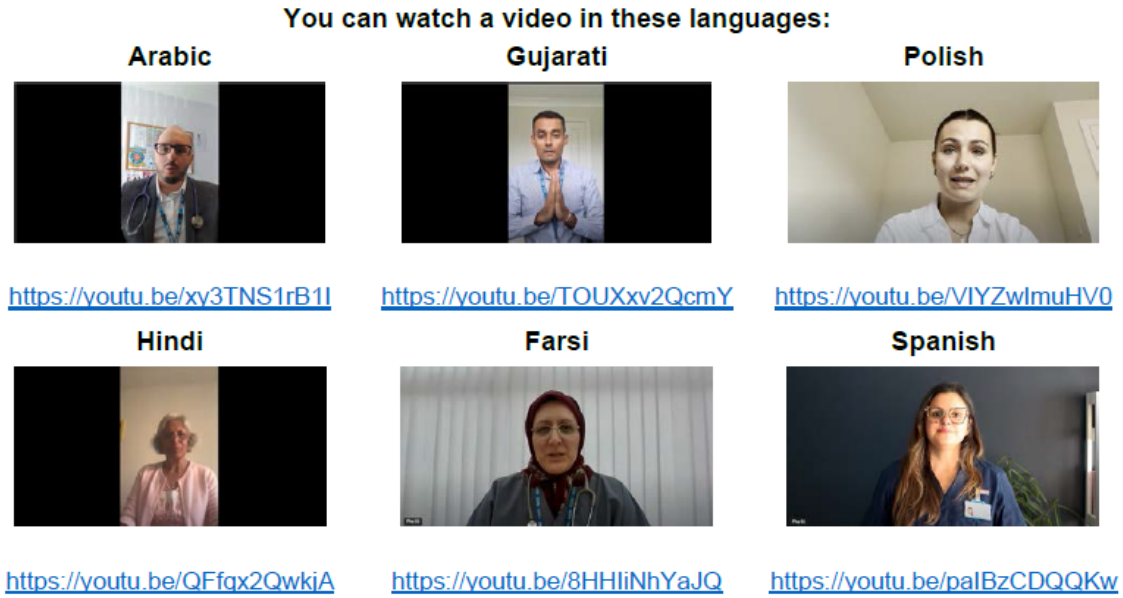
The injection is given into the muscle in the upper arm, which may cause soreness.

This vaccine is offered as an alternative if the nasal spray is not suitable due to medical reasons.

This vaccine does not contain porcine gelatine.

Updated programme to include

- Video resources in different languages.



- Materials created to inform young people about the vaccinations (e.g., animations, banners).

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Winter Planning – Adult Social Care
Presented to the Health and Wellbeing Board by:	Kate Galoppi, Director of ASC and Commissioning; Mark Abbot, Head of Service; Jagjit Singh-Bains, Head of Independent Living
Author:	Kate Galoppi

EXECUTIVE SUMMARY:

It is well understood that the pressures in care and health are particularly acute during the Winter. Adult Social Care works in collaboration with health to support Winter planning to manage the demand and flow that is associated with this time of year.

The Director of Commissioning and Heads of Service from Adult Social Care will present a summary of the actions in place locally to support a resilient social care system that is able to provide people and their carers with the support they will this Winter.

All parts of the adult social care sector play a critical role over the winter period, including:
Residential care; domiciliary care; extra care and supported living; shared lives; intermediate care; voluntary and community services; local authority staff including social work practitioners, occupational therapist, families and unpaid carers.

This presentation outlines the contribution of Adult Social Care to Winter planning by ensuring that people are supported home wherever possible, and are kept well in their communities.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: receive and make comment to the presentation.

Leicester City Adult Social Care

Contribution to Winter Planning

Leicester
City Council

Vaccination

- Identified leads within Dept to work with system partners
- Strong relationship with providers, supporting roll out to Care Homes, and frontline care workers
- Established communication channels to share messages
- Monitoring and supporting uptake – including front line social care workers

Leicester City Council

Urgent and Emergency Care (1)

Admission avoidance

Well established Integrated Crisis Response Service (ICRS) with impact on reduced conveyance (e.g. falls), and support to Unscheduled Care Coordination Hub

Typically 450 – 500 people supported at home each month and 85% require no additional support following ICRS intervention

Work in care homes (e.g. falls technology)

Proactive community support – Care Navigators

Leicester City Council

Urgent and Emergency Care (2)

Discharge

Demand for support +8.2% (Q1 2022 vs Q1 2023)

Commissioned beds for Pathway 2

Significant pathway redesign – "RRR" (Reablement, Rehab, Recovery)

Investment of available funding to grow workforce and expand professional skills (supporting greater complexity) within Reablement and TEC services

New 'Intake' offer through RRR supporting all appropriate discharges home = reduced use of commissioned care at point of discharge

Reduction of use of beds for discharge and swifter discharge home

Night time care through contracted dom care arrangements

Aug 23 - 72% of city people going home are discharged within 24 hours from request for support

94% receiving Reablement still at home 3 months later

Winter ambition – 90% of people go home within 24 hours and 95% of these are supported via our 'RRR Intake' Service (from 1 Nov)

Gone Live with the Virtual Frailty Beds Pilot – being supported by ICRS from a social care aspect

Leicester City Council

Community

- Use of workforce to promote winter wellness
- Cold homes initiatives
- New Leicester Energy Advice service – fuel poverty (driving poor health / risk of admission)
- LeicesterCare Community Alarms and Technology Enabled Care Service – expanded offer and increased capacity
- Promotion of falls services (e.g. Steady Steps)

Leicester City Council

Funds

Discharge Fund (23-24)

£2.4m (LA), £2.3m (ICB)

- To ensure those people who need to draw on social care when they are discharged from hospital can leave as soon as possible.
- Boost workforce capacity
- Prioritise approaches to free up hospital beds

Market Sustainability and Improvement Fund – Workforce fund 23-24

£2.4m

- increasing fee rates paid to adult social care providers in local areas
- increasing adult social care workforce capacity and retention
- reducing adult social care waiting times

Leicester City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Public Health – Winter Planning
Presented to the Health and Wellbeing Board by:	Gurjinder Bans & Kate Huszar
Author:	Gurjinder Bans

EXECUTIVE SUMMARY:

This update looks at:

- Health impacts of cold weather
- Whole council response – cost of living IMT
- Public health contribution
- Children and Young People: Baby basics & Leicester mammas
- Food Poverty
- Mental Health
- Fuel poverty
- Damp and Mould
- Warm Spaces

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: note the ongoing work within Public Health as we head into Winter, crisis and to make any observations as it sees fit.

Leicester City Council

November 2023

Public Health – Winter Planning

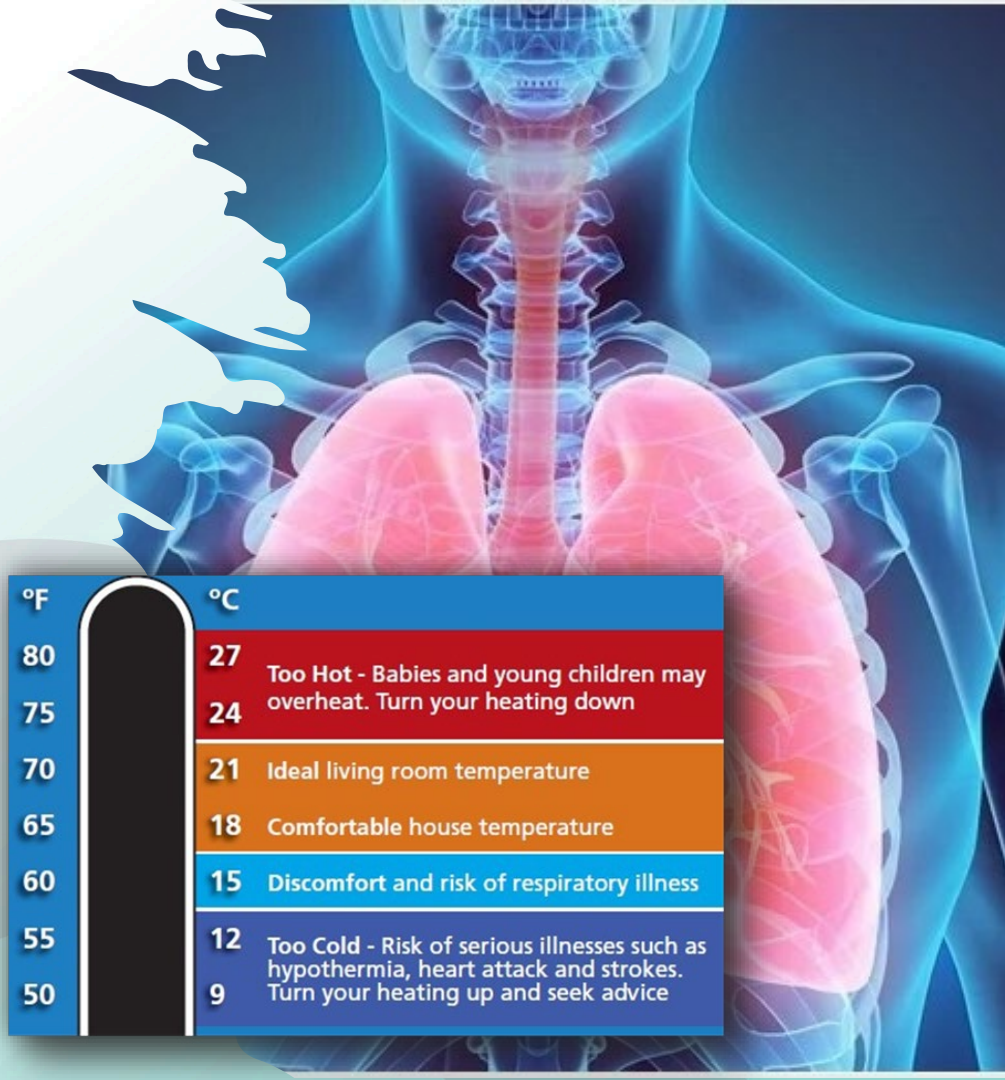
Gurjinder Bans & Kate Huszar; Programme Managers in Public Health

Contents

- ❑ Health impacts of cold weather
- ❑ Whole council response – cost of living IMT
- ❑ Public health contribution
  - Children and Young People: Baby basics & Leicester mammas
  - Food Poverty
  - Mental Health
  - Fuel poverty
  - Damp and Mould
  - Warm Spaces

Health impacts of living in a cold home

- Estimate excess winter deaths
  - 10% attributable to fuel poverty
  - 21.5% are attributable to cold homes.
- Lowers immune system
  - increasing the risk of contracting colds/flu viruses which thrive in colder environments
- Causes/worsens cardiovascular and respiratory illness
  - e.g. strokes, heart attacks, heart disease, asthma
- Trips and falls
- Worsens pre-existing chronic medical conditions
  - e.g. chronic obstructive pulmonary disease (COPD)
- Mental health and wellbeing
  - increases likelihood of social isolation
  - known risk factor for suicide.



Who is at risk/most vulnerable?

- Older people (aged 65 and over)
- People with cardiovascular conditions
- People with respiratory conditions (in particular, chronic obstructive pulmonary disease and childhood asthma)
- People with mental health conditions
- People with learning and/or physical disabilities
- Young children (particularly those aged under 5)
- Pregnant women
- People on a low income

Source: Gov Guidance: Supporting vulnerable people before and during cold weather: healthcare professionals ; September 2023

Established support programmes

What Public Health can influence

Social Isolation

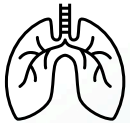
Damp and Mould

Physical Activity (WSATO)

Housing and Homelessness

Mental Health

122

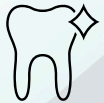


Smoking

Community (Wellbeing Champions)

Fuel Poverty

Children and Young People



Oral Health

Warm Spaces

Health Protection

Sexual Health

Food (Poverty)

Children & Young People: Baby Basics

- National charity - local branch in Leicester
- Leicester - second busiest branch nationwide
- Most people - volunteers
- Provide expectant, and new, families with the basics to support keeping baby safe and promote bonding and attachment
- Provision of cots and mosses baskets, nappies, cloths, bottles, steriliser, books etc
- Professionals refer families (people cannot self-refer).
    - 50% of referrals come via the Public Health Nursing (Health Visiting) team, and Public Health help fund transport too

Lead Officer: Clare Mills

Baby Basics Leicester

Tue at 20:19 ·

One of our regular midwives we work with recently shared this with us-
'I walked into the hotel room of the client who has 5 children. I started bringing in the items, of which a double buggy was included. The mum was sitting in bed feeding her baby. The mum put the baby down and rushed over to me and threw her arms around me, sobbing with tears of joy. She could not believe her eyes at the items being delivered. To the majority of people, quite simple items really, but to her they meant everything.' 😍

233 7 comments • 6 shares

Like Comment Share

Baby Basics reverse advent calendar

"Baby–basics" Leicester

As a family, team or community find an empty box and take it in turns to put a NEW item in from the list during the Christmas season. Lets spread a little Christmas cheer and love to those that need some extra support at this time.

1. Nappies (size 0,1,2)
2. Nappy sacks
3. Baby sponge
4. Baby shampoo
5. Nappy cream
6. Cotton wool
7. 0-2yrs toothbrush
8. 0-2yrs toothpaste
9. Baby towel
10. Shape sorter/ Stacking toy
11. Baby rattle/ teething toy
12. Bath toy
13. Board book
14. Maternity towels
15. Sanitary towels
16. Breast pads
17. Ladies shampoo
18. Ladies Conditioner
19. Ladies shower gel
20. Adult tooth brush/toothpaste
21. Ladies Deodorant
22. Hand soap
23. Hand sanitiser
24. A box of chocolates

Or to buy off our wish list visit:
www.forcommongood.co.uk/pages/baby-basics-leicester

Last date to drop off items -14th December 2023
donationsbbl@gmail.com

Children and Young People: Leicester Mammas

- Supports any pregnant or new mum & baby/ families throughout the First 1001 Days, from pregnancy to 2 years
- Part of Leicester NHS Healthy Together Healthy Child Programme
- Women-led, mother-to-mother; evidence-based and specialist help
- Breastfeeding and all other feeding support – one-to-one and through groups
- Help to address adversity and food insecurity

mammas

Mammas Baby Project - Protecting the most vulnerable

- Mammas Baby Project set up in June 21 as part of Starting Well Leicester (DHSC funded) until March 23. Now funded by Better Care Fund
- Referrals from health professionals, food banks, children's centres and community and faith organisations
- Providing emergency supplies (nappies, sanitary products etc) where needed, **including issuing formula and food vouchers** in line with WHO Code and clothing/baby equipment from donations
- Giving one-to-one antenatal and postnatal breastfeeding/feeding support
- Prioritising access to Healthy Start vouchers

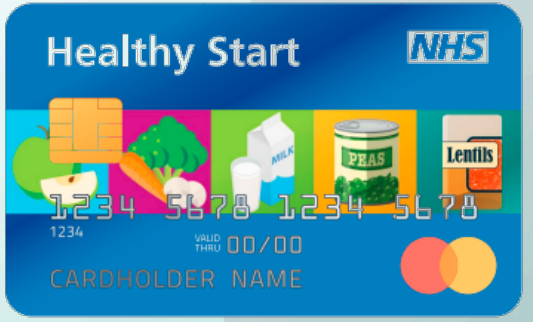
January – September 23

- 142 vouchers issued totalling £2290 (93 Formula, 49 Food)
- Benefitting 49 families in total

Leicester Mammas

- **Breast Feeding Hospital Peer Support** - 7 women in total undertaking 10-week training. New cohort planned for February 24
- South Leicester Additional Funding – **Baby Café** (drop in feeding support and opportunity to connect with other mums); **Baby Massage** (starting 18th January); **Big Cook Little Cook** (Healthy meals on a budget)
- **Baby Massage** (5 week course) – West and East Leicester (Braunstone starting 20th Nov, Tournby Lodge starting 14th November, Netherhall and Highfields starting January 24)
- **Baby & Me In-Person & Online Weekly Sessions -** topics such as Safe Sleep messages, Family finances, caring for baby teeth, weaning, returning to work
- **Mammas Online Antenatal Courses-** Rolling programme of 4 sessions each month covering health in pregnancy, preparation for birth, getting off to a good start with breastfeeding and managing in the early weeks with a newborn
- **Free breast pump loan scheme** - 2020 - 30 loans, 2021 - 47 loans, 2022 – 51 loans, 2023 - 50 loans

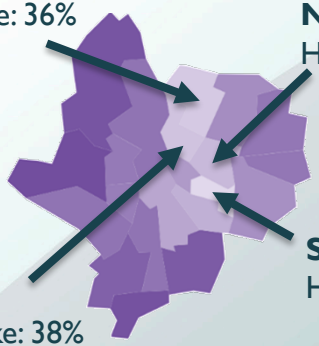
Healthy Start



Healthy Start is an NHS scheme to give eligible families financial support to buy essential food/drink items and access to vitamins

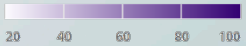
Rushey Mead
Healthy Start Uptake: 36%

North Evington
Healthy Start Uptake: 41%



Spinney Hills
Healthy Start Uptake: 31%

Belgrave
Healthy Start Uptake: 38%



Healthy Start Uptake July 23

Healthy Start Steering Group

- Facilitated by Public Health
- Set up to share information and develop collaborative approaches to improve uptake
- Membership includes Leicester City Council, Leicestershire County Council, NHS, VCSE

Online Training

- Training aimed at Health Professional

Campaign

- Winter campaign to promote scheme

LEICESTER'S FOOD PLAN

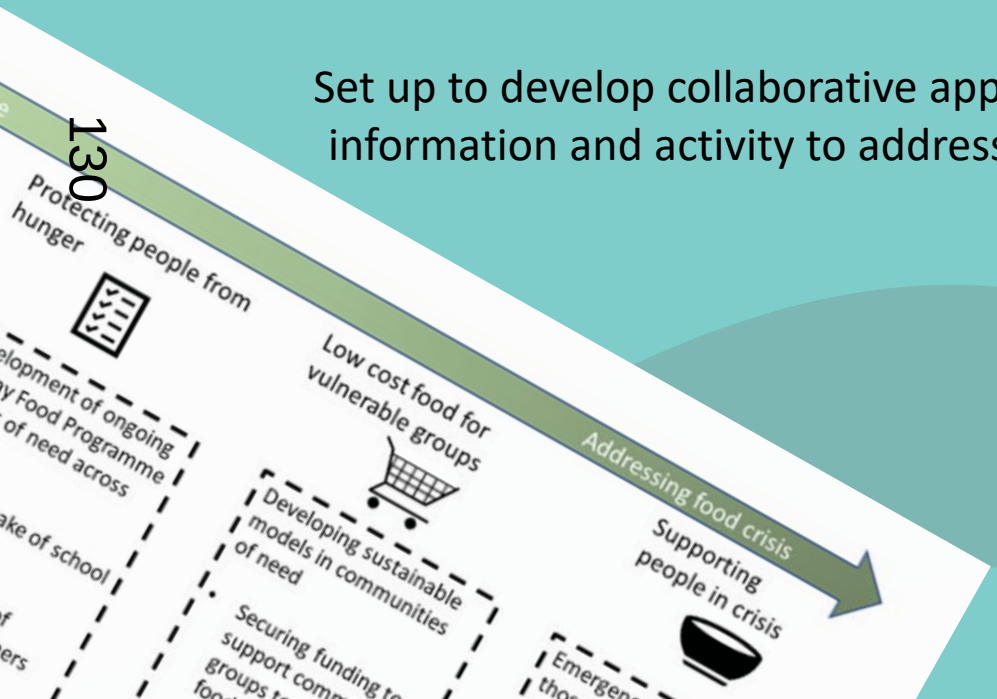
2 Ambition 2: Tackling food poverty

Feeding Leicester Partnership

Multi-agency partnership (from 2018)

Facilitated by Public Health, Chaired by Liz Kendall

Set up to develop collaborative approaches, share information and activity to address food poverty

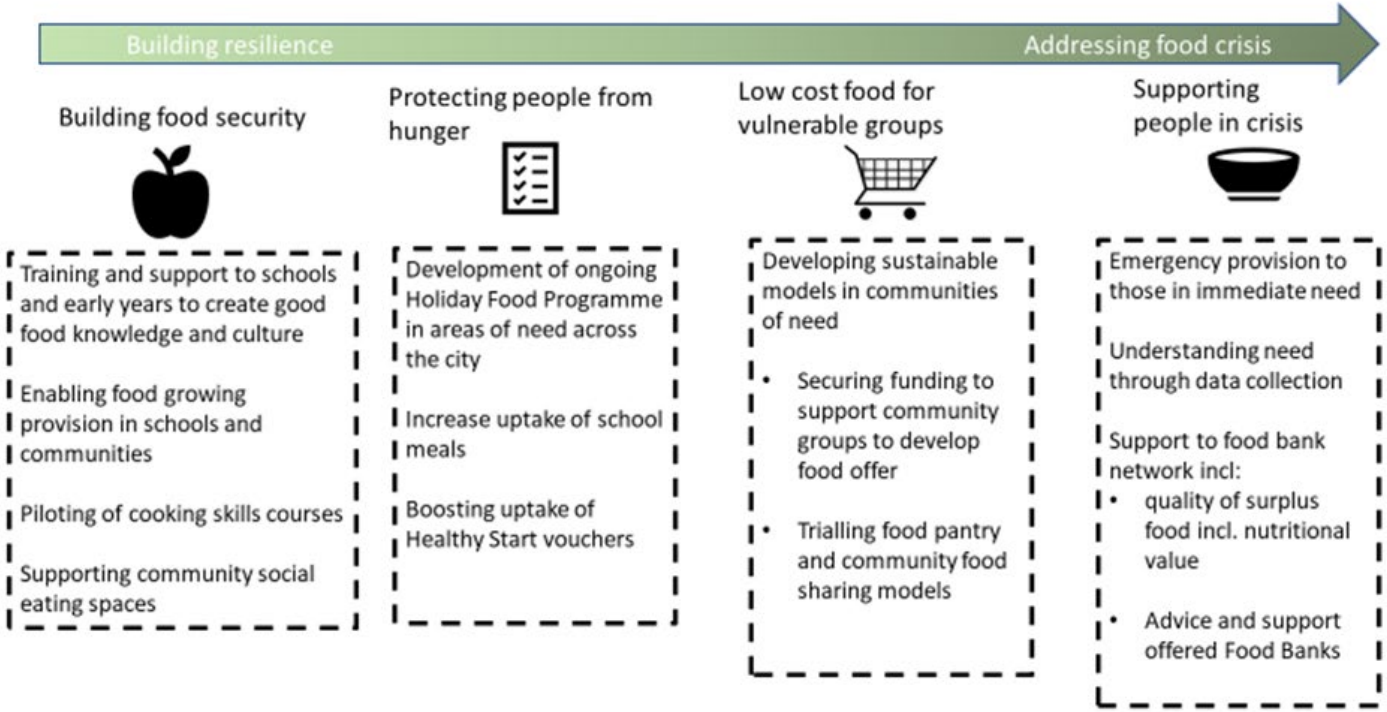


Membership includes

LCC, NHS, Universities, VCSE (Local and National inc. Reaching People, Community Advice and Law Service (CALS), Trussell Trust, Feeding Britain Charity)

Leicester City Council

Feeding Leicester's Themes



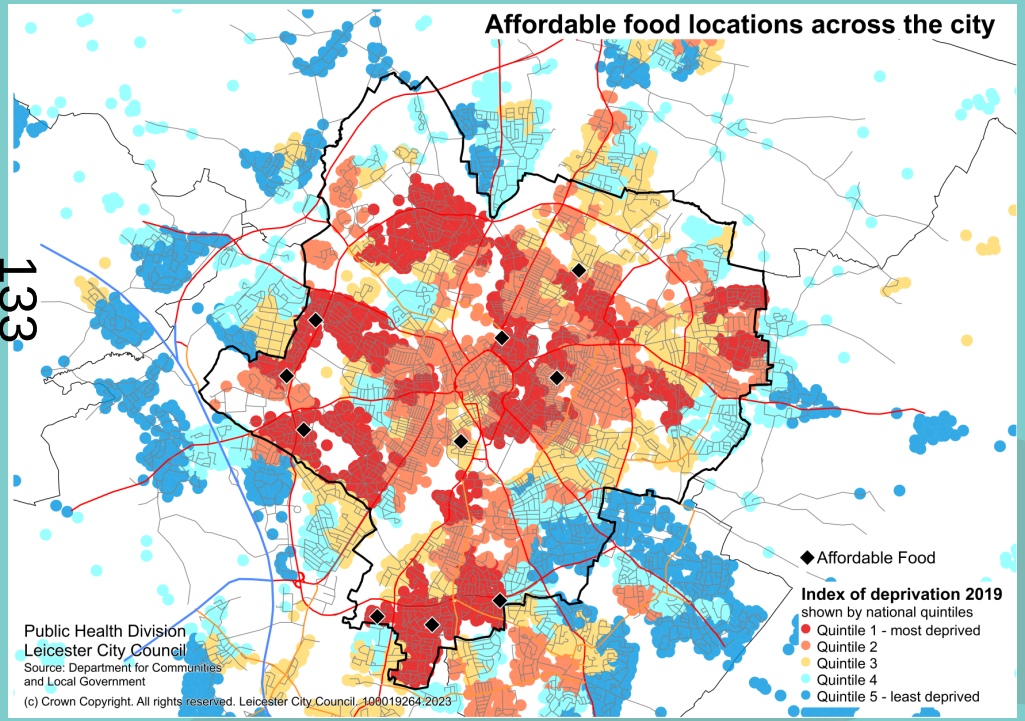
Food Aid Provision in the City

- **'Charitable' aid –** 22 food banks in the city since 2013 (R&CS review)
- **Bespoke support** to Food Aid Projects in City – Reaching People Charity – Funded by R&CS, LCC
- Development of an **emergency food partnership** across 22 Food Bank in the city
- Development of **debt and advice offer** focused within 6 food banks in the city
- **Supporting projects to be self-sufficient**/development of 'co-operative' style partnership being explored
- **Last 3 years unprecedented funding** to Food Aid projects via Housing Support Fund
- **Longer term** – reducing dependency on food aid, supporting low-cost food pantry models (map next slide) - strengthening partnership to explore bulk buying/increase access to nutritious food and reduce dependency on food aid

LEICESTER'S FOOD PLAN

Leicester City Council

Low-Cost Food ‘Pantry Models’



Over 10 projects in the city

Offering reduced cost food
Widening inclusion to offset ‘stigma’ associated with ‘foodbanks’

Sustainability key objective and challenge

Leicester City Council

Community support and mental wellbeing

- Financial worries have an impact on mental wellbeing, making it more difficult for people to manage and putting them at greater financial and psychological risk.

- Public Mental Health, Community Advice and Law Service (CALS) and Reaching People to deliver Foodbank Plus since April 2022. The emphasis of the work is the impact of financial adversity on mental health.

- Financial advice and signposting people to local schemes supportive of mental wellbeing. For instance, friendship groups, organised walks, growing schemes.

Community support and mental wellbeing

The public mental team is supporting initiatives to develop social capital to promote resilience to mental health problems. These include:

- **Volunteer Co-ordination:** Promote initiatives and self-supporting groups in neighbourhood and community venues.
- **Study support:** A warm place after school for young people to do their homework in a warm environment and for parents to gain some confidence in helping their children with their schoolwork.
- **Mental Health Friendly Places:** Free access to short courses to help people to feel comfortable and confident to have conversations about mental health.
- **Counselling support:** Counselling for people accessing fuel poverty support, who have problems with undiagnosed anxiety.

Fuel Poverty and Health Programme

Leicester Energy Action

Funded by LLR Integrated Care Board

Delivered by NEA and Leicester City Council – Public Health Division

NHS
Leicester, Leicestershire and Rutland

NEA
Action for Warm Homes

Leicester City Council

What is Fuel Poverty?

Definition:

National Energy Action defines fuel poverty as when a household spends 10% of its income on keeping its home at a satisfactory heating level.

The UK government's definition for fuel poverty in England uses the Low Income Low Energy Efficiency (LILEE) indicator. Under this indicator, a household is considered to be fuel poor if:

It is living in a property with a fuel poverty energy efficiency rating of band D or below, and when they spend the required amount to heat their home, they are left with a residual income below the official poverty line.

- National Energy Action

Leicester Energy Action

January 2023 Project underway

Recruitment and training

Project infrastructure and processes.

Outreach underway.

February 2023 - Advice Service Launches. LCC Housing Teams/Community Groups

March 2023 - First C&G Training Cource. 89 Referrals to the Advice Service.

April to September 2023 - growth of the service

NHS Teams, social prescribers, further community group/VCS connections - many more...

Advice Service referrals averaging around 30 per week and growing.

2 further C&G courses delivered, webinar courses consistently oversubscribed Primary School Sessions sucessful

October to December 2023 (close of year one) - Being ready for Winter.

- Advice Service
- Outreach
- Training
- Education

Energy efficiency/health impacts

Damp/mould in properties

Managing energy debt/negotiating with suppliers

Linking to government support/ tackling barriers such as digital exclusion

Linking to existing retrofit schemes

Long-term solutions as well as short-term remedies

Claire's Story

Claire is 69, living in three-bedroom house. Language barrier and a visual impairment - unable to read fuel bills and other correspondence

Had an unsuccessful knee replacement - cannot walk without assistance. Long term illness and fear of not been able to afford to keep her family warm

Claire's health conditions leave her isolated, suffering with severe depression and anxiety, and she had a debt of £680.10 with British Gas

Claire was also struggling with food - not accessed local food banks as anxious about facing stigma

- Conducted a home visit and a conference call with client and supplier - uncovered that the client was in credit.
- We worked with British gas to reduce the Claire's monthly payments from £92.82 to £69.01 per month for the next 12 months.
- We put Claire on the priority services register, and so now she will be sent bills monthly in large print

- Referred to We Care UK for a food parcel - tailored to the clients' needs and delivered to her home.
- Signposted to Zinthiya Trust for benefits advice, Age Concern for befriending, Vista Blind for assessment and support, and applied for the Severn Trent Water Big Difference Scheme.
- Worked with Claire around efficient use of appliances, healthy room temperatures, heating and hot water controls, keeping warm and healthy in colder weather, and low-cost energy efficiency behavioural changes.

£40


Outreach
Community Groups
LCC and NHS Teams
Advice Providers
Events/forums

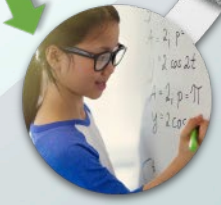

Knowledge
Awareness
Better Health
Behaviour Change
Access

Education

Knowledge and Understanding

Resources

Practical Advice



Connected to the curriculum

Learning

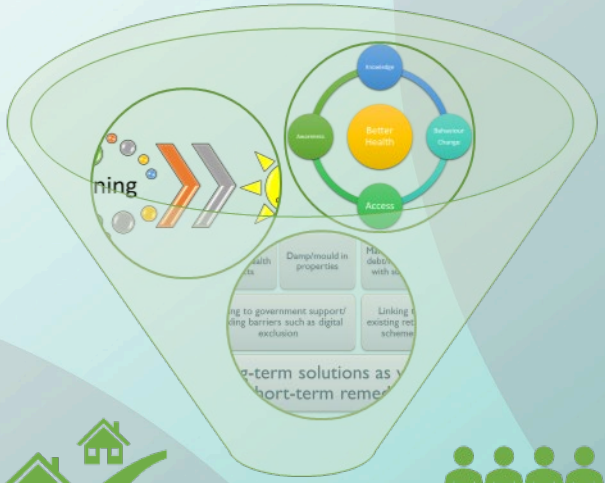
Long-term change

Training

Community Groups

LCC and NHS Teams

Advice Providers



Embedded in communities

Winter warmth packs

Funds would support Winter Warmth Support Packs for our most vulnerable and at-risk clients.

Each pack contains household energy efficiency items and guidance.

Packs are developed by our Fuel Poverty Programme partners, National Energy Action.

Distribution to discharged NHS patients returning to cold homes, to homes identified by Health Visitors, and to patients on virtual wards.

- Thermometer card.
- Warm, wearable Blanket.
- Vacuum flask.
- Windable torch
- LED Lightbulbs.
- Draughtproofing strips.
- Internal door draughtproof
- Radiator Reflector Panels
- Packets of soup
- Hoodies
- Home energy checklist electricity appliances usage
- NEA Leaflets
- Further info leaflets
- Baby Cardigans

Damp and mould

- **Causes**:
  - Inadequate ventilation,
  - Excess moisture,
  - Inadequate insulation,
  - Inadequate heating

- **Health impacts**:
  - Respiratory impacts, particularly for children e.g. asthma
  - Coughing/sneezing, sinusitis, rhinitis,
  - Skin problems
  - Headaches and migraines
  - Watery, itchy eyes

- **What we're doing:**
  - Referrals from fuel poverty advice service
  - Respiratory JSNA update
  - Damp and Mould HNA/HIA

• Warm Welcome

- Public Health, Adult Learning and Neighbourhood Services – free activities in a safe space

- Community Centres and Libraries
- Information on website
- Warm welcome awaits at Leicester's libraries this winter

- **Let's Get Resourceful courses**
- Eat well on a budget
- Keep warm in the home
- Sew to save

- **Taster sessions**
- Jewelry, festive cards gonks and more….

Free activities and support

‘Let’s Get Together’

Free activities :

- Together Tables * Health Walks
- Sociable strolls * Gardening
- Volunteering opportunities

2 free 3 hour sessions.

- Social needs online
- Medical needs online

Email: bringingpeopletogether@leicester.gov.uk

‘Let’s Get Growing’

Free activities:

- Food growing courses
- Short workshops * Free seeds
- Advice and support
- Volunteering opportunities