LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: MONDAY, 9 OCTOBER 2017

Time: 3:00 pm

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.

G. J. Carey
For Monitoring Officer

NOTE:

This meeting will be webcast live at the following link:-

http://www.leicester.public-i.tv

An archive copy of the webcast will normally be available on the Council's website within 48 hours of the meeting taking place at the following link:-

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

MEMBERS OF THE BOARD

Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Adam Clarke, Assistant City Mayor, Energy and Sustainability

Councillor Piara Singh Clair, Assistant City Mayor, Culture, Leisure and Sport

Councillor Abdul Osman, Assistant City Mayor, Strategic Partnerships and Change

Councillor Sarah Russell, Assistant City Mayor, Children, Young People and Schools

City Council Officers:

Frances Craven, Strategic Director Children's Services

Steven Forbes, Strategic Director of Adult Social Care

Andy Keeling, Chief Operating Officer

Ruth Tennant, Director Public Health

NHS Representatives:

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

Roz Lindridge, Locality Director Central NHS England – Midlands & East (Central England)

Healthwatch / Other Representatives:

Karen Chouhan, Chair, Healthwatch Leicester

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Chief Superintendent, Andy Lee, Head of Local Policing Directorate, Leicestershire Police

Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service

STANDING INVITEES: (Not Board Members)

Toby Sanders, Senior Responsible Officer, Better Care Together Programme
Will Legge, Divisional Director, East Midlands Ambulance Service NHS Trust

Information for members of the public

Attending meetings and access to information

You have the right to attend formal meetings such as full Council, committee meetings, City Mayor & Executive Public Briefing and Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

Dates of meetings and copies of public agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk, from the Council's Customer Service Centre or by contacting us using the details below.

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Wheelchair access – Public meeting rooms at the City Hall are accessible to wheelchair users. Wheelchair access to City Hall is from the middle entrance door on Charles Street - press the plate on the right hand side of the door to open the door automatically.

Braille/audio tape/translation - If you require this please contact the Democratic Support Officer (production times will depend upon equipment/facility availability).

Induction loops - There are induction loop facilities in City Hall meeting rooms. Please speak to the Democratic Support Officer using the details below.

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If you intend to film or make an audio recording of a meeting you are asked to notify the relevant Democratic Support Officer in advance of the meeting to ensure that participants can be notified in advance and consideration given to practicalities such as allocating appropriate space in the public gallery etc.

The aim of the Regulations and of the Council's policy is to encourage public interest and engagement so in recording or reporting on proceedings members of the public are asked:

- ✓ 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 Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

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 **Appendix A (Pages 1 - 30)**

The Minutes of the previous meeting of the Board held on 17 August 2017 are attached and the Board is asked to confirm them as a correct record.

4. WINTER PLANNING ARRANGEMENTS **Appendix B (Pages 31 - 86)**

Tamsin Hooton, Director of Urgent and Emergency Care and Jennifer Smith, Head of Operational Resilience and Emergency Planning, West Leicestershire Clinical Commissioning Group, will present the Leicester, Leicestershire & Rutland Health and Social Care Economy Winter Care Plan 2017-2018.

5. WINTER PLANNING ARRANGEMENTS - COMMUNICATIONS, ENGAGEMENT AND MARKETING PLAN **Appendix C (Pages 87 - 108)**

Melanie Shilton, Communications Manager, Leicester City Clinical Commissioning Group, will present the Winter Communications, Engagement and Marketing Plan 2017/18.

6. FLU VACCINATION ARRANGEMENTS

Appendix D
(Pages 109 - 142)

Chloe Leggat, Screening and Immunisation Co-ordinator (Leicestershire, Lincolnshire and Northamptonshire), Public Health England, will make a presentation on Flu and Vaccination Programmes – Leicester City.

7. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

8. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will be held on the following dates:-

Thursday 7th December 2017 – 10.30am
Monday 5th February 2018 – 3.00pm
Monday 9th April 2018 – 2.00pm

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

9. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 17 AUGUST 2017 at 4:00 pm

P R E S E N T :

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
Karen Chouhan	–	Chair, Healthwatch Leicester.
Andrew Brodie	–	Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service
Ivan Browne	–	Deputy Director of Public Health
Councillor Piara Singh Clair	–	Assistant City Mayor, Culture, Leisure and Sport, Leicester City Council.
Frances Craven		Strategic Director, Children's Services, Leicester City Council.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group.
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
Wendy Holt	–	Better Care Fund Implementation Manger, Central NHS England, Midlands and East (Central England).
Helen King	–	Chief Finance Officer, Office ofthe Police and Crime Commissioner.
Debra Mitchell	–	Integrated Services Programme Lead, University Hospitals of Leicester NHS Trust.
Richard Morris	–	Director of Operations and Corporate Affairs,

		Leicester City Clinical Commissioning Group.
Supt Shane O'Neill	–	Local Policing Directorate, Leicestershire Police.
Councillor Abdul Osman	–	Assistant City Mayor, Strategic Partnerships and Change, Leicester City Council.
Councillor Sarah Russell	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council.

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

84. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

John Adler	Chief Executive, University Hospitals of Leicester NHS Trust
Lord Willy Bach	Leicester, Leicestershire and Rutland Police and Crime Commissioner
Councillor Adam Clarke	Assistant City Mayor Energy and Sustainability, Leicester City Council
Andy Keeling	Chief Operating Officer, Leicester City Council
Will Legge	Divisional Director, east Midlands Ambulance Service NHS Trust
Roz Lindridge	Locality Director Central NHS England – Midlands and East (Central England)
Sue Lock	Managing Director, Leicester City Clinical Commissioning Group
Dr Peter Miller	Chief Executive, Leicestershire Partnership NHS Trust
Toby Sanders	Senior Responsible Officer, Better Care Together Programme
Ruth Tennant	Director of Public Health, Leicester City Council

85. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business

to be discussed at the meeting. No such declarations were made.

86. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the minutes of the previous meeting of the Board held on 17 August be confirmed as a correct record subject to Councillor Osman's title being amended to Assistant City Mayor, Strategic Partnerships and Change, Jill Smith being amended to Julie Smith and Professor Farooqi's name being amended to Professor Azhar Farooqi.

87. PRIMARY CARE STRATEGY AND GENERAL PRACTICE FORWARD VIEW

Leicester City Clinical Commissioning Group submitted a report detailing the approach to delivering the General Practice Forward View (GPFV) in Leicester City and how delivering this national work links to the development of the Sustainability and Transformation Plan delivery across Leicester, Leicestershire and Rutland.

The Director of Operations and Corporate Affairs presented the report and the following comments were noted:-

a) Access to primary care was still a concern to patients in the city and the CCG had met the national milestone of 50% of the public having access to week-end and evening GP appointments by March 2018. The 3 hubs at Westcotes, Belgrave and Saffron had provided 1,300 extra appointments a week, equivalent to an additional 135 hours. The hubs were operating at 95% capacity but there was a noticeable drop off in demand on Sunday afternoons. The CCG were continuing to work with GPs to have extended access in all GP practices.

b) There was continued local recruitment for GPs which recently resulted in the appointment of 11 new GP. The second phase of the recruitment in May had resulted in a further 4 new GPs and expressions of interest from others. A further initiative to recruit from overseas, based upon pilot scheme in Lincolnshire, was planned. There were also now 9 clinical pharmacists working in GP practices. The local NHS England target was to recruit an additional 25 GPs in the city by 2020. As 25% of GPs were currently over 55 years old, retention of existing GPs was also important.

c) A toolkit looking at all models of care and case studies from elsewhere, was being developed. A second edition of the toolkit was going live later in the year and a number of practices were already moving forward with the intitiative.

d) The CCG had re-invested more than £500k from existing funds to bring the base line for GP practices in Leicester up to and above the national

minimum level of funding of £85 per patient. It had also recycled approximately £2m of funding from within its existing budgets to provide additional funding for primary care services in Leicester. £200k has also been made available for training in primary care.

Following questions from Members the following responses were received:-

a) The Merlyn Vaz Centre had been a walk Centre for a number of years and it had now been procured as 4th hub. It would initially offer the existing walk in facility but would also have a new pre-booked focus with the aim of increasing the level of pre- booked appointments.

b) The CCG would aim to replace gaps in GPs services as and when established practices closed. Some practices were currently understaffed, but the CCG had no powers to direct staffing levels in existing GP practices as this was the responsibility of the individual GP.

c) The CCG tried to encourage continuity of care and encourage more GPs to be employed by individual practices in preference to being locums who moved around several practices. It was however, that some of the younger GPs preferred to be a locum. All hubs and GP practices had access to a common computer system so they all the ability to see a patients full record. Training was provided on safeguarding issues and every practice has a safeguarding lead.

d) It was recognised that new GPs wanted a portfolio career often involving 3 days in a GP practice and 1 day in a university or hospital setting. The CCG were working with all involved to assist the development of this offer for new GPs. The CCG had also made podcasts of new GPs who had been following this portfolio approach to promote the system and proactively promote their experiences and the benefits of working in Leicester.

e) It was not known if the reduction of appointments in the hubs on a Sunday afternoon had resulted in increased activity at A&E or created a spike on Monday mornings in GP practices.

f) The University had altered their undergraduate course and students now spent more time in GP practices as part of the training.

RESOLVED:

That the report be received and that a monitoring report be submitted on a quarterly basis.

88. HEALTH AND WELLBEING WORKSHOPS OVERVIEW

The Director of Public Health submitted a report that explained the purpose of the workshops, the key findings and how these would be applied to the draft strategy and future work. The report was supported by a presentation.

It was noted that:

a) The Health Start workshop was scheduled for September and others had already taken place.

b) Increases in life expectancy had resulted in a significant gap between health life and life expectancy; both nationally and in Leicester. It was now estimated that males and females in Leicester could expect 20 years of not being in good health. This was attributable to the increase in the inequalities of living a health life expectancy and more people living longer in poor health

c) The outcomes of the Workshops that had already been held were summarised on the slides of the presentations which are attached to these minutes.

d) Due to the reducing budgets for public health it would be necessary to have a targeted approach in future. Feedback supported continued working collectively across all health systems to avoid missing those most in need and them and causing stigma. The community based approach would help to target whole families as opposed to individuals.

The Chair commented that the next Health and Wellbeing Strategy needed to be different from the current one as it needed to be more challenging and aspirational; with the aim of bringing about improvements in health well beyond the 5 year life of the plan. The challenges would be around how this could be done differently to achieve the aspirational aims within the limited resources that would be available.

Members commented that low physical activity often contributed to poor health, and whilst 1 in 5 were happy to participate in physical activity, more was needed to address the cultural change to enable people to engage in more physical activities. The City had quality open spaces and 33 open space gyms and initiatives to increase their usage would be important. The challenge was to reach those sections of the community that didn't take regular exercise, such as those on low incomes, unemployed people and BME women.

RESOLVED:

That the report and the feedback from the workshops be received and welcomed and that these be fed into the revised draft strategy. Members of the Board were also encouraged to submit comments and suggestions to shape the next Strategy.

89. LEICESTER CHILDREN AND YOUNG PEOPLE'S HEALTH AND WELLBEING SURVEY 2016

The Director of Public Health submitted a report on the Leicester Children and Young People's Health and Wellbeing Survey 2016 that provided a cross-

sectional snapshot of health and wellbeing issues for children and young people in the city. A presentation was made at the meeting which had previously been circulated with agenda.

The results of the survey provided the views of approximately 3,000 children in years 6, 8 and 10. The majority of those surveyed had generally expressed positive experiences. The west of the city had poorer outcomes in health and education and differences had been observed in the risk factors. It was felt the survey was a useful tool to triangulate data on risks and risks in specific groups.

The view was expressed that further thought needed to be given to how the survey results could be used proactively along with other information that was currently, held since the more sources of data that could be triangulated the more it helped to focus on groups that were at risk. It was noticeable that 1in 5 children worried about not having enough to eat and that also 1in 10 children were having takeaway meals on most days. This indicated that some children were not getting sufficient nutrition to support growing bodies and minds and this could have a significant detrimental impact on the health system in 20 years' time. This needed to be addressed by all partner organisations on the Board. There was concern that there may not be sufficient or adequate resources needed to support families adequately.

The Chair commented that the survey provided real empirical date and was a valuable resource which the Board needed to use to the full in order to inform and redesign policies.

The Deputy Director of Public Health stated that the results of the survey were available for everybody to use. It provided a realistic picture of real experiences based upon a good sized sample. There was a significant amount of core data supporting the summary which could be broken down further should Board members find this useful.

RESOLVED:

> The Board welcomed the report and survey results and supported the dissemination of the survey results to enable partner organisations to inform and implement their own initiatives.

90. BETTER CARE FUND

Leicester City Clinical Commissioning Group submitted a report on the Leicester City Better Care Fund 2017-19.

It was noted that the draft was being submitted later than usual because the planning guidance and the requirement of the Better Care Fund were not issued by NHS England until mid-July with a submission date of 7 September 2017. The draft narrative of the plan was contained in the current draft document narrative template and the final planning template had only recently been received since the Agenda was published and this was being completed.

Guidance had been drip fed to the CCG by NHS England and the Final Key Lines of Enquiry had only been received from NHS England earlier in the week and work was now progressing to complete these. The Plan, therefore, may change to reflect any additional information requested by NHS England before the formal submission date.

The current draft had been prepared jointly by the CCG, the Council, partner organisations including UHL and LPT and Police and Fire Services and had recently been considered by the patient's participation group for STP and had been largely supported.

The plan was measured against a matrix of 5 indicators to ensure the efficacy of the Plan and these were:-

- Non-elective Admissions
- Delayed Transfer of Care in both the acute and non-acute sites
- |Admissions to residential care
- Number of Patients at home 91 days after a hospital episode.

2 of the 5 matrix indicators had been achieved in 2016-17. The non-elective admissions had been missed by 203 admissions. Although this may appear significant this represents a huge decrease on the previous figures which missed the target with figures in excess of 1,000s. Delayed Transfer of Care had reduced significantly at the acute hospital site and there were now only a few local authority attributed delays as a result of previous initiatives taken under the better care together fund. The LLR A&E Delivery Board had already addressed this issue and had approved a plan to achieve the target by March 2018. Work was also progressing with health trusts to minimise delays in the future in relation to mental health and learning disability facilities.

The BCF Implementation Manager, NHS England (Midland and East) commented that she was a member of the Assurance Panel and felt the plan was well written and one of the better ones that had been received. It was pleasing to see an increased focus on delayed care, community settings and learning disabilities. The links to housing needed strengthening as this was significant to peoples' health and wellbeing.

The Healthwatch Chair expressed concerns in relation to the other challenges in Chapter 2 of the draft and felt these did not fit completely with the positive narrative following the risk assessment that had subsequently been received and asked for assurances on these aspects.

In response, it was noted that there had been a huge reduction in delayed transfer of care and non- elective surgery admissions which had reduced the previous numbers of 14-15 delayed transfers per week to the current level of 8-10. Overall there was a 2.62% reduction in the number of patients in hospital beds than in the previous year, which was considered to be a significant achievement. Year on year reductions where now being observed which was seen as a significant improvement against the previous backdrop of 5-6% growth per year.

A Member commented that the supporting appendices sent out after the agenda had been published, particularly the high impact changes to support local health and care systems to reduce transfers of care in LLR, had many actions listed in them but it was hard to see what impact these actions had achieved. For example, the care homes with most ambulances attendances and the Braunstone Blues initiative supporting care homes, which had the highest use of ambulances, by providing policy change and education (EMAS).

It was also noted that the Braunstone Blues initiative had had a dramatic impact in reducing the number of ambulance activations to the 2 care homes and the conveyance rate had increased

It was also noted that the impact of actions could be put into a summary when final plan was submitted together with a comment on the impact they made. It was felt that this would make the document easier to digest.

Members commented that any additional information that made the document easier to read from a lay perspective and enable readers to assess the impact of actions and initiatives was to be welcomed.

RESOLVED:

1) That the draft narrative of the Leicester City Better Care Fund plan 2017-19 be approved and that the Chair of the Health and Wellbeing Board be given delegated authority to approve the final narrative plan and planning template prior to its formal submission.

2) That the Board receive regular monitoring and progress reports so that any system critical areas of challenge can be addressed and resolved.

91. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair invited questions from members of the public.

The Vice Chair of Healthwatch asked of the documents that had been sent to Members of the Board after the agenda had been published could be made available to the public.

It was confirmed that these documents would be published with the minutes of the meeting.

92. DATES OF FUTURE MEETINGS

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

Monday 9th October 2017 – 3.00pm

Thursday 7th December 2017 – 10.30am
Monday 5th February 2018 – 3.00pm
Monday 9th April 2018 – 2.00pm

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

93. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

94. CLOSE OF MEETING

The Chair declared the meeting closed at 5.18pm.

Health & Wellbeing Workshops

Ivan Browne

Health & Wellbeing Board

17th August 2017

Leicester City Council

Health & Wellbeing Strategy Workshops

To support development and delivery of the new Health and Wellbeing Strategy.

Healthy Start

Healthy Lives

Healthy Mind

Healthy Places

Healthy Lives

Many health challenges in the city are preventable. We need to focus on reducing risks to health: sedentary behaviour, poor diet, as well as continuing to reduce smoking and excessive alcohol consumption. Pushing prevention up the agenda of all our organisations is central to our vision.

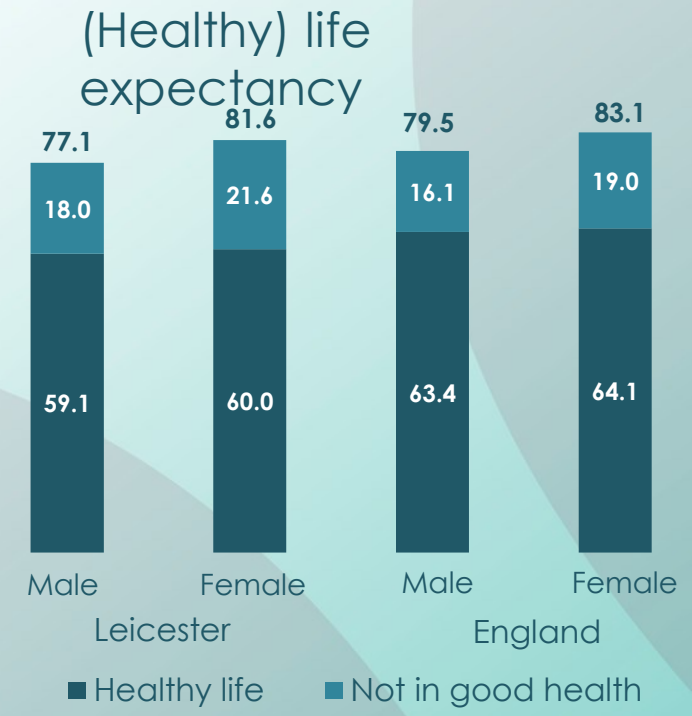
Unless checked healthy-life-expectancy will not keep pace with life-expectancy.

It is estimated that males and females in Leicester can expect about 20 years 'not in good health'.

Increases in life expectancy has resulted in a significant gap between healthy life and life expectancy both nationally and in Leicester.

These years 'not in good health' come at a high cost for health and social care services.

Life expectancy and healthy life expectancy differs across the city and is closely linked to patterns of



Source: ONS 2013-15

With a reducing budget for prevention, what are the priorities?

Working intensively to establish healthy behaviours from a young age and focussing on:

PREGNANCY – Learning starts early!! Establishing good habits, nutrition, healthy environment, stress management and tackling addiction.

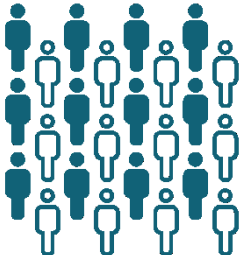
EARLY YEARS – family based initiatives, healthy diets, promoting activity, providing advice and support.

TEENAGE YEARS – age appropriate advice and incentives, embedding of healthy behaviours and habits for adulthood.

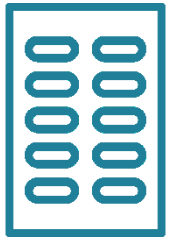
HOW:

- *Holistic support for pregnant women and their families.*
- *Encouraging a holistic family based approach to living a healthy life.*
- *Greater investment in helping teenagers develop & maintain healthy*

Should individual support only be available to certain disadvantaged or high risk groups?



Moving away from targeting only specific groups - Hard to work with definitions and inadvertently causes stigma.



Move away from solely targeting reductions in specific diseases -This is often reactive rather than preventative and it does not address other unhealthy aspects not linked to the disease.

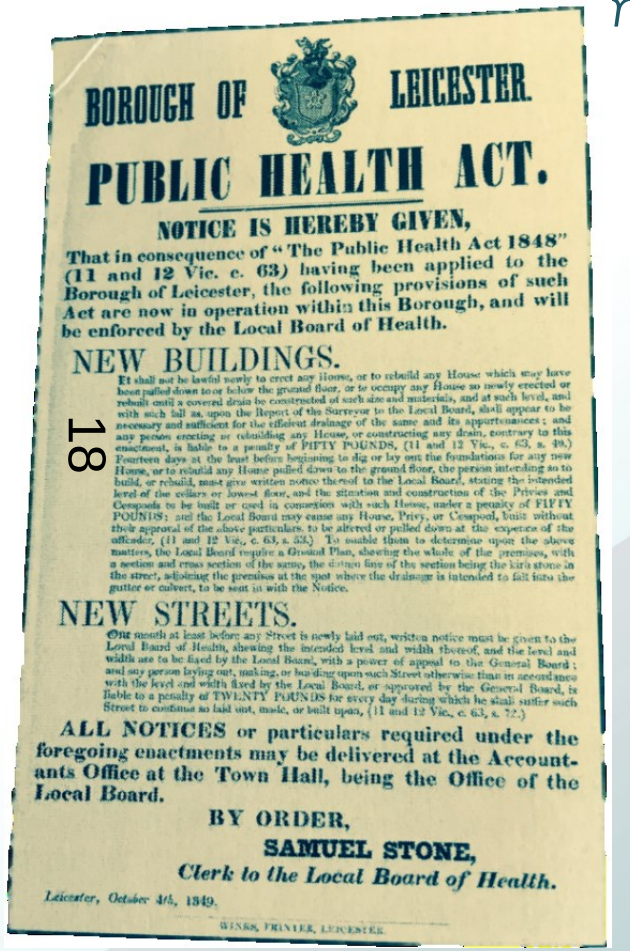
HOW:

- *Target whole families rather than individuals.*
- *Promote community based approaches to good health.*
- *Encourage community areas or workplaces to hold health MOT's.*

Healthy Places

A focus on healthy places, encourages collaboration to improve health by considering the range of environments in which people live their lives. Improving health through a focus on environment has a long history.

The Healthy Places Movement looks to address the impact the environment can have on people's health.



BOROUGH OF LEICESTER.

PUBLIC HEALTH ACT.

NOTICE IS HEREBY GIVEN,

That in consequence of "The Public Health Act 1848" (11 and 12 Vic. c. 63) having been applied to the Borough of Leicester, the following provisions of such Act are now in operation within this Borough, and will be enforced by the Local Board of Health.

NEW BUILDINGS.

It shall not be lawful newly to erect any House, or to rebuild any House which may have been pulled down to or below the ground floor, or to occupy any House so newly erected or rebuilt until a covered drain be constructed of such size and materials, and at such level, and with such fall as, upon the Report of the Surveyor to the Local Board, shall appear to be necessary and sufficient for the effectual drainage of the same and its appurtenances; and any person erecting or rebuilding any House, or constructing any drain, contrary to this enactment, is liable to a penalty of FIFTY POUNDS, (11 and 12 Vic., c. 63, s. 49.) Fourteen days at the least before beginning to dig or lay out the foundations for any new House, or to rebuild any House pulled down to the ground floor, the person intending so to build, or rebuild, must give written notice thereof to the Local Board, stating the intended level of the cellars or lowest floor, and the situation and construction of the Privies and Cesspools to be built or used in connexion with such House, under a penalty of FIFTY POUNDS; and the Local Board may cause any House, Privy, or Cesspool, built without their approval of the above particulars, to be altered or pulled down at the expence of the offender, (11 and 12 Vic., c. 63, s. 53.) To enable them to determine upon the above matters, the Local Board require a Ground Plan, shewing the whole of the premises, with a section and cross section of the same, the datum line of the section being the kirb stone in the street, adjoining the premises at the spot where the drainage is intended to fall into the gutter or culvert, to be sent in with the Notice.

NEW STREETS.

One month at least before any Street is newly laid out, written notice must be given to the Local Board of Health, shewing the intended level and width thereof, and the level and width are to be fixed by the Local Board, with a power of appeal to the General Board; and any person laying out, making, or building upon such Street otherwise than in accordance with the level and width fixed by the Local Board, or approved by the General Board, is liable to a penalty of TWENTY POUNDS for every day during which he shall suffer such Street to continue so laid out, made, or built upon, (11 and 12 Vic., c. 63, s. 72.)

ALL NOTICES or particulars required under the foregoing enactments may be delivered at the Accountants Office at the Town Hall, being the Office of the Local Board.

BY ORDER,

SAMUEL STONE,

Clerk to the Local Board of Health.

Leicester, October 4th, 1849.

GINKS, PRINTER, LEICESTER.

18

The environment impacts upon the following:

Epidemic of chronic diseases	Cardiovascular diseases, arthritis, diabetes and cancer
High obesity rates	Around two thirds of adults in the city are overweight or obese.
Low physical activity	A third of adults inactive
Mental health disorders	Increasing prevalence

Discussions involved the following themes…

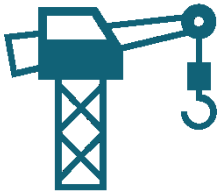
Improving air quality

Promoting active travel

Protecting access to green space

Developing a healthy built environment

What opportunities do we have to make health a key component within local policies across the council and beyond?



DESIGN, PLANNING AND DEVELOPMENT- make sure that places and spaces support and encourage healthy behaviours.

TRANSPORT – reduce the number of vehicles in the town centre.

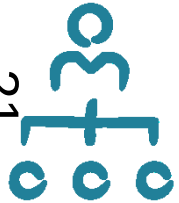
HOMES – provide living accommodation of a decent standard so as people live in a healthy environment.

HOW:

- *Involve health professionals and people in the design and planning process.*
- *Introduce and promote sustainable travel options and improve air quality.*
- *Regulate private landlords to maintain housing and ban smoking in LA*

How can we collectively deliver a healthier living environment?

TRAVEL: actions to make sustainable travel more appealing and the health and environmental benefits clearer.



ORGANISATIONAL INPUT: get businesses and organisations to 'buy in' to promoting healthy actions and behaviour amongst their workforce.

USING ASSETS: prioritise the maintenance of parks and green spaces. Greater promotion of the use of green spaces to maintain health and wellbeing.

HOW:

- *Improve city signage to include travel options, how long they take and the potential health benefits.*
- *Work with organisations to champion the benefits of a healthy workforce.*
- *Raise awareness of green spaces and ensure they are well maintained and*

What features may lead to some community assets becoming more successful than others?

ACCESSIBILITY – assets are accessible by bike, on foot or bus and accessible for all including disabled and the elderly.

SAFETY: people feel safe travelling to and using the community asset. Issues such as adequate lighting are important.

ATTRACTIVENESS: assets need to be appealing and have something to attract people of different ages and cultures.

HOW:

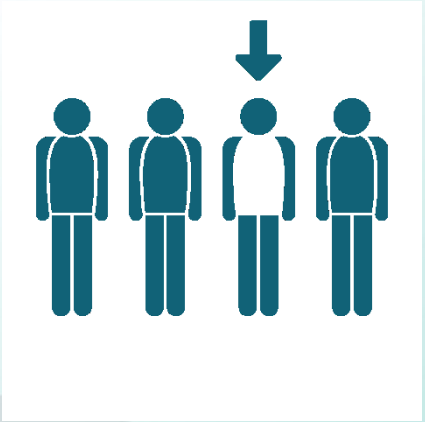
- *Plan bus, cycling, walking routes around assets and make places accessible.*
- *Generate safe routes and look into improving lighting at parks.*
- *Ensure that assets are multi-purpose and plan in activities for the young and elderly*

Healthy Mind

Sustaining mental wellbeing is crucial for people to live long healthy lives. People with mental illness often make poor lifestyle choices; they are more likely to smoke, drink alcohol, and use drugs and less likely to exercise or eat well. Therefore having much shorter life expectancies.

Discussions involved the following areas…

Mental health amongst Children and Young People

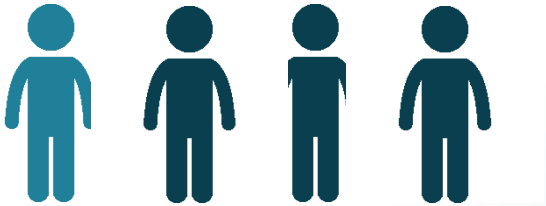


Tackling Stigma and discrimination

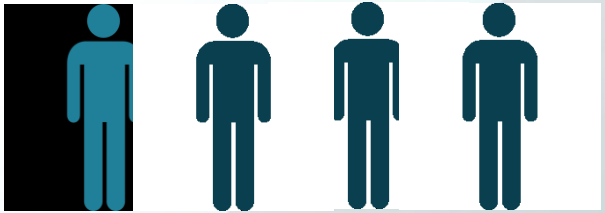
Focusing on three themes including supporting parents, raising awareness and teaching through schools, and using other agencies such as CAMHS.

Great emphasis was placed on identifying early warning signs, building resilience, and creating a parity of esteem between physical and mental health.

Children with a parent with mental health problems are more likely to experience poor mental health as an adult.

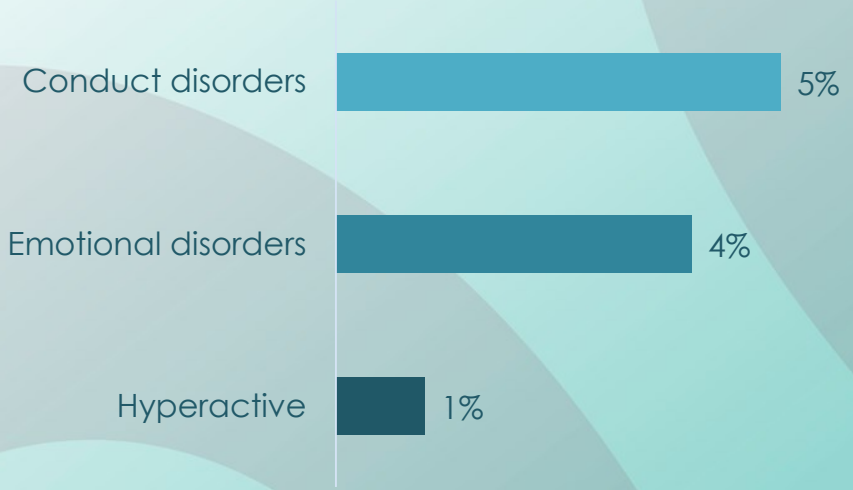


1 in 4 children have a parent at risk of common mental health problems.



1 in 4 adults in mental health care is likely to be a parent

One in ten children between 5 and 15 have a mental disorder. These include:



What actions should we take to protect children and young people's mental health?

PARENTAL SUPPORT - providing help and support to parents and families from pregnancy and then as the children grow.

EDUCATING- better support for children particularly around times of transition and enabling staff to recognise and address poor mental health.

UNITED ACTION – less emphasis on labelling children and more access to CAMHS.

HOW:

- *Make it easier for parents to get support to promote and protect their own mental health and the mental health of children*
- *Teaching mindfulness and building resilience as part of the school curriculum, particularly important at times of transition.*
- *Better join up of services supporting young people.*

Many people with a mental health problem feel isolated; they find it difficult to get employment or housing. People in work are often uncomfortable talking to their employer about mental health problems.

One in four working age adults and one in ten older people have a common mental health problem.

About 1 in 100 have a serious mental health illness.

Those with a severe mental health problem are significantly more likely to have a shorter life expectancy.

Issues in the city include:

- Under diagnosis of depression
- Higher rates of hospital admission for mental illness
- Worse than average outcomes

How can we tackle stigma and discrimination around mental health?

EARLY YEARS – Equipping children with the language to describe their feelings and seek help.

AWARENESS- ensuring that more people are able to spot the 'warning signs' particularly in schools and workplaces.

PARITY – change the language so as mental health to be treated the same way as physical health to reduce stigma.

HOW:

- *Provide lessons and training in schools*
- *Training for school staff and*

Next steps:

1. Explore feasibility and practicality of suggestions raised in the workshops

2. Deliver the Healthy Start workshop

3. Redraft the Health and Wellbeing Strategy

4. Public consultation

APPENDIX B

LEICESTER, LEICESTERSHIRE & RUTLAND HEALTH AND SOCIAL CARE ECONOMY

WINTER PLAN

2017 -2018

Document Control	
Document Name	LLR Winter Plan 2017-18
Purpose of Document	This document sets out the steps that are being undertaken across the LLR health and social care community to ensure that appropriate arrangements are in place to provide high quality and responsive services throughout the winter period.
Document Version Number	V4 September 2017
Document Status	Adopted
Document Owner	A&E Delivery Board
Document Author	Jennie Smith – Head of Operational Resilience and Emergency Planning
Last Updated Date	8th September 2017
Contributors	University Hospitals of Leicester Leicestershire Partnership Trust ELR Urgent Care Centres Loughborough Urgent Care Centre TASL Patient Transport Social Care City Social Care County EMAS East Leicestershire and Rutland CCG West Leicestershire CCG Leicester City CCG DHU – 24/7 Home Visiting and Clinical Navigation NHS 111

LLR Winter Plan 2017/2018

Contents:

These Appendices are available upon request.

1. Introduction:

This document provides planning and readiness information to support all aspects of Leicester, Leicestershire and Rutland (LLR) Service Delivery throughout the winter period 2017/18.

Winter is defined in this document as running from the beginning of October 2017 through to the end of April 2018, to include the management of surge during the Easter period.
The winter period is recognised as a time when significant additional demand is placed upon LLR Unscheduled Care Services. This relates primarily to higher prevalence of winter illness and an increase in the ageing population with co-morbidities resulting in complex care needs.

LLR urgent and emergency care economy is currently seeing increased levels of demand. Although the number of emergency attendances has remained stable (YTD against 2016), at approximately 113,500, there has been a rise of 6% (YTD against activity over the same time period in 2017) in emergency flow, specifically to short stay and through GPAU. The system experiences peaks of demand which can be fairly predictable, associated with Mondays and the days immediately after bank holidays.

2. LLR 2017/2018 Winter Planning:

2.1 Governance and Assurance

LLR A and E Delivery Board has overall responsibility for leading on surge and resilience plans , and proactively planning for the increase in patient demand throughout the winter period.

To effectively manage system pressures, the A and E Delivery Board (AEDB) acknowledge that performance is dependent on maintaining strong multi- agency collaboration; and particularly improving acute patient flow. The Board currently manage a work plan consisting of four key areas:-

- Supporting the current structure and performance of LLR urgent and emergency care economy;
- Reforming and redesigning the wider Urgent and Emergency care system
- Delivering the nationally mandated best practice guidance - the delivery of the 95% four hour wait emergency standard and the 75% standard for the 8 minute emergency ambulance response.
- Leading on assurance and oversight of plans in preparation for the winter period.

To ensure alignment to national winter planning protocols, the AEDB and A&E Improvement Group (AEIG) have developed an improvement plan and High Impact Action plan, structured around three main themes of in-flow, flow and discharge work streams. This approach incorporates:

- Demand and Capacity Plans

- Front Door Processes and Primary Care Streaming
- Flow through the Urgent and Emergency care pathway
- Effective discharge processes
- Planning for peaks in demand
- Ensuring the adoption of best practice.

As in previous years, LLR Urgent Care system, supported by the Urgent and Emergency Care Team hosted by WLCCG has taken a collaborative approach to planning for winter. The Operational Winter Planning Group, reporting into the AEDB, has representation from all relevant service providers integral to all stages of planning. This ensures that comprehensive preparation for winter challenges are in place. Historical data, and lessons learned from previous years, are also utilised to ensure robust planning for the winter period.

2.2 2016/2017 Lessons learnt and key actions taken to support winter 2017/2018

Key risks identified for the LLR System from winter 2016/2017:

In March 2017 the AEDB e undertook a review of winter 2016/2017 which identified a number of key issues and made some recommendations for winter planning 2017/2018 (Appendix A). The following section details the key learning, the known risks in the system and the actions we have taken to address those areas of risk for the coming winter.

Inaccurate demand and capacity planning in some providers:

A contributing factor of this inaccuracy was the unusual way that Christmas and the bank holidays fell. In particular, DHU (NHS111) did not have historical data for a Christmas falling on a Sunday followed by two bank holidays.

Action: Capacity plans for winter 2017/2018 will be adjusted using this learning. In particular we are mindful that there will again be a four day 'long weekend' when core general practice capacity is not operational and patients requiring immediate treatment will need to be directed to access the alternative services that exist across LLR.. We are undertaking a system wide analysis of demand and capacity, including looking at trends from last winter, and this will be used to inform operational capacity planning for winter and the Christmas and New Year period particularly. We have strengthened community based urgent care services in 2017/2018 (more details given in inflow section) which will help to mitigate the expected surge of patients after the Christmas and NY break.

Poor capacity and flow in ED leading to very long ambulance handovers:

This issue resulted in poor ambulance response times and raised risk in the community. Long handover times were a feature of the LLR system in 2016/2017 and were one of our key performance risks.

Action: The opening of the new LRI ED in April has led to a very significant improvement in ambulance handover times, as a result of increased major's capacity and improved handover processes. In July 2017, average pre-clinical handover times at LRI stood at 18m 11 sec and, total lost hours 438. This compares to 29:43 in July 2016 and 32:18 pre-clinical handover in Jan 20/17, with 1381 lost hours in July 2016 and 1617 lost hours in Jan 2017.

The system is therefore at lower risk of ambulance handover delays compared to last winter. Where these do occur at times of pressure, there is a SOP for a cohort area in the LRI ED which has been signed off by both EMAS and UHL.

High occupancy rates/poor flow and medical capacity:

Actions:

UHL have increased medical capacity by 38 beds compared to 2016/2017 plan. Flow and discharge planning processes have been improved across both acute and community providers as a result of closer system working; and the implementation of SAFER and R2 has been rolled out across medical wards and is much more embedded than in winter 2016, where there was limited implementation, which was halted over the Christmas and New Year period.

DTOCs at UHL are historically low at around 2% of bed days, and improved system oversight of discharge processes has seen external delays drop since the processes were introduced in February 2017. More details of our plans to support flow and hospital bed capacity are contained in the section on DTOCs and in UHL's provider plan.

We have reviewed our system surge and escalation protocols, including how we escalate actions in response to raised occupancy rates in hospitals. A particular issue identified by our review of winter and the work of the AEIG, has been the need to improve discharge processes from UHL to LPT and a workshop was held on this over the summer, leading to revisions to operational processes and the escalation protocols. This should result in more balanced actions to support flow in both UHL and LPT to avoid bottlenecks in community hospitals and support more consistent discharges from UHL to community hospitals.

Aligned to this, we have undertaken **Director on Call training for CCGs,** and plan to undertake further joint training with LPT and UHL DoC teams to improve understanding of the surge and escalation plan and improve organisational response to pre-empt increasing escalation levels by ensuring that the agreed actions are taken forward at relevant points.

Insufficient communications to patients:

Specifically in relation to when GP practices are open, and communications stressing the many alternative urgent care services that are open in LLR out of hours, routes to get repeat prescriptions etc.

Action: This is addressed in our communications plan, (outlined in section 3). There is good availability of extended primary care and Urgent Care Centre provision in LLR so alternatives to GP practices and ED are open 24/7, 7 days a week. We have strengthened clinical navigation and the ability to directly book patients into alternatives to ED from NHS 111 and clinical navigation and the LRI front door compared to last winter. This will enable providers to direct patients to an appropriate urgent care service.

Lack of real time information to support system response to surges:

Action: As part of our Vanguard work, we have developed a predictive modelling tool which takes real time information from UHL and EMAS and uses it to predict forward weekly demand patterns

which will be used to plan organisational capacity and response. We expect this to be in operational use from November 2017, in time for the peak winter period.

System wide capacity and demand modelling has commenced to identify specific surge points and bottle necks, relating to individual service providers. It has been agreed by all service providers that undertaking analysis of organisational activity over the last 3 years, (focussed specifically on the winter period), will identify trends in relation to system capacity pinch points, enabling pre-emptive alignment and wider system support by all system partners. The outcomes of the system capacity and demand modelling, will enable each organisation to submit detailed plans for the festive period, outlining the service and resources gaps seen in previous years and the mitigating actions being taken to avoid duplication. The expected completion date to ensure accurate system modelling is the end of September 2017.

There is an expectation that organisations plan to increase staffing levels and discharge activity both before and immediately after the bank holidays, to provide assurance that predicted surges in activity will be effectively managed, without putting additional pressure on the system.

3. LLR System Wide Winter Plan

The following section describes out processes for managing pressures in the urgent care system for winter 2017/2018 and gives some detail on specific initiatives and services that are in place. It concentrates on some of the key themes in the winter planning guidance, and supplements the detailed provider plans by giving a system overview of the main elements of our plan.

3.1 Inflow (including primary care)

Clinical Navigation

One of the key differences in the LLR system in comparison to last winter is the embedding of The Clinical Navigation Hub forms which is an integral part of the LLR Integrated Urgent Care Model. The hub sits alongside a number of 24/7 urgent care services across LLR including LLR Home visiting service, LRI front door assessment and streaming service and NHS 111.

The hub has a single entry point via NHS 111 from which there is access to 24/7 fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, health advice, sign-posting and multi-disciplinary care and treatment.

The LLR Clinical Navigation Hub offers those who need it access to a wide range of advice, assessment, care, signposting and information and support from a range of clinicians, both experienced generalists and specialists either via the telephone or referrals to face to face services, for example the Home Visiting Service, primary care hubs and UCCs.

Clinical advice is also provided to staff within care homes who have direct access to the Hub – during the Out of Hours period & where appropriate, onward referral to the Home Visiting Service.

Since the integration of the clinical navigation service in directing patients to the most appropriate care settings, positive outcomes have been seen in the reduction in ambulance demand and ED referrals (80% of green ambulance dispatches are avoided and up to 70% of ED dispositions are

directed to alternative services). This has contributed to ED attendances being down 2.2% year on year at August 17 compared to the previous year.

LRI Front Door and integrated primary care service

Alongside the implementation of the clinical navigation hub, a primary care streaming model is in place at LRI ED to support in the appropriate signposting of patients to the right pathway within the integrated ED.

The model utilises a single front door approach, which is delivered by an integrated workforce made up of nursing staff, ANP's, ENP's and GP's supported by medical staff, which incorporates previous UCC capacity and the OOH overnight base, to provide 24/7 access to urgent primary care at the LRI site.

One of the key elements of the model is its capability of redirecting patients to primary care. The front door has the ability to directly book patients into City Hubs and UCCs.

Primary Care:

Primary care capacity includes core general practice services, GP Out of Hours provision and extended primary care as well as pharmacy and dental services. Extended primary care in LLR is delivered through a combination of practice based extended hours arrangements, and activity provided through primary care hubs and UCCs in each of the three CCGs. LLR has good coverage of extended and enhanced primary care, and the changes to urgent care put in place in 2016/2017 and from April 2017 as part of our re-procurement of integrated primary and community urgent care have strengthened capacity to meet patients' needs both in and out of hours. Details of individual services and their winter plans are given in the organisational appendices for each of the LLR CCGs and Derbyshire Health United services. This section summarises some of the key services in place and actions taken to ensure there is sufficient access to primary care across LLR through the winter period.

The key services in place in LLR which supplement core general practice to provide a 24/7 model of primary care include:

- Loughborough Urgent Care Centre (24/7 walk in access plus bookable appointments, including day time urgent primary care and overnight OOH services).
- Primary care hubs in WLCCG at Hinckley and Coalville (bookable through NHS 111 and CNH)
- Leicester City CCG Primary Care Hubs (Westcotes, Brandon St, Saffron, Merlyn Vaz) delivering walk in and booked appointments, 12 hours a day 7 days a week
- ELR CCG UCC capacity including: Oadby Walk in Centre 12 hours a day 7 days a week, bookable from NHS111 and clinical navigation, and 3 additional sites providing daytime minor injury services , evening and weekend urgent care provision integrated with GP OOH services (at Market Harborough, Oakham and Melton Mowbray)
- 24/7 Urgent Home Visiting Service providing a rapid home based response to patients who require medical review and care at home. The service is accessed via NHS 111 or directly by care homes and has a strong focus on admission avoidance. From August 2017 this service

also incorporates a night time nursing service, therefore providing a fully integrated GP and nursing service across LLR.

- Out of Hours service based at LRI ED, operating 7 days a week.

There is therefore really good availability of additional services which provide additional access to same day urgent and primary care across LLR. All the a

Additional capacity in 2017/2018

Primary and community urgent care services in LLR have been strengthened since winter 2017/2018 in the following ways:

An additional 13,500 appointments in WLCCG UCCs (4,400 of which are in the new sites of Coalville and Hinckley). These appointments are also used by patients from ELRCCG and LCCG when necessary. In addition to this, from October there will be a 'test bed' of general practice in hours referral to LUCC to provide additional primary care access for Charnwood patients, using existing commissioned activity within LUCC.

643 additional appointments in ELR general practices over 8 weeks of the winter period

City Hub Challenge Fund capacity has now been consolidated into 4 hubs, including a recommissioned service at Merlyn Vaz

Increased coverage of 24/7 visiting, particularly to provide increased capacity and cover for all ELRCCG patients. Clinical staffing will be increased over key days over winter, based on modelling of activity peaks in 2016/2017 (i.e. the long Christmas weekend and immediately after the NY).

DHU intend to increase GP coverage at the LRI ED OOH service and on selected days over the Christmas and New Year period and weekends in response to analysis of activity in 2016/2017.

If additional financial resources are received by the CCGs this will be channelled through hubs and UCC services as well as to those practices which are able to offer additional appointments over the winter period.

Plans are being put in place to ensure that we pre-empt anticipated surges in demand over weekends and bank holidays over the winter period, by working pro-actively with patients identified as being at higher risk. These patients will be given enhanced access to booked appointments at hubs and UCCs in each of the LLR CCGs and given direct access to the Home Visiting service. This scheme has developed out of a 'passport' scheme put in place in WLCC in previous winters which was effective in ensuring that patients at highest risk of admission or ED attendance are directed into alternative urgent care services.

Pharmacy

We have implemented the NUMSAS pharmacy service across LLR, accessible via NHS 111

There is an emergency repeat prescription service available from community pharmacies which prevent the need for patients to access OOH or attend ED for repeat prescriptions. NHS England has

the information on which practices operate extended hours and we expect that community pharmacies will be open to cover those hours.

Core General Practice

The three CCGs will write to GP practices to stressing contractual expectations and asking all practices to confirm their opening hours and capacity. This will enable the CCGs to ensure that access to core general practice does not dip over the holiday season.

WLCCG requests that practices which are closed on Thursday 21st December do not close.

The communications plan (see later in this document) will stress messages that general practice is open as normal, and that there are evening and weekend services available both in General practice and in hubs.

If there is additional funding we would seek to commission practices to deliver additional capacity. Increasingly, this would be done on a hub basis or via UCCs , and patients would be booked into those services by their registered practice or by NHS111.

Core general practice appointments will be directly bookable by NHS111 and clinical navigation in LLR from October, following pilots within the Vanguard and we are rolling this out over the three CCGs between October and December.

Extended Hours :

The CCGs are working with practices to make sure that the DES activity for the bank holiday and weekend days are redistributed, and where access is on 24th December practices are expected to deliver that access, as per the DES.

The changes to the EOH DES from October are still to be worked through. This could mean that some practices that are currently providing EOH via the DES will no longer be able to if they have in hours closures during the week. As this relates to registered lists the impact will be small, however,

2017/2018 Admission Avoidance Schemes:

As a part of the urgent care service improvement programme, system wide initiatives have been devised to support admission avoidance into secondary care services.

We commissioned a new 24/7 visiting service from April 2017 which incorporates daytime acute visiting and support to care homes, overnight home visiting and night nursing. The integrated service has a strong focus on avoiding unnecessary admissions and since April we have seen evidence of impact including a drop in care home admissions, particularly in ELR, where there was previously no service. As the service works 24/7 it will enable continuity of admission avoidance over the Xmas and NY bank holidays.

Other initiatives in the AEDB plan include:

PHEM GEM – training on management of frailty supporting EMAS crews and care home staff to keep patients at home or in their normal place of residence

Consultant Connect – telephone based support to primary care to prevent unnecessary admissions. We will strengthen this service by December 2017 to put in place dedicated clinical time to respond to calls, and open up the service to EMAS crews

EMAS are providing a see and treat service in Leicester town centre, to deal with individuals incurring injuries over the Christmas and bank holiday periods, specifically focused to avoid ED attendances. UHL are creating a number of admission avoidance initiatives to support the system over the winter period but also a long term solutions to support system escalation. The plans include: Increased early frailty unit's capacity and frailty at front door, specialty presence within the emergency department including therapies, increased utilisation of GPs within primary care and assessment zones and the increased utilisation of hot clinics. The Integrated Discharge Team described elsewhere will have an ED facing role to turn people around without full admission.

Social care services have planned increased staffing levels in ED to avoid admission where needs are social care, not clinical. Crisis Response Service will aim to avoid admissions by providing urgent support to people in the community and CRS/HART will take referrals and broker support until 10pm, including weekends and bank holidays.

Additional accommodation in Community services is coming online in October to help with patient flow to enable capacity throughout the urgent care system.

Care Home Support:

LLR recently completed the self-assessment against the Enhanced Health in Care Homes Benchmarking Tool (Appendix B), from which we have identified our areas of priority that are reflected within the action plan attached (Appendix C).

The implementation of the 'Red Bag' scheme across LLR care homes has been identified as a priority within the LLR Care Home Sub-Group. Currently the work is being scoped with learning from the Vanguard Site in Sutton and funding from LLR STP has been identified to support acceleration of the work through the purchase of the red bag, with the view to implementing scheme within the year.

Scoping work for the utilisation of a telehealth solution, to support the reduction in 999 calls and Ambulance Conveyance to ED from Care Homes across LLR, is to commence within September to consider and develop a local tailored model of delivery, with a view to pilot the scheme once a viable solution has been identified.

3.2 Flow

Improving the access to emergency care is a priority within the UHL Trusts 2017/18 Quality Commitment via the 'Organisation of Care Programme'. At a high level the plan to address the gap includes:

Increase (in the short term) the bed base - New actions to increase our bed base at the LRI and GGH
Improved internal efficiency - Delivery of all pre-existing actions including, SAFER flow, red to green & GPAU expansion
A new model of step down care - UHL working more effectively downstream to care for step down patients in a non-acute setting

A new pathway for frail complex patients

This programme aims to take a more rigorous approach to improve access to emergency care for patients via 3 work streams:

- Emergency Department & Acute Medicine
- Medical and Cardio-respiratory beds
- Interface & Integration

The plans underpinning these improvements have been split into 3 work streams:

Efficient & Effective Emergency Department:

Objective – Reduce time to see a decision maker and time to decision.

The key action across the whole of the work stream is providing a solution for improving evening and overnight resilience of the demand and capacity for senior decision makers, largely senior medical staff. This is a key element of the 'September Surge' (1st to 15th September) where there is a high fill percentage of uptake for senior shifts overnight. This is expected to keep the waiting time to be seen by a decision maker lower in the evening and night.

A new standard operating procedure for Majors has now been developed by the ED teams and approved by Emergency Department Group, this describes what patients can expect at each stage of the 4 hour wait within the department. This SOP will now be monitored to assess our progress against its implementation.

The command structure has now been revised as part of the 'September surge' with changes in the meeting times and reporting of actions, along with a strengthening of the 'Silver' tier of the rota with more senior management support. This has also included basing a Duty Manager within the ED. It is forecast this will lead to more robust whole hospitals leadership and problem solving during the day.

Additional portering has been introduced to the ED for the 'September Surge' to provide logistics support to the ED clinical teams.

An Efficient and Effective Bed Capacity:

Objective - Mitigate the 105 bed capacity gap for 17/18 and Increase the % of patients in majors who move to a bed within 120 minutes to 95% from 78%.

The Trust commenced the year with a bed demand and capacity gap of 105 beds and had a plan to mitigate this by the opening of 55 extra beds and improving the efficiency of the specifically the medical and cardio-respiratory bed bases by c. 50 beds mainly through the rigorous roll out of 'Red to Green'. Figure 5 below shows the positive progress being made on reducing the gap. During July, an unmitigated gap would have been 110 beds and the Trust planned to have a gap of 53 beds. The actual position in July was a gap of 30 beds.

This performance better than plan was mainly associated with bed efficiency of 23 beds from both Medicine and Cardio-respiratory (which is also demonstrated on Figure 2 showing the reduction in the average length of stay in medicine). Unfortunately, some of this efficiency is being used for the

8% (662 patients) increase in emergency admissions above plan being seen by the end of July for ESM.

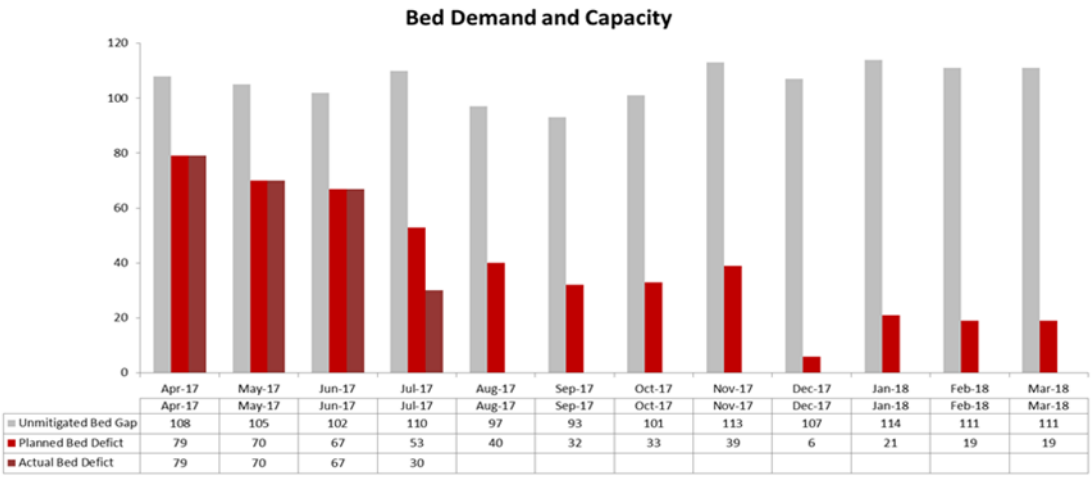


Figure 1 – unmitigated, planned and actual bed demand and capacity gap

Work on the physical bed expansion is progressing positively, with 36 beds open at LRI Medicine pathway.

Beds 'taskforces' are now in place for both LRI Medicine (chaired by the Chief Operating Officer) and GH Cardio-Respiratory (led by the Clinical Director for RRCV) to drive the improvement in 'Red to Green' They continue to focus on 3 key areas; firstly ward team reviews on their progress against the metrics, secondly ensuring the delivery of reductions in turnaround times against the top 3 delays, and finally delivering intensive support to wards that are not making required progress in this area.

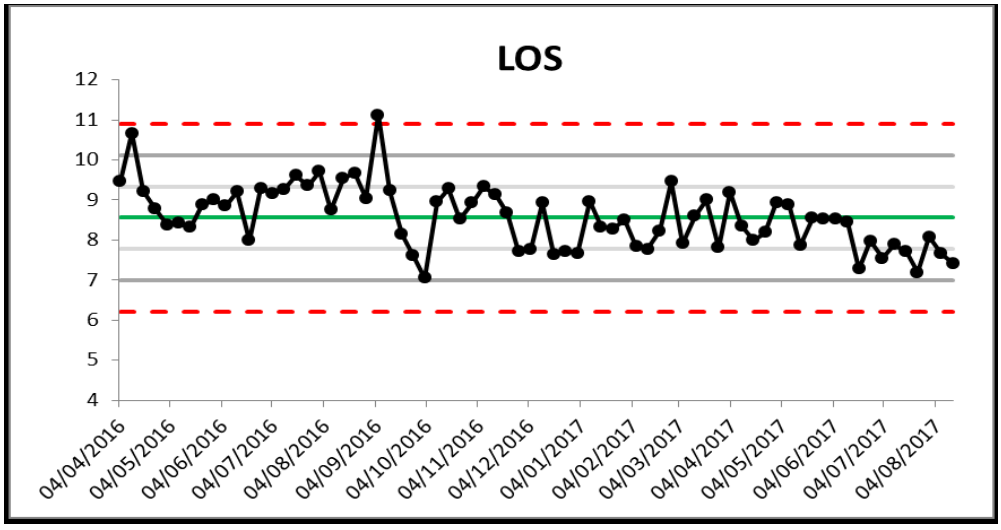


Figure 2.Average Length of stay in Medicine base wards LRI

This is having some success in reducing the length of stay for patients within medicine (as shown in figure 2) and it is now around 1 day lower than in corresponding period in 2016, but there is still work to do to ensure patients are discharged earlier in the day, as well as increasing the discharges at the weekend. These are two current focusses of Red to Green for medicine at LRI.

A plan has been developed by the Head of Service for imaging to delivery Keogh standard turnaround times (a maximum of 1 day) and a new TTO process is being trialled as part of the 'September Surge' that is likely to support the earlier prescribing and therefore production of those TTO's.

Within Cardio-respiratory, the Glenfield is much earlier in its journey on Red to Green having launched in July, but there remains a great deal of opportunity for improved efficiency which is being progressed with the teams there over the next 8 weeks.

In addition, UHL are mobilising resources to support the increasing demand going into winter. This includes:

- Additional paediatric medical shift (ST4 or above) between 1800 to 0300hrs
- Additional adult medical shift (ST4 or above) between 1800hrs to 0600hrs
- All senior nursing teams matron & above are booked into clinical sessions to support the teams
- Duty management team has been doubled up to enable one DM to be based in ED and the other to support the wards.
- Additional bed coordinator shifts have been requested as overtime.
- Requested 1 additional ambulance crew per day between 1600hrs to 12midnight via CCG
- GPAU staffed until midnight with senior consultant presence
- Additional surgical registrar on both sites 0800-2000 hours

External Interface and Integration Medical Step down Project:

Objective - To create a Medical Step down facility to support the mitigation of the current imbalance of demand and capacity gap.

The proposal of this scheme is to define the cohort and number of patients who would be applicable to use the medical step-down facility and then develop the clinical model and staffing model to support these patients outside of a UHL acute setting. An options appraisal will confirm the best location for the new facility and finally a business case for any new facility and deliver the new facility by November 2017. This scheme also has a key role in the system wide STP and hence is also reporting into the 'Home First Board' as one of the work streams of the STP ensuring that is in line with the overall approach to home first for patients.

As the Medical Step Down Project seeks to close the gap between demand and capacity (amongst other things), there is a key interdependency with the overall reconfiguration projects.

This project seeks to improve flow throughout the hospital which benefits all reconfiguration projects. This project will support the newly opened Emergency Department by helping to ensure performance does not decline over the winter.

SAFER and Red to Green Alignment

UHL:

A work stream to ensure alignment to the Red to Green principles is in place. Its remit is to:

- Review of current implementation on medical wards at LRI for learning with reference to a re-launch on these wards
- Refocus the implementation of Red to Green and SAFER as a priority on the Medicine wards at LRI relentless tackling the top 3 delays (including the implementation of Inter professional standards)
- Rigorous implementation of SAFER/Red to Green at Glenfield Cardiology & Respiratory wards
- TTO project started with an aim of achieving standards relating to TTO writing 'day before' and discharges before noon
- Review of AMU performance against SAM guidelines ensuring demand & capacity are optimised.

The project began in June 2017 and is on course to be fully implemented by the end of December 2017.

LPT:

Although the SAFER Patient Flow Bundle was designed to support acute adult inpatient wards, the principles outlined have been adapted by Leicester Partnership Trust (LPT) Community Hospital wards to ensure a consistent, all system approach to inpatient bed management across Leicester, Leicestershire and Rutland (LLR)

The implementation of the Red to Green approach commenced in March 2017 and the aim is for the roll out to be completed by the end of December 2017. The full roll out plan is attached as Appendix D.

Monitoring and managing 'stranded patients' – MADE

We plan to undertake a Multi-Agency Discharge Event (MADE) in preparation for Christmas, to create improved discharge flow in the second half of December and again in January, to maximise medical capacity over Christmas and to assist with coping with the surge in admissions in early January. One of the aims is to get as many patients into packages of care before the Xmas break as possible, as care agency response has been known to slow down over the holiday weeks. This will build on the process we have already put t in place for the weekly escalation of discharge delays, and bring together senior leads from each agency to activity plan for escalated discharge activity in anticipation of and response to the peak period of admissions after the New Year.

The continuous support of all services throughout the winter period includes the ability to utilise flex bed capacity effectively. Flexible bed options are available within UHL to manage increased demand, which is in turn supported LPT community based services, increasing their flex capacity to divert activity into lower settings of care. Where appropriate patients are discharged into interim beds whilst awaiting the procurement of appropriate services to support discharge .In addition there are flexible bed and service capacity available within Adult mental health and Learning disability services for both step up (admission avoidance) and step down purposes, for utilisation in times of significant pressure.

3.3 Discharge

Discharge processes and reducing delayed transfers of care

The Eight High Impact Changes for Managing Transfers of Care tool was implemented across LLR in September 2016, with a system wide review and update in May 2017. Furthermore, many service and system leaders attended the locally arranged regional event on 5th July where speakers from across England came to share service developments. (Document attached as appendix E).

Health and Social Care discharge capacity

A bed based patient step down audit was completed across UHL and LPT beds in July 2017. The review demonstrates where additional capacity may be required across the discharging services and where existing beds could be used differently. Plans are being discussed to create short term actions for Winter (e.g. review criteria for access into community services such as OPAT and ICS) and medium to longer term plans for the rest of the financial year (e.g. procurement for an improved discharge to assess service). The review will provide data and insights for the following pieces of work:

- ICS review
- Community Hospital bed utilisation plans
- STP bed based work streams
- Pathway 3 – Discharge to assess plans

An Integrated Discharge Team commenced within LRI Medical Wards on 3rd July 2017. The team brings together existing staff groups in Social Care, Primary Care Coordinators and Hospital Discharge Sisters to work as a single team to manage and progress complex cases and provide ward teams with skills to plan simpler discharges (such as re-starts of domiciliary care packages).

The team are working towards acting as trusted assessors on behalf of each other's services, which will provide a flexible capacity to complete assessments and procure services for discharge and reduce duplication of effort and reduce confusion about which local authority should be involved with the patient. The Integrated Discharge Team approach will roll out to specialty medical wards and an approach will be designed for surgical wards. These plans are in discussion with a completion date for delivery by March 2018.

The Urgent and Emergency Care Team has commissioned a system flow modelling tool which the first draft has been demonstrated. It aims to give predictive modelling for the acute trust for 7-10 days in advance. The model provides enough information to predict a surge in community hospital beds and a surge in requiring discharge assessment teams.

Commission additional home-care packages

There is capacity within the discharge to assess domiciliary care packages (Hart for the County and ICRS for the City) to take more patients during surges in demand. Full capacity is not currently utilised due to a number of internal actions that need to be completed especially for 'health' patients. (See appendix F – DTOC action plan for details of actions).

Implement a 'placement without prejudice' process

LLR already has a discharge to assess process which has agreed funding structures with the CCG, for placing patients into a non-acute bed whilst their CHC needs are assessed. There are further actions to enhance this within the LLR DTOC action plan (see appendix F for details).

Trusted Assessor Guide

The LLR Tiger Team for IDT is aware of the trusted assessor guide and is building it into the Trusted Assessment training and development within the IDT. Programme leaders are in the process of attending the webinars, and links have been made with Lincolnshire to view the service they provide.

Trusted assessment is already in place for the majority of current Discharge to assess placements into care homes, and for reablement domiciliary care packages.

4. Whole System Resilience / Escalation Arrangements

LLR has in place a system to provide daily capacity and performance monitoring of operational pressures, across providers throughout the year (not just the winter and Easter periods).

LLR manages surge and capacity utilising a whole system approach, which acknowledges predictable peaks in demand, for example over the Christmas and New Year period (As well as unusual peaks in demand as experienced throughout the year). Our commitment is to ensure that we have adequate 'system wide' resilience plans, to respond to operational difficulties in parts of the system, occurring in isolation or as a building pressure across LLR.

The key element is each organisations response to escalation. A common escalation policy has been agreed with each organisation and an agreed definition set to aid consistency and communication.

The LLR Surge and Capacity Management Plan seeks to have in place:

- Clear identification of the escalation process, agreed by all partners
- Key organisational contacts are identified
- That potential risks have been identified and contingency measures agreed
- That the provision of high quality patient services are maintained through periods of pressure
- That national targets and finance are managed during pressured periods
- That processes are in place to meet local and National reporting requirements

The underlying principle is that sufficient capacity has been planned to be in place to enable providers, under expected levels of planned activity and within expected levels of tolerance, to provide emergency care services and planned elective capacity in accordance with agreed targets.

Each organisation within LLR has developed their own internal Surge and Capacity and winter resilience plans and provides detailed confirmation of their preparedness across a number of areas.

Any organisation within LLR is able to 'call' for a health economy wide alert, but it is the responsibility of the CCG's as the lead commissioners for health services to 'declare' the health economy status.

Without prior discussion, no action will be undertaken by one constituent part of the system, which may undermine the ability of other parts of the system to manage their core business. The CCG will communicate system pressures to NHS England.

To support all organisations in the safe management of patients in times of high escalation, the LLR system wide escalation protocol enables a multi organisational approach to risk sharing.

4.1 Operational Pressures Escalation Levels (OPEL) Framework:

The LLR escalation policy is based upon an integrated status report, which details differing levels of capacity availability and trigger indicators. Listed below are the summary actions:

Escalation level 1 actions summary

- Situation monitored to prevent escalation
- Potential whole-system causes of escalation identified and dealt with
- Communication of any actual escalation

Escalation Level 2 actions summary

- Situation monitored to prevent further escalation
- Action to improve situation carried out
- Potential whole-system causes of escalation identified and dealt with
- Plan formed and being acted upon to re-establish level 1 working

Escalation Level 3 actions summary

- Situation monitored to prevent further escalation
- Action to improve situation carried out
- Potential whole-system causes of escalation identified and dealt with
- Command and Control within individual organisations and co-ordinated through LLR Emergency Care Director /CCG Director level, plan formed and being acted upon to re-establish level 1 working.

Escalation Level 4 actions summary

- Situation monitored to prevent system failure
- Action to improve situation carried out
- Potential whole-system causes of escalation identified and dealt with
- Command and Control led by CCG Managing Director/ On-Call Director: plan formed and being acted upon to enable de-escalation. Co-ordination of action plans led by CCG.

Commencing on the 1st December and continuing through the winter period, a daily escalation call is held system wide support, with the focus on swiftly de-escalating specific parts of the system in times of high pressure.

The call is undertaken where rapid system engagement is required in response to individual or LLR pressures, to collectively take action and plan for recovery. Examples of escalation issues rectified on the call include:

- The agreement of funding and operational provision of additional ambulance crews, to support flow.
- The utilisation

The aim of the call is to:

- To establish an operational escalation position for each organisation in order to understand the wider risks across the health and social care.
- Identify the risks within individual organisations and collectively the implications to the wider system.
- Agree actions to mitigate risk individually and collectively and identify who is leading on progressing the action.
- To update on actions taken on previous calls and if appropriate agree further actions required.
- Agree timeframes and feedback
- Plan for recovery

The teleconferences will be held in response to:

- declaration of a level 3/4 escalation within the LLR Health Economy
- as a proactive measure to prevent declaration of level 3/4 escalation
- commissioner initiated to escalate, communicate and plan a response to the management of urgent care system pressures (for example during periods of expected peak activity – BH, winter)

Any organisation can trigger a T/C based on deteriorating escalation status by conversation with the CCG - On-call Director or Urgent Care Lead.

In addition, an online escalation tool is used, providing all service providers with partner updates and identified issues that may lead to increased escalation levels within the respective organisations. This tool is updated twice daily (10am and 4pm) and is utilised to enact proactive solutions prior to increases in escalation levels; and moves the system away from reactive modelling.

UHL provide daily capacity updates to the system, outlining gaps in capacity against specific specialties across the 3 hospital sites. This report is used as an indicative measure to alert the wider system of building pressures within the hospitals. LLR wide Surge and Escalation protocols are in the process of being reviewed, including how we escalate actions in response to raised occupancy rates in hospitals. A particular issue identified by our review of winter and the work of the AEIG, has been the need to improve discharge processes from UHL to LPT and a workshop was held on this over the summer, leading to revisions to operational processes and the escalation protocols. This should result in more balanced actions to support flow in both UHL and LPT to avoid bottlenecks in community hospitals and support more consistent discharges from UHL to community hospitals. The

proposed plan outlines available system support from each service provider to the wider system, specifically in times of high escalation.

To support effective management of escalation protocols, the LLR Urgent and Emergency care team provide in hours support to the system, with an Out of Hours on call rota in place. As mentioned above, we have undertaken Director on Call training for CCGs**,** and plan to undertake further joint training with LPT and UHL Director on Call teams, to improve understanding of the surge and escalation plan and improve organisational response.

4.2 On-Call Arrangements:

We are in the process of reviewing the LLR system surge and escalation protocols, this forms part of the work plan of the A&E Improvement Group and will be commenced at the next group meeting on 13th September, with a further workshop to be held to agree and align actions.

Following on from the lesson's learnt last winter and throughout the year, we identified that a weakness across the system, was the inconsistent training for on-call directors in regards to managing significant escalating issues. With this in mind, we have undertaken Director on Call (DoC) training for CCGs, and plan to undertake further joint training with LPT and UHL DoC teams to improve understanding of the surge and escalation plan; and improve organisational response to pre-empt increasing escalation levels by ensuring that the agreed actions are taken forward at relevant points.

To support UHL further, in times of increasing pressure and escalation, the UHL and CCG Directors on call (DOC) work collaboratively, the UHL DoC will update the CCG DoC after each gold command meeting or calls, which are held twice daily as required. The outlined support and required system actions will be discussed and the CCG DoC will convene further system wide escalation calls throughout the day as required.

5. Communication Plan

Increasing the number of eligible patients who need the flu jab

- Raising awareness of the flu jab amongst target groups and the potential risk associated with not getting it
- Supporting GPs to deliver more jabs through support for booking appointments

Supporting patients to seek help earlier before their condition becomes acute

- Raising awareness of the benefit of early intervention with some of the most common conditions seen in ED which cover the early warning signs of each condition and how people can seek help early.

Supporting patients to understand the services available to them over the winter period

- Early communications of service opening times and repeat prescriptions ordering
- Raising awareness of the options when services are closed over Christmas

Improving internal communications on ED pressures to practices and care home partners

- Improving communications to primary care, avoiding messages that can be seen as blaming any part of the system for inappropriate behaviour and alerting them to new initiatives which can help, including hot clinics
- Improving communications channels to care homes to ensure that we can effectively distribute the messages that they need
- Working with the care homes sub group to understand what care homes need and how they want to be communicated with.

Ensuring as far as possible messages are co-ordinated and do not overwhelm the system

- Identifying and recording all campaigns being run by our partners particularly around self care
- Identifying where possible potential areas where we will need to issue reactive communications, such as upcoming icy weather and preparing messages and materials in advance.
- Agreeing which organisations lead and who speaks on each area so that we can react quickly to more unexpected pressures
- Capitalising on joint working opportunities across LLR whilst avoiding silo working.

Raising awareness of the benefits of NHS 111 and clinical navigation hub

- Communicating areas where the clinical navigation hub makes a difference, such as booking appointments
- Raising awareness of services for both physical and mental health needs to ensure parity of esteem.

Improving the perception of NHS111 and the clinical navigation hub

- Increasing trust and countering myths around NHS 111

Improve the understanding of discharge process and benefits with patients

- Raising awareness of the patient benefits of speedy discharge with both patients and family members.
- Supporting patients to choose appropriate settings

The full communications plan to support winter 2017/2018, is included in Appendix G

6. Flu Planning:

Following on from our Flu planning and vaccination success from last winter, we want to build on this further this coming winter, to have a system wide vaccination uptake of 75%. Our plans have been informed following exercise CYGNUS in October 2016 and July 2017.

System wide, Flu immunisation is offered by all NHS organisations in LLR to all employees directly involved in delivering care.

The guidance of vaccination against flu is included in all organisations policies for the protection of transmission of flu to protect patients, staff and visitors and is an integral part of the infection prevention policies and protocols.

Although we are aware that the uptake of the vaccination is on a voluntary basis, all services across LLR are providing easily accessible and alternative methods for immunisation to staff to increase the uptake and to minimise the risk of infection. As in previous years, the roll-out of immunisation primary school-aged children will continue, against the new PHE guidelines and we are aiming to increase vaccine uptake rates, particularly among those who are most vulnerable to the effects of flu.

All services are commencing their flu campaigns and clinics from the beginning of October. The details of each organisations plan is outlined in their individual winter plans in section 2.3.

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7. LLR UEC Service Provider Winter Plans

University Hospitals of Leicester Winter Plan 2017/2018	
Assurance	
Identified service lead for winter planning:	Chief operating officer Tim-Lynch
Reporting and Escalation process:	Three times Daily operational command meetings Silver Command On call cover 24/7 Daily LLR escalation calls Director on call level
Identified risks and mitigating actions:	**Risk: Bed Capacity** **Mitigation** utilisation of SAU. Opening of additional capacity on EDU (x 6 beds) /AMU (x 4 beds) /Ward 21 Spec Med (x 28 beds) R2G/safer officially launched over Spec Med / RRCV Opening of escalation paediatric capacity Front door admission avoidance schemes Early opening of GPAU/Ambulatory (November 2017) **Risk: Workforce** **Mitigation**: Corporate/specialist nursing to support inpatient nursing Continued recruitment in all areas Utilisation of support staff i.e. trainee assistance practitioners to relieve trained nurse **Risk: Not funded for 7 day service in all areas** **Mitigation**: bespoke additional shifts agreed at peak times of pressure.

System Capacity
Additional capacity planned in comparison to winter 16/17:
Additional paediatric capacity planned to cope with winter pressure (CSSU x 5 beds 24/7) Early opening (November) of GPAU Flexible capacity in EDU (x 6 beds) and SAU (x 6 beds)
Capability to Flex above planned capacity:
Utilisation of EDU/EFU capacity Utilisation of AMU escalation area Flexible use of SAU (LRI site only) Opening of discharge lounge area as overnight capacity (LRI only) Ambulatory Surgical Unit (ASU) should be considered when the organisation is on an

internal critical incident Opel 4+ but balanced against cancellation of elective activity.

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

Safer/red to green implemented in January 2017 to focus on reduction in stranded patient (focussed on Speciality Medicine wards at LRI and RRCV at the GGH site)
To act on all patients in excess of seven days length of stay
There is further role out planned for Gastro and Orthopaedics
Integrated discharge team to extend services to all wards within UHL to focus on DTOC and MFFD

Impact of planned bed or service reductions on winter planning:

No planned bed reductions
Possible impact of planned elective surgical reduction may release capacity during peak months i.e. December/January
GGH site had 28 additional beds opened in 16/17 to absorb respiratory/cardiology emergency patients. This ward has now been handed to Vascular surgery. There is currently no solution to increasing bed capacity at the GGH site.

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

Flu staff campaign in place and starts in October 2017
Management against all IP policies and procedures
Planned to maintain system capacity during an outbreak will follow success of previous years utilising cohorting within wards/bays.
Increased cleaning presence and focus on prevention of spread

Planning for Peaks in Demand

Outline of current demand management processes:

Senior clinical presence at all front doors
Hot clinics for appropriate surgical and medical specialities
Utilisation of ambulatory medical assessment units (GPAU)
Senior clinician in all ambulance assessment areas
Possible utilisation of GP in cars visiting nursing homes etc.
Primary care co-ordinators at front door

What additional demand management schemes are in place or planned in comparison of winter 16/17

plans in place to support demand surges are outlined in section, namely:
Increased GPAU capacity from November 2017 and Specialities at front door (such as GI

Surgery).
What additional resource (service and staffing) has been planned to meet this demand?
Additional paediatric medical shift (ST4 or above) between 1800 to 0300hrs Additional adult medical shift (ST4 or above) between 1800hrs to 0600hrs All senior nursing teams matron & above are booked into clinical sessions to support the teams Duty management team has been doubled up to enable one DM to be based in ED and the other to support the wards. Additional bed coordinator shifts have been requested as overtime. Requested 1 additional ambulance crew per day between 1600hrs to 12midnight via CCG GPAU staffed until midnight with senior consultant presence Additional surgical registrar on both sites 0800-2000 hours
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
Workforce gaps both at middle grade and nursing levels to maintain consistent flow and management of escalation areas.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
Increased early frailty unit's capacity and frailty at front door DCC presence within the emergency department including therapies Increased utilisation of GP's within primary care scheme and assessment zone Increased utilisation of hot clinics
Predicted service impact:
Reduced medical take onto the assessment units Reduction in non-admitted breaches Increased ambulatory throughput to avoid admission onto a base ward Improved patient experience

Leicestershire Partnership NHS Trust (LPT)	
Assurance	
Identified service lead for winter planning:	• Pete Cross: Director of Finance Business, Estates and Facilities (**Accountable Emergency Officer**) • Rachel Bilsborough: Director for Community Health Services, with support from Pat Upsall, Clinical & Operational Lead, IM&T, Data Quality and Information Governance CHS • Helen Thompson: Director for Adult Mental Health with support from Samantha Wood • Helen Thompson: Director for Families, Young People and Children's Services with support from Julia Bolton • Bernadette Keavney: Head of Trust Health and Safety Compliance **(Overall lead for winter planning)** • Michael Ryan: Resilience and Security Manager **(EPRR Manager)** • Vicky Hill: IM&T Business Continuity Lead
Reporting and Escalation process:	• Operational Escalation Tool • Whole System Conference Call • Community Services Daily Bed State –submitted at 0830
Identified risks and mitigating actions:	• Surge in Operational Pressure – **Mitigating documents** • LPT Winter Arrangements 2017/18 • Leicestershire and Rutland 4x4 Policy (To Support Community Service Delivery) • Flexible Bed Management Policy • Seasonal Flu Campaign 2017/18 • IPC Policy • SAM Policy

System Capacity
Additional capacity planned in comparison to winter 16/17:
CHS - Flexible Bed Management agreement in operation for Community Hospital physical health beds AMHLD – A further 6 bedded female PICU ward opening in Oct 2017
Capability to Flex above planned capacity:
Yes – As per the agreed timelines set out in the LPT Flexible Bed Management agreement.

AMHLD have a set bed stock that is open 24/7 – This is managed by the AMHLD Bed Management Team and report on 3 x daily.

Going forward the LPT daily capacity will be reported on the operational escalation tool

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

Limited evidence of impact on delayed transfers at this stage of roll out however evidence suggests a reduction in LoS and therefore increased capacity for admissions

Impact of planned bed or service reductions on winter planning:

Nil

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

- Isolation Beds opened to support operational delivery
- IPC Policy offers guidance and support in managing these situations.
- Seasonal Flu Vaccine available from October to support the campaign to protect frontline staff from seasonal flu
- SAM Policy sets out direction for managing staff during infectious outbreak. Bank staff would be rostered in to cover gaps or off framework agency would be used to provide staff.
- If a Business Critical Incident was declared, a priority of work would be agreed and staff would be moved to deliver the trust priorities.

Planning for Peaks in Demand

Outline of current demand management processes:

LPT Winter Arrangements 2017/18 are aligned to the Operational Escalation Level Framework, and provide direction on actions to be carried out as operational triggers are met.

AMHLD Bed management team to manage, out of area placements, demand and capacity reviewed 3 times daily by bed management.

What additional demand management schemes are in place in comparison of winter 16/17

What additional resource (service and staffing) has been planned to meet this demand?

Reviewed Winter Arrangements Plan 2017/18
Bed management team capacity can manage this with existing resources.

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Therapy and ANP working 5 days. Mitigation in place which supports nurse led discharge on physical health wards to support discharges at the weekend.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

AMHLD - Crisis House.
Crisis team gatekeeping.
Home treatment via the crisis team.
Move on accommodation coming online in October to help with patient flow to enable capacity.

Predicted service impact:

No predicted impacts at this stage – LPT are able to deliver a safe level of service going into winter 2017/18

East Leicestershire and Rutland Urgent Care Centres

Assurance

Identified service lead for winter planning:	Rachel Taylor
Reporting and Escalation process:	• Senior team leader on call during weekend at peak times • Operations Manager on call 24/7 • Clinical Manager on call 24/7 • Chief Executive on call 24/7 • Daily Handover reports • Conference calls during peak times (internal and external with partners as per LLR requirements)
Identified risks and mitigating actions:	• Surge over and above predicted contracted activity – internal escalation process and mutual aid from within Vocare group. • Weather restrictions – severe weather, deployment of 4x4 staff transport as required. • Reliance on Agency and Locum staffing has significantly reduced following successful recruitment campaigns • Operational winter Plan in place

System Capacity

Additional capacity planned in comparison to winter 16/17:
Currently running with full staffing levels, standard appointment slots in place as per weekend and bank holiday plans.
Capability to Flex above planned capacity:
Bank holidays will be fully operational at all sites
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak

e.g. D&V/Norovirus/Flu
All frontline staff within Vocare will be offered vaccination. Planned vaccinations planned to commence October/November supply dependant. The plan is for all staff to take up the offer of vaccination, however our current target is 75%

Planning for Peaks in Demand

Outline of current demand management processes:
Swift export of additional staffing from other areas if support required. Continue to use agency staff to help support existing team
What additional demand management schemes are in place in comparison of winter 16/17
Annual Leave Embargo is in place for peak times. List of clinicians available who will support the service at short notice is in place. Additional nurse to be deployed on all BH to manage festive period surge in demand.
What additional resource (service and staffing) has been planned to meet this demand?
Recruitment underway for more bank staff to ensure that peak times (weekends and bank holidays) are well staffed.
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
Limited to number of staff able to work at any one time due to space restrictions in the centres.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
NA
Predicted service impact:
NA

Loughborough Urgent Care Centre	
Assurance	
Identified service lead for winter planning:	Rob Haines
Reporting and Escalation process:	Standard Daily to Organisation Monthly to Commissioners Enhanced Organisation and escalated to Commissioners
Identified risks and mitigating actions:	Space may be a contributing factor for enhanced treatments and reviews.(limited space) Unexpected referrals out from the LUCC may have prolonged wait from other Emergency services (EMAS) if under pressure. Potential unstable patients not being transferred as LUCC seen as place of safety..

System Capacity

Additional capacity planned in comparison to winter 16/17:

The service has been recommissioned since winter 2016/2017. Additional activity has been purchased through the contract at LUCC to reflect the new service model. In addition, primary care hub 'spokes' at Hinckley and Bosworth provide bookable appointments via 111 and clinical navigation in evenings and weekends (Hinkley) and Saturday mornings (Coalville). These new services provide a net increase in appointment capacity of 13,500 appointments, 4,400 of which are in the new primary care spokes.

Capability to Flex above planned capacity:

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

NA

Impact of planned bed or service reductions on winter planning:

NA

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g D&V/Norovirus/Flu

Vaccinations will be available through local Occupational Health. There will also be the opportunity for staff to attend the drop in clinic provided by DHU on site. It is hoped all staff will take up the opportunity in receiving this treatment.

Planning for Peaks in Demand

Outline of current demand management processes:
Swift export of additional staffing from other areas if support required. Continue to use agency staff to help support existing team
What additional demand management schemes are in place in comparison of winter 16/17
Practices in WLCCG can e-refer patients to LUCC for ambulatory assessment and diagnostics as an alternative to ED referral, this has an admission avoidance impact. In addition, we are running a 'Test bed' with Charnwood practices to provide a direct referral to LUCC from GP practices in hours for 'acute' primary care patients. This provides additional resource to same day access and supports the UTC model at LUCC. Annual Leave Embargo is in place for peak times. List of clinicians available who will support the service at short notice is in place. Additional nurse to be deployed on all BH to manage festive period surge in demand.
What additional resource (service and staffing) has been planned to meet this demand?
Recruitment underway for more bank staff to ensure that peak times (weekends and bank holidays) are well staffed.
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
Limited to number of staff able to work at any one time due to space restrictions in the centres.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
NA
Predicted service impact:
NA

TASL PTS (contract does not commence until October 2017)

Assurance

Identified service lead for winter planning:	Stewart Briggs – Operational
Reporting and Escalation process:	Lee Barham – Chief Operating Officer
Identified risks and mitigating actions:	• Seasonal Flu – Encourage Flu Vaccine take up by key staff • Severe weather – Implement Resource Escalation Action Plan – Prioritise patients' activity – Conference Calls with CCG & Health Care Partners – 4 x 4 vehicles mobilised • Disruption to base – key staff to use laptops – scheduling still possible via pda – request support from alternative bases – relocate operational support to nearby base if required – organise overtime, ready bank staff and review rotas • Staff unable to get to work – available staff to work additional hours to cover absence and service demand – request operational support vehicles/staff from other bases – liaise with CCG/Providers to prioritise transport priorities if service disruption to be severe • Regular communications with staff – Conference calls at appropriate frequency with Operational and Senior Staff to provide overview of situation, escalating in frequency if the situation deteriorates.

System Capacity

Additional capacity planned in comparison to winter 16/17:

Capability to Flex above planned capacity:
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
Staff are encouraged to obtain the seasonal flu vaccine and TASL has, where possible, all linked into local provider arrangements for staff to attend their OH sessions.

City Social Care	
Assurance	
Identified service lead for winter planning:	Mat Wise
Reporting and Escalation process:	Ruth Lake
Identified risks and mitigating actions:	Most obvious risk is that resources have been diverted from Hospital Discharge Teams to support the Integrated Discharge Team. Should this appear to be creating problems, the Service Lead will discuss with the IDT Systems Lead and escalate if appropriate.

System Capacity
Additional capacity planned in comparison to winter 16/17:
No plans to increase capacity vs. 16/17 as there were no issues with delays last winter. Locality Teams not who are responsible for a very small percentage of discharges will be advised to prioritise these to maintain flow.
Capability to Flex above planned capacity:
Currently in discussion with ASC Strategic Commissioners as to whether additional Assessment Beds can be purchased from current contracted residential homes over the winter period. In addition, hospital discharge is a relatively small part of ASC activity and there is scope, should it be needed, to utilise community facing staff to increase assessment capacity.
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
Acute DtoCs attributable to City ASC are practically zero so we do not foresee a problem. We are trying to increase the number of discharges before formal assessment notices are received.
Impact of planned bed or service reductions on winter planning:
We have no plans for service reduction prior to winter 17/18. We will continue to provide services in accordance with statutory requirements as a minimum but will always look to work in a multi-agency, integrated way, in order to assist partner organisations where we can.
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
Corporate Business Continuity and Incident Response Plan 2017/18 in place and more specific Health Transfers Business Continuity Plan 2017/18 also signed off.

Planning for Peaks in Demand

Outline of current demand management processes:
As above, there are additional community facing staff that can be called upon in the event of increased demand for assessments. Reablement provider service can also exclusively support discharges if demand peaks.
What additional demand management schemes are in place in comparison of winter 16/17
None
What additional resource (service and staffing) has been planned to meet this demand?
Current talks to temporarily expand number of assessment beds over the winter period.
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
None. We have presence 6 days a week with ICRS taking over on Sundays and any bank holidays not covered by the Hospital Discharge Teams.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
No change in avoidance admission vs winter 16/17. ICRS continue to respond to referrals from pre-admission wards to facilitate return to the community.
Predicted service impact:
N/A

County Social Care	
Assurance	
Identified service lead for winter planning:	Jackie L Wright
Reporting and Escalation process:	Surge and Escalation Plan
Identified risks and mitigating actions:	

System Capacity

Additional capacity planned in comparison to winter 16/17:

HTLAH Domiciliary providers:

- More stability within live HTLAH lots with greater security and sustainability for providers in the market
- Re-procurement of 3 vacant HTLAH lots nearing completion. Transition stabilisation measures will be put in place for new providers
- Work ongoing with Providers in closed Lots to enable these to be opened prior to the winter.
- Working with providers to increase capacity across all lots
- Domiciliary care 'await care' data is improving
- Monitoring and liaising with providers regarding time to pick up packages
- Evidence that reablement packages are reducing numbers of service users requiring maintenance packages

Residential/Nursing Care

- There is confidence that there will sufficient capacity to support

HART (Leicestershire County Council in House Reablement Service)

- Reduced demand on HART for maintenance packages, with improved stability of reablement throughput;
- Maintenance of existing staff resources, no reductions during 2017/18;
- Average weekly contracted hours for care staff is 20-25 hours, therefore there is some ability to increase these on a short term basis without impacting on working time directive;
- Effective use of Crisis Response Service (CRS), which currently operates 7.00am – 10.30pm;
- Development of 24/7 CRS – implementation due in November 2017.

Leicestershire County Council – Occupational Therapy Service

- Single Handed Care project – review of double-up care packages to ascertain if single handed equipment reduces the need for two carers, releasing capacity into the domiciliary sector.

Operational - Social Work Capacity /functions

- Increased number of staff at UHL in the IDT/ hospital social care team and A&E over 7 days (subject to funding)
- Continuation of NWB pathway to include residential and domiciliary services (subject to funding)
- Continuation of the Pathway 3 (Peaker Park) initiative (subject to funding)
- Daily communication with health and ASC staff with appropriate levels of skill and authority. The triggers for these are described in the LLR Surge and Resilience Plan

Integrated working at UHL

3 July saw the start of the Integrated Discharge Team – the overall aim is to reduce duplication of assessments; IDT members linked to busy medical wards; more effective throughput of patients; ensuring patients are identified for the correct discharge pathway thus reducing readmissions.

I**ntegrated working between ASC and CCHS/Integrated Locality Leadership**

Joint working is established and continued to develop in in four main areas:

-Joint approach to community hospital discharge and a monthly joint discharge MDT meeting

- Joint 'early intervention' monthly community MDT meeting for our shared complex community caseload

- Building a local published contact directory to make contact with each other easier

- Establishing a joint locality monthly management oversight meeting to drive and build upon the above activities, bringing teams closer together.-

Each locality has a timetable for bringing these mechanisms to life, being led by Service Managers and CCHS Operational Leads.

Integrated Locality Leadership Meetings are in place/developing to review our shared caseload and the opportunity to improve outcomes for patients/service users and staff. Implementation is led by the CCG's.

Capability to Flex above planned capacity:

- Continued work to support HTLAH providers with regard to expectations, and multi-agency working through a HTLAH joint management group
- Contingency HTLAH providers adding extra capacity where required
- Residential/Nursing care provision – option to contract with additional providers
- Business Contingency Plans specify minimum staffing levels at times of predicted surge in demand and also actions in the event of unplanned staff loss to protect critical business functions.

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

Impact of planned bed or service reductions on winter planning:

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

Internal frontline staff

- Subject to Corporate Management sign off (which we do not expect to be a problem) the County Council will be expanding the arrangements regarding the seasonal flu vaccination of internal front line staff and other key personnel, such as those in our Customer Service Centre.
- Based on an evaluation on last year's scheme, we will be offering surgeries across the county, vouchers and re-imbursement options to identified staff groups.
- Staff get individual emails (or for those not on the email system information through their line manager) about booking into a surgery, ordering a voucher or information on how to get reimbursed for a vaccination purchased in a local pharmacy etc. It will also encourage those eligible for a free vaccination from their GP to do so.
- A communication plan will support the roll out and which will also include how to stay safe and well over the winter, infection control - pertinent to flu and other outbreaks (hand hygiene, respiratory etiquette) etc. This information is also available on our intranet.
- The authority is considering possible incentives – but no decision has been made regarding this matter.
- The scheme is cross authority and includes all departments and is endorsed by unions.
-

Examples of eligible staff groups

- Adult and Children's social work staff
- Quality & Contracts staff visiting providers
- HART (in-house home care)
- Visiting Finance and Benefits Officers
- Passenger Transport Driver Attendant Loaders and Escorts for adults and children
- Staff working in adults and children's day services
- Staff working with vulnerable adults in Adult Learning

External Providers (Residential and Domiciliary Care)

- We do not reimburse our providers for the seasonal flu vaccinations that their staff may have; but we do encourage them to do this and provide information in line with that produced internally regarding those who might be eligible for a free vaccination through their GP, potential to reduce sickness rates and minimising risk to their vulnerable service users and infection control. We also send a letter to them from the Director of Adult & Communities (Adult Social Care) Director Children and Families Services and Director of Public Health to support seasonal vaccinations.
- The Infection Prevention Team (IPT) and Quality Improvement team and Contracts Officers support this initiative each year. The Infection Prevention Champions in each home receive information and the IPT undertakes training.

Planning for Peaks in Demand

Outline of current demand management processes:

What additional demand management schemes are in place in comparison of winter 16/17

What additional resource (service and staffing) has been planned to meet this demand?

Service resource – HTLAH

- More stability once final three lots awarded
- Assisting providers with recruitment and retention plans

See also Additional Capacity Section

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

- 3 HTLAH lots vacant; however, re-procurement is underway and there are contingency arrangements in place for vacant lots
- Operational staff (Social Work) are not contracted to work over 7 days but we will mitigate for this by negotiation with staff and commissioning of additional staff/agency over the winter period (subject to funding)

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

Admission Avoidance

- Increased staffing levels in ED to avoid admission where needs are social care, not clinical.
- Crisis Response Service will aim to avoid admissions by providing urgent support to people in the community.
- CRS/HART will take referrals and broker support until 10.00 p.m. and over weekends and bank holidays.

Predicted service impact:

EMAS Winter Plan	
Assurance	
Identified service lead for winter planning:	Dave Whiting Chief Operating Officer - EMAS
Reporting and Escalation process:	Ben Holdaway Deputy Director of Operations - EMAS
Identified risks and mitigating actions:	• Severe Weather - 4x4 Activation Plan / EMAS Winter Operational Plan • Increase in Demand and Key Dates – REAP / CMP Action Plans / Local Surge & Escalation Action Cards / Review of available Resources for known key dates. • Hand over delays at LRI due to increase demand at front door & reduced patient flow through the Acute Trust. Halo / Conference Calls with CCG & Health Care Partners / Opel actions. • Seasonal Flu – Flu Vaccine program for EMAS Staff & Community Responders / EMAS Pandemic Influenza Plan

System Capacity

Additional capacity planned in comparison to Winter 16/17:

Additional A&E Resource for identified key dates being planned to help manage the predicted increase in demand.

Multi Treatment Centre Unit will be deployed in the city centre for Key dates building up to and over the Christmas & New Year Period to help reduce attendance at LRI A&E department.

POLAMB vehicles will be deployed on a Friday & Saturday Night in Leicester City & Loughborough to help manage the night time economy.

Capability to Flex above planned capacity:

- Reap Action Plan
- Capacity Management Plan
- Proactive Halo cover for LRI acute unit to manage Clinical coordination and to support Ambulance hand over and turn around activity, when capacity / flow issues are being experienced within the local A&E department.
- A senior EMAS manager will also be available to discuss options with LRI management team re EMAS hand over delays and look at working with the LRI management to formulate & implement solutions to help reduce extended hand

over delays.

- Review Predicted activity on key dates for possible increase in demand over & above expected activity

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

Impact of planned bed or service reductions on winter planning:

Increase in Ambulance Turn Around Times at A&E due to poor flow at front door will lead to Impact on ability to reach 999 calls / patients in the community leading to impact on Ambulance Service delivery and Performance.

Plan to maintain system capacity (Staffing & Service) in the occurrence of an Outbreak e.g. D&V/ Norovirus/Flu

EMAS Trust IPC Policy & Procedures
EMAS Trust Business Continuity Plan
EMAS Trust Influenza Plan

EMAS Vaccination Plan
EMAS brings together a team of 'flu fighters' from across the Trust to plan and implement the flu campaign, the team is drawn from each of the divisions, Emergency Operations Centre (EOC) and enabling services ensuring the planning approach is Trust wide, including input and flu vaccine delivery by our occupational health provider.

- Each year drop in clinics are held across all of our divisions within the region with specified dates and times. EMAS also use a mobile vehicle to reach staff that is not able to attend any of the available clinics.
- An e-learning package has been created to train/refresh paramedics and nurses in the flu vaccination procedures
- Influenza vaccination available to all EMAS staff

The clinics usually begin in October running through until the end January

We aim to reach the national target of 100%, but some staff refuse to have the vaccine for personal reasons. Last year we achieved a 60.5% across EMAS NHS Trust.

Planning for Peaks in Demand

Outline of Current demand Management Process:

Ambulance Response Programme (ARP)

- ARP has been introduced into EMAS from the 19th July 2017 to identify life

threatening conditions quicker and to ensure the most appropriate response is provided for each patient first time.

Resource Management Centre now operating at divisional HQ at Birstall in Leicester - responsible for planning of Divisional operational A&E work force.

Local review of predictive demand & forecasting activity, and management of resource to enable planning of resources to meet divisional activity & demand.

Christmas and New Year arrangements

- Suspend all annual leave from 18th December 2017 to 7th January 2018
- Focus on Christmas & New Years staffing with dynamic deployment of Relief / Flexible Working / Bank staff over this two week period.

What Additional demand management schemes are in place in comparison of Winter 16/17:

- Review use of VAS/PAS
- Manage Increase in supplies of essentials (Medicines / Blankets / Vehicles & Winter Vehicle Supplies)
- Review of Current Alternative Care Pathways available to EMAS with local CCG & Health Care Partners
- Monitor & proactively manage peaks in demand, use REAP and Capacity Management Plan to manage available resources to meet demand and maintain regular updates to local Stake Holders.
- Monitor illness trends/ patterns in local community that may effect specific patient cohorts, escalate to local Stake Holders re increase of trends / patterns of certain illness currently being seen / managed by EMAS within the local community.
- Encourage use of alternative care pathways (Hear & Treat & See & Treat) with staff following Pathfinder / NEWS guidance.
- Proactively Manage Booking On & Mobilisation Times, review extended on scene times.
- Proactively Manage Turn Around times at the Acute Hospital with Acute Trust Partners
- Proactively Manage Sickness with early referrals to Occupational health

What Additional Resource (Service & Staffing) has been planned to meet this demand:

Multi Treatment Centre Unit will be deployed in the city centre for key dates building up to and over the Christmas & New Year Period to help reduce attendance at LRI A&E.

POLAMB vehicles will be deployed on a Friday & Saturday Night in Leicester City & Loughborough to help manage the night time economy.

Additional A&E Resource on identified key dates to help manage the predicted increase in demand.

Increase in management cover within the division and 24/7 on call Strategic & Tactical management cover.
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
Alternative Care Pathways available to EMAS are available via the SPA these include: Cellulitis Pathway Acute Urinary Retention Falls Pathway Community Hospital Bed Rapid Intervention Team (City only) Intermediate Care Team (County & Rural) Hypoglycaemic Pathway OOH GP Urgent Care centre LRI Overnight Nursing Assessment Unit Integrated Crisis Response Service Loughborough Urgent Care Centre
Predicted Service Impact:

East Leicestershire and Rutland CCG	
Assurance	
Identified service lead for winter planning:	Paula Vaughan, Deputy Chief Operating Officer ELR CCG
Reporting and Escalation process:	In line with NHS England requirements, the LLR CCGs will be involved in multi-agency conference calls and meetings facilitated by the NHS England, to discuss the operational position across the whole LLR health and social care system. The CCGs will direct any appropriate communications to primary care providers highlighting operational issues as required. The 3 CCGs have a leadership role to ensure that the health and social care systems across the LLR system are co-ordinated to respond to the increased needs and/or service demands throughout the winter period, particularly where there is increased activity exceeding the seasonal norm and where response and recovery is beyond the internal capabilities and escalation procedures of an individual NHS commissioned service. Situation Reports (SITREP) and Winter Reporting In order to manage the day to day activity, daily SITREPs will commence in December. In the event of significant issues being reported, NHS England will also be notified at the same time as the SITREP is submitted.
Identified risks and mitigating actions:	All risks and actions will be taken via the A&E Delivery Board and A&E Improvement Group

System Capacity

Additional capacity planned in comparison to winter 16/17:

This is based on a number of assumptions and will require ratifying.

2016/17 the CCG provided 643 additional appointments per week for an 8 week period, we anticipate being able to increase this by 50%, however, there is a dependency on mobilisation taking place earlier than in 2016/17.

Currently ELR CCG is working closely with our GP federation to develop a plan to integrate the evening and weekend services provided by the out of hours provider, GP extended hours and the service provided in the 4 urgent care centres to have a single GP led service that includes both walk in, pre-bookable appointments.

Capability to Flex above planned capacity:
We are currently exploring appetite with member practices and Federation for additional shifts during the Christmas and New Year period, however, the CCG is committed to ensuring services are funded that offer value for money.
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NHS England and NHS improvement asses that providers should aim to operate at a bed occupancy level of 92% or below to support patient flow. Therefore it is vital that UHL ensure patients are being placed in the most appropriate setting or word. This will be reviewed and assessed by the CCG and the Integrated Care Co-ordinators via the daily 11am and 2pm.
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
All East CCG staff will be offered vaccination from Sept 2017 and appointments are currently being arranged, this is supported across all member practices. Both CCG and member practice Business Continuity Plans have been reviewed and where necessary, recommended changes to pathways have been implemented.

Planning for Peaks in Demand

Outline of current demand management processes:
The CCG monitors peaks in demand such illness patterns in the local community and weather changes that may affect specific patient cohorts. A dedicated demand management lead has been identified within the CCG, and they report to the CCG Executive Committee. The ELR Out of Hospital Care Board also reviews and considers performance in areas such as A&E attendances, availability if community beds/step down, DTOC etc.
What additional demand management schemes are in place in comparison of winter 16/17
The CCG has specifically commissioned a Demand Management Community Based Service which all its member practices are signed up to deliver via the GP SIP scheme. This scheme includes regularly reviewing
What additional resource (service and staffing) has been planned to meet this demand?
ELR federation are supporting its 31 member practices, full details are being finalised at the moment, but this includes resourcing of additional staff and premises at short notice to

meet surge in demand.
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
Funding release

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
Effective care planning is integral to delivery. Revisions have been made to the Integrated Care Planning template to support GPs and Nurses in active sign posting, discussions around staying well over winter etc. Each of the CCG localities are committed and support the Integrated locality Team model and a number of Test Beds are currently underway.
Predicted service impact:
At the moment we predicate a reduction in attendances circa 10,000 over the winter period.

West Leicestershire CCG	
Assurance	
Identified service lead for winter planning:	Ian Potter
Reporting and Escalation process:	In line with NHS England requirements, the LLR CCGs will be involved in multi-agency conference calls and meetings facilitated by the NHS England, to discuss the operational position across the whole LLR health and social care system. The CCGs will direct any appropriate communications to primary care providers highlighting operational issues as required. The 3 CCGs have a leadership role to ensure that the health and social care systems across the LLR system are co-ordinated to respond to the increased needs and/or service demands throughout the winter period, particularly where there is increased activity exceeding the seasonal norm and where response and recovery is beyond the internal capabilities and escalation procedures of an individual NHS commissioned service. **Situation Reports (SITREP) and Winter Reporting** In order to manage the day to day activity, daily SITREPs and system escalation calls will commence in December. In the event of significant issues being reported, NHS England will also be notified.
Identified risks and mitigating actions:	All risks and actions will be taken via the A&E Delivery Board and A&E Improvement Group

System Capacity
Additional capacity planned in comparison to winter 16/17:
Capability to Flex above planned capacity:
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
GP Practices are planning now (August) for the Flu Campaign (commencing September) to ensure that patients in the 65+ and At Risk cohort are able to receive a flu vaccination in a timely way ahead of the winter period. Public Health England monitor flu vaccination uptake rates and the CCG is a stakeholder on the regular Flu

planning meeting.

Planning for Peaks in Demand

Outline of current demand management processes:

Following the cessation of support from Arden GEM CSU, all 48 practices have had the opportunity to download risk stratification data allowing them to plan appropriately for patients most at risk of hospital admission, and those where risk factors increase in the winter months. This risk stratification will continue locally at practice level until the completion of a new risk stratification tool being developed in partnership with Midlands and Lancashire CSU.

Practices are already producing care plans for their at risk and frailty patients as part of core contractual requirements. These care plans are developed in collaboration with patient and their carers, including nursing and residential homes patients, and are refreshed at least annually and / or post a hospital attendance / admission and subsequent discharge.

Practices are expected to plan for any surge in demand as a result of exacerbations in patients with Long Term Conditions; this links with effective care planning and supporting patients to self-manage. This includes maintaining links with the home visiting service as part of the integrated urgent care offer and supporting patients to access services appropriately.

Practices are also expected to ensure that they have a robust business continuity plan in place, and that this is refreshed such that it is reflective of current circumstances and arrangements that can be quickly effected to mitigate potential service disruption as a result of adverse weather conditions e.g. flash flooding, snow drifts, or in the event of staff illness e.g. flu, norovirus. Wherever possible, these plans should demonstrate contingency arrangements and often depict a 'buddying' arrangement with other practices locally to ensure continuity for patients. Practices are encouraged to alert the CCG where there are specific issues in order that they can be supported to address these.

WLCCG write out to all 48 practices confirming the expected contracting arrangements for the Christmas and New Year period. This approach will be in alignment with Leicester City CCG and East Leicestershire & Rutland CCG, ensuring appropriate cover arrangements are in place for all patients and allowing ample time for practices to plan and confirm capacity arrangements to the CCG accordingly.

Offer of the Emergency Repeat prescription service from a community pharmacy without the need to access OOHs and reduce the risk of patients attending ED as a result of running out of their medication.

What additional demand management schemes are in place in comparison of winter 16/17

Practices will be reminded of the importance of updating any current Special Patient Notes and ensuring that these are shared appropriately with DHU to enable visibility of care plan details to out-of-hours clinicians.

Practices currently routinely closed on a Thursday afternoon will be requested to open on Thursday 21st December ahead of the four day closure from Friday evening at 6.30pm through to Wednesday morning at 8.00am. This will include a request to:

- Provide clinical sessions across the entire day and not just the morning
- Telephone lines to be manned throughout the day
- Practice buildings to be open for patients from 08.00 – 18.30 to manage any queries from patients

- The rationale for asking practices to open on the 21 December 2016 is to:
- Support the overall surge for Christmas and New Year period.

Provide additional access to patients during an already stretched time of year

What additional resource (service and staffing) has been planned to meet this demand?

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

UHL Admission Avoidance Pathways

Please refer to attached UHL Directory of Services which details all ambulatory admission avoidance pathways, which includes hot clinics and rapid access clinics. This includes how to access bed bureau and SPA. Admission avoidance pathways are also available to practices through PRISM.

Electronic Referrals

Please refer to attached list of specialities covered through the E-Referral Service. The E-Referral Service offers specialist advice and guidance to GPs, there is also an opportunity to discuss cases with consultants through Consultant Connect.

CDU Ambulatory Pathway

Direct referral to CDU for respiratory and cardiac problems.

Loughborough Urgent Care Centre Ambulatory Care Pathways

A number of ambulatory care pathways have been commissioned through the Loughborough Urgent Care Centre;
Asthma, Diabetes, Gastroenteritis, Heart Failure, Hyperkalaemia, Pneumo/Chest Infection and Sepsis.

Integrated Urgent Care Offer - NHS 111 Clinical Navigation Hub

Patients clinically triaged through NHS111 are referred to the most appropriate care setting through the clinical navigation hub.

Predicted service impact:

Leicester City CCG	
Assurance	
Identified service lead for winter planning:	Rachana Vyas
Reporting and Escalation process:	In line with NHS England requirements, the LLR CCGs will be involved in multi-agency conference calls and meetings facilitated by the NHS England, to discuss the operational position across the whole LLR health and social care system. The CCGs will direct any appropriate communications to primary care providers highlighting operational issues as required. The 3 CCGs have a leadership role to ensure that the health and social care systems across the LLR system are co-ordinated to respond to the increased needs and/or service demands throughout the winter period, particularly where there is increased activity exceeding the seasonal norm and where response and recovery is beyond the internal capabilities and escalation procedures of an individual NHS commissioned service. **Situation Reports (SITREP) and Winter Reporting** In order to manage the day to day activity, daily SITREPs and system escalation calls will commence in December. In the event of significant issues being reported, NHS England will also be notified.
Identified risks and mitigating actions:	All risks and actions will be taken via the A&E Delivery Board and A&E Improvement Group

System Capacity
Additional capacity planned in comparison to winter 16/17:
All urgent care centres are open 12 hours a day seven days a week and are fully integrated with local urgent care services. All appointments are bookable through 111 as well as GP referral.
Capability to Flex above planned capacity:
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

Flu clinics have been arranged and all LC CCG staff will be offered flu vaccinations.

Planning for Peaks in Demand

Outline of current demand management processes:
LLR CCG's look to create capacity in both the clinical navigation hubs and home visiting services, this includes an increase in night nursing capacity and the number of slots available in community integrated urgent care services for 111 and CNH referrals.
What additional demand management schemes are in place in comparison of winter 16/17
3 x extended hour primary care centres will be in place offering a mixture of walk-in, 111 and health professional booked appointments. With support of GP/RN and ECP if required. City GP's have been sent a proforma to outline their Christmas and New Year opening plans. This has been undertaken to ensure that practices are meeting their contractual requirements and to deter patients away from utilising alternative healthcare services.
What additional resource (service and staffing) has been planned to meet this demand?
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
GP's encouraged to utilise clinical navigation hubs for variety of options (clinician to clinician conversations, hot clinics, ambulatory care pathways, home visiting service etc) to promote admission avoidance where clinically appropriate.
Predicted service impact:
NA

DHU – 24 /7 Home Visit Service	
Assurance	
Identified service lead for winter planning:	Rob Haines / Malcolm King
Reporting and Escalation process:	
Identified risks and mitigating actions:	Current volume and contract agreements

System Capacity

Additional capacity planned in comparison to winter 16/17:

Currently running the 24 hours HV service. Previously tap switched off. We will not do this. Increase in number of clinicians that have kit and can undertake home triage. Pick up at short notice.
Can increase by an additional crew car
Pharmacist support
Increase clinician numbers

Capability to Flex above planned capacity:

We have an on call service where clinicians sit in on-call shifts. These will be looked at and increased based on the discussions above.

We have communicated with clinicians that there needs to be flexibility and movement to where the demand is. Triage training is in place so that clinicians have the ability to move to triage if required.

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

N/A

Impact of planned bed or service reductions on winter planning:

N/A

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

Flu vaccinations being ordered for all staff. Current training and meticulous standards in relation to IPC.

We have a plan for extra capacity if required in relation to any outbreak

Planning for Peaks in Demand

Outline of current demand management processes:

- Review of daily and weekly volumes, linked to same period last year.
- Duty Manager presence at Fosse House, escalation to CCG and Directors on-call.
- Liaison with DHU 111 duty manager. Review in-bound call types and volumes.
- Consider mutual aid from City UCC: identify types and number of patients that may be redirected. Early liaison with UCC managers.
- Hourly monitoring/reporting and review

What additional demand management schemes are in place in comparison of winter 16/17

- Indemnity cover – increase employed workforce. People coming forward
- Senior Manager on site at Fosse House with other DHU managers mobilised (clinical bases presence)
- Senior Manager maintains liaison with DHU Director on call
- Continue to deploy additional resources available.
- Liaison with CCG in place
- Review 111 dispositions against capacity – defer patients with appropriate dispositions (e.g. “Contact practice within 24 hours” not seen within NQR of 6 hours).
- Collaborative working with City UCC and LUCC in place. Streaming of appropriate patients to agreed numbers, types and acuities. Hourly review with UCC leads.
- Public communications strategy (in conjunction with CCG) to advise and promote appropriate use of all available services.

What additional resource (service and staffing) has been planned to meet this demand?

- All off duty staff contacted, leave cancellation
- Maximise all LLR remote locations to increase capacity. Liaison with LPT Community Hospitals.
- Consider collaborative working with other DHU sites.
- Liaison with cross-border providers of OOH/UCCs/WICs. Consider diversion of patients via 111 or following clinical advice.
- Deployment of additional clinical and operational resources throughout the service to meet service demands (telephone advice, base/home visits) by locality from within DHU and engagement of locums.
- All non-essential meetings cancelled.
- Planned training reviewed and cancelled where possible.
- Consider redeployment of staff appropriate to skills (e.g. administration/management staff able to perform patient navigator/dispatcher, supervisor or HCA/driver roles, and management team with current clinical

qualification/practice skills).

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

- Discussions currently taking place with Commissioners
- Communicating processes regarding increased liaison with other services EMAS etc real time if trends r peaks are identified.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

- Currently re triaging of ED disposition cases
- Looking at purchase of D Dimers for HV vehicles
- Re triage of 111 green 2 etc can be put in place if required
- Liaison with EMAS for real time trend activity if we see a spike in any area / conditions

Predicted service impact:

NHS 111	
Assurance	
Identified service lead for winter planning:	David Hurn, NHS 111 Head of Performance
Reporting and Escalation process:	
Identified risks and mitigating actions:	High absence rates. Dedicated 111 HR resource for absence management with Team Management restructure.

System Capacity

Additional capacity planned in comparison to winter 16/17:
DHU 111 have increased forecast by 3.1% for Oct17-Jan18, compared with actual demand for same 4 months last year. Forecast staffing requirement increased in line with projected demand.
Capability to Flex above planned capacity:
Reasonable capability to flex resource using internal contingency process on/off site.
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
N/A
Impact of planned bed or service reductions on winter planning:
N/A
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
Internal contingency to be invoked with relocation to be considered. Internal processes to be followed.

Planning for Peaks in Demand

Outline of current demand management processes:
Reviewed demand for same period last month, increased by 2.5%, staffing increased accordingly.
What additional demand management schemes are in place in comparison of winter 16/17
On-going recruitment to target service needs, G2 ambulance validation line, pharmacists cover.
What additional resource (service and staffing) has been planned to meet this demand?
Increased capacity with home working clinicians, review of rota patterns to meet peak requirements (Health Advisors, Clinical Advisors, Dental Nurses, Pharmacists, Shift Leads, Team Managers and Senior Management), and a review of internal processes to improve efficiency, targeted training to reduce call lengths and support needed. Continued work on 999 and ED referrals rates.
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
High absence rates.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
N/A
Predicted service impact:
N/A

Leicester, Leicestershire and Rutland

Winter communications, engagement and marketing plan 2017/18

Contents

1. Introduction

This communications, engagement and marketing plan has been developed to support the delivery of the Leicester, Leicestershire and Rutland (LLR) Health and Social Care Economy winter plan for 2017/18, which ensures appropriate arrangements are in place to provide high quality and responsive services throughout the winter period.

The communications, engagement and marketing plan specifically focuses on activities which will be undertaken to address the pressures presented by winter. It also takes into account and supports the wider goals of the urgent and emergency care workstream for Better Care Together – the Sustainability and Transformation Partnership (STP) for LLR and the Urgent and Emergency Care Improvement plan.

This plan has also been set in the context of the work undertaken through other Better Care Together workstreams, particularly the Integrated Teams workstream. In addition, it takes into account the context of the Unified Prevention Board and the Health and Wellbeing Board in their support of Self Care and the work of LLR Prepared.

Partner organisations

This plan has been developed in partnership with the following organisations:

- DHU CIC (DHU)
- East Leicestershire and Rutland Clinical Commissioning Group (CCG)
- East Midlands Ambulance Service (EMAS)
- Leicester City CCG
- Leicester City Council
- Leicestershire County Council
- Leicestershire Partnership NHS Trust (LPT)
- University Hospitals of Leicester (UHL)
- West Leicestershire CCG

2. Situational Analysis

In order to develop this plan we have undertaken an analysis and evaluation of current qualitative and quantitative data to understand the problems and issues in order to identify actions which offer solutions and supports the goals of the LLR Health and Social Care Economy Winter Plan.

This Situational Analysis highlights seven areas of key learning from analysis and evaluation of data to ensure the recommendations we make are evidence based.

1. A&E attendances

The top reasons for attendance at Emergency Department over winter 2016/17 at UHL:

- Head Injury
- Falls
- Abdominal pain
- Viral illness
- Sepsis
- Respiratory Tract Infection
- Sprains

People are still unsure of where to attend for urgent care, and still will default to ED, even when they would be treated more quickly elsewhere.

Feedback from last year indicated that many of the patients within the top reasons for attending ED are waiting too long to seek help and becoming acutely ill, where they could have been treated in the community effectively if they had accessed services when they first became ill. Falls, sepsis and respiratory tract infections are some of the most common categories seen in ED and often can be addressed through earlier intervention

The new Emergency Department opened in April 2017. Following a spike in attendance on the week it opened, there has not been a large discernible increase in attendance. We have seen lower numbers in August both in attendance and a reduction of breaches on the 4 hours wait. There has been a body of work completed to reduce ambulance handover delays which are also reduced from last winter. There are ongoing issues with visitor flow around the site with both taxis and people still following the old routes, which will take some time to change.

The implementation of the action plan continues, and there is additional potential for behaviour change through the “September Surge”.

However as winter pressures start attendance is predicted to rise in line with last year’s figures. When ED becomes busy as a system we resorted quickly to issuing reactive messages asking people not to attend, which has been proved to be counter-productive. Communications were issued regularly to all primary care across LLR asking them not to refer into ED, which has caused some unease.

The focus within ED for winter is admissions avoidance and maintaining the flow in ED, managing patients being moved through the system quickly in majors and preserving turn around in minors. Hot clinics will be in operation again, with a frailty focus, but GPs are not always aware of which clinics are happening and that they can refer to the clinic rather than just to ED.

2. NHS 111, Clinical Navigation Hub and new models of care

The volume of calls to NHS 111 remains broadly in line with 2015/16 across the winter period. NHS 111 reported a surge in calls on the Tuesday bank holiday, which caused the system to struggle and, had a resultant knock on effect on ED attendance. The majority of these calls were caused from people who were unaware that the double bank holiday meant that their GP was closed on the day after Boxing Day.

Through the work of the Vanguard, and in line with the national directives, the clinical navigation hub went live in April 2017. This means that all calls to NHS 111 which are result in an ED disposition are transferred directly to a clinician for assessment. Following assessment the clinician can book appointments for the patient at new primary care hubs and the Loughborough Urgent Care Centre in West Leicestershire, primary care hubs and Merlyn Vaz in the City, and urgent care centres in East Leicestershire and Rutland. The can also refer patients to the LLR wide home visiting service.

Regionally NHS 111 is also providing clinical triage for Green Two calls, as well as dispositions to ED with illness. These two initiatives are hoped to relieve pressure on the ambulance service and ED by clinically triaging the cohorts to more appropriate routes of receiving care.

Early results from the Clinical Navigation Hub have shown it to be a success with 81% of callers being successfully redirected to other services. However engagement work done with active patients shows that there is still a mistrust of NHS 111, with people being unaware that they can speak to clinicians and a perception that they will be sent an ambulance for minor ailments, even if they don't want one. However, this does differ from research with users of NHS 111 services.

3. Better Care Together – Urgent and Emergency Care Work stream

The Urgent and emergency care workstream of Better Care Together has been tasked with meeting a series of targets related to performance of the whole urgent and emergency system in line with national directives.

An improvement plan has been created to address these targets falling broadly into three categories

1. Inflow
2. Flow
3. Discharge

Many of the goals of the improvement plan are out of scope of the specific winter plan. The following areas have been identified as those in which communications will play a role.

- Increasing proportion of attendance at urgent care centres and hubs which are through pre-booked appointment via 111
- Discharge and supporting patients to choose appropriate settings

4. Influenza remains a threat to the health system

Influenza remains a significant risk to the health and social care system. It is the cause of 12,554 deaths in the UK every year [1], and affects one in five people during the winter spike between November and March[2]. It also accounts for a high proportion of self-treatable conditions which present at ED nationally, as well as increased pressure on admissions. A pandemic of flu would place an immense strain on the system, and the potential impact can only be reduced through the process of vaccination.

Prior to 2016/17, the uptake of the flu vaccination in LLR had been following a downward trend since 2012/13. 2016/17 marked an upwards swing, but there is still more work to be done.

We have identified that the cohorts who have most impact on the health system if they do fall ill with the flu are the over 65s, and those living with a long term condition. Even though there has been a marked increase in the proportion of those with a long term condition receiving the flu jab, from 42.29% to 49.17% of the population, this is still not close to the recommended level of 75% of population vaccinated, as stated by the World Health Organisation. Over 65s account for the largest proportion of the population eligible for the flu jab, but also are more at risk of complication and admission than other cohorts.

Directly targeted support was offered to practices across LLR to contact patients with cardio-respiratory diseases and those over 65, with an outreach worker spending time in practices calling on their behalf from provided lists. In total 20 practices were visited across LLR, with 267 appointments being made and a conversion rate of 44.3% conversation to booking.

5. Previous marketing campaigns

Last winter a cross-channel marketing campaign was undertaken with the goals of:

- Increasing the influenza vaccination rate across at-risk groups
- Embedding NHS 111 into people's minds as the first contact, both for physical and mental health, whatever the need – include triage for appropriative patients.
- Promoting clarity, maximum reassurance and confidence among health and social care professionals and voluntary and community sector and intermediaries in NHS 111 and the Navigation Hub.

A full analysis of activities and outputs can be found in Appendix A. Our key learnings from the campaign were:

- Successful joint working led to better co-ordination of proactive messages
- Our work with patients and the work of our partners led to an increase in the number of flu vaccinations in our target audiences.

- Joint work with GP practices strengthened relationships with primary care which can be built upon in 2017/18
- Positive response from voluntary sector to the campaign has led to the development of new channels through which communications can be cascaded.

The weakness of the campaign, which we aim to address this year include:

- Too many initiatives undermined our ability to measure the impact, particularly around NHS 111
- Lack of budget
- Despite planning we were still being reactive to issues and resorted to 'don't go to A&E messages when we were in crisis, which had no impact and could have contributed to more attendances at A&E
- Common pressure points in winter such as a cold snap and icy conditions are approached reactively and are not always issued in a timely manner
- Christmas communications, although covered in the media, were picked up late and there was widespread misunderstanding with the public regarding GP opening times and leading to a rise in calls to NHS 111 and ED attendance.
- Feedback from last winter suggested that providers and third sector organisations are receiving a lot of information regarding winter from many different sources, with no indication of priority.

Over the summer period we undertook additional activities to support the urgent and emergency care system.

Joint partnership working with universities across Leicestershire has opened up new channels to reach students and staff, including access to the student intranet, closer links to the National Union of Students, training for security staff, campus wardens and other supporting staff at the universities in collaboration with 111 so they can direct students appropriately to services.

6. Multiple campaigns across the system

Across the system there are many individual initiatives and campaigns taking place to support specific areas of the urgent and emergency care system during winter, led by our partners and providers. These include

- Better Care Together Work stream - Integrated Teams

Through the Integrated Team's workstream there is a planned campaign which will run over the winter period focusing on supporting Falls Prevention and how patients can access services to support them to remain healthy. Falls were the second most prevalent reason for attendance in ED and pressure on the ambulance service last winter, so links to the goals of the wider system winter plan.

- Leicester Partnership NHS Trust – Falls campaign

Working with the falls team to amplify the prevention message to at risk groups.

Education around steps to prevent falls for patients, family carers and potentially wider audiences. Directional links to the Integrated Teams campaign.

- Unified Prevention Board

  The Unified Prevention Board (sub group of the Leicester County Council Health and Wellbeing Board) are planning a campaign supporting self-care, with a focus on healthy living, living with a long term condition, and how to access appropriate services. This campaign will focus on diabetes, as well as supporting people to engage in more physical activity.

- Leicester, Leicestershire and Rutland Self-care Campaign

  Leicester City CCG are leading on a self-care campaign which will bring together all health and social care partners to combine ideas and resources to produce a larger-scale self-care campaign for patients in Leicester, Leicestershire and Rutland. This campaign will be delivered under the Stay Well this Winter branding, and is aligned to the goals of the wider winter plan.

- LLR Prepared

  LLR Prepared are undertaking several initiatives which may have impact on the winter plan. This includes LLR Prepared Week 2017, which will take place between October 9 and 13, including daily webinars (one called Getting Ready for Winter) and a weeklong schedule of social media messaging to support systems resilience.

To date there is no overall schedule for these campaigns and there is potential for the media and ultimately patients to receive a high volume of different and conflicting messages at the same time which leads to lower impact for all campaigns and communicate fatigue from the public.

7. NHS England Guidance for winter

NHS England has issued guidance for 2017/18 and a series of system priorities for winter. The following areas have been identified as those in which communications may play a role.

- Supporting care homes and the 350,000 older people who live in them – communications with care homes are still poor and there is lack of understanding of referral routes. There is no quick route for direct communications to the care homes.
- Discharge – Patients are still unaware of the benefits to their health of quick discharge. Patients and the families are often reluctant to be discharged early to home and strategies such as discharge to assess are not widely understood.
- Peaks in demand – although the priority from NHS England is to address workforce planning on recognised peaks, there is still work to be done in educate patients to change their behaviour thus reducing the size of the peaks.
- Encouraging usage of the clinical navigation hub and new models of care

3. Stakeholder analysis

To ensure that we reach all our stakeholders we have undertaken a stakeholder analysis to identify the target audiences that we need to communicate with and engage, and prioritised and ranked them.

After analysing our target audiences (see analysis overleaf) we believe that initially our most important target group are health and care staff and partners, as well as the voluntary sector. They are our biggest asset and if they have a good understanding of the services and information around winter, could act as advocates helping us to deliver positive messages and signposting to patients/services users.

By concentrating in the first instance on this group and ensuring they have bought into our messaging, particularly around NHS111 and the benefits of the flu jab, they will become ambassadors who will deliver our key messages to a wider audience, acting as a trusted intermediary to change behaviour in some of the groups which we find harder to reach. All our other key groups to reach and communicate with immediately are outlined in the analysis table in the 'key players' and 'involved boxes'. In the longer term this strategy will be developed to include activities that reach the wider audience.

Involved – channels for communications	**Key players – Partners and staff**
• Providers - UHL, DHU, EMAS, Alliance, TASL • LPC • County and City Councils • Better Care Together • LLR Prepared • Healthwatch x 3 • PPGs and patient groups • Care Homes & hospices • Voluntary Action Leicester • Voluntary and community sector groups (general) • Disease specific groups (Asthma, COPD) • Carers through carer groups • Private, voluntary and independent sector providers • District / borough councils • Customer Services/SPA teams • Universities / Student Unions	**Internal** – Leicester City Council, Leicestershire County Council, Rutland County Council, Leicester City CCG, East Leicestershire and Rutland CCG & West Leicestershire CCG's, LPT, UHL, DHU, primary care, localities/federations Each partner will need to ensure the following areas of the organisation is updated with progress: ▪ Corporate management teams / Transformation boards ▪ CCG boards ▪ Health and Wellbeing Boards ▪ Lead member/support member ▪ Cabinet ▪ Group Leaders ▪ All council members ▪ Adult Social Care/Community Health Managers ▪ GP's/Clinical Leadership Teams/GP Federations ▪ Primary care staff
Inform – use for communications	**Consult - Show consideration**
• Wider public • All staff across LLR health and social care organisation • People eligible for flu vaccination • Activated patients through patient groups • Patients being discharged	Police Trade unions 38 Degrees Print and broadcast media Trade / specialist media National media

4. Priorities for winter communications 2017/18

Through our situational and stakeholder analysis we have identified the following priorities for communications in 2017/18:-

1. Increasing the number of eligible patients who need the flu jab
   - Raising awareness of the flu jab amongst target groups and the potential risk associated with not getting it
   - Supporting GPs to deliver more jabs through support for booking appointments

2. Supporting patients to seek help earlier before their condition becomes acute
    - Raising awareness of the benefit of early intervention with some of the most common conditions seen in ED which cover the early warning signs of each condition and how people can seek help early.

3. Supporting patients to understand the services available to them over the winter period
    - Early communications of service opening times and repeat prescriptions ordering
    - Raising awareness of the options when services are closed over Christmas

4. Improving internal communications on ED pressures to practices and care home partners
    - Improving communications to primary care, avoiding messages that can be seen as blaming any part of the system for inappropriate behaviour and alerting them to new initiatives which can help, including hot clinics
    - Improving communications channels to care homes to ensure that we can effectively distribute the messages that they need
        - Working with the care homes sub group to understand what care homes need and how they want to be communicated with.

5. Ensuring as far as possible messages are co-ordinated and do not overwhelm the system
    - Identifying and recording all campaigns being run by our partners particularly around self- care
    - Identifying where possible potential areas where we will need to issue reactive communications, such as upcoming icy weather and preparing messages and materials in advance.
    - Agreeing which organisations lead and who speaks on each area so that we can react quickly to more unexpected pressures
    - Capitalising on joint working opportunities across LLR whilst avoiding silo working.

6. Raising awareness of the benefits of NHS 111 and clinical navigation hub
    - Communicating areas where the clinical navigation hub makes a difference, such as booking appointments
    - Raising awareness of services for both physical and mental health needs to ensure parity of esteem.

7. Improving the perception of NHS111 and the clinical navigation hub
    - Increasing trust and countering myths around NHS 111

8. Improve the understanding of discharge process and benefits with patients
    - Raising awareness of the patient benefits of speedy discharge with both patients and family members.
    - Supporting patients to choose appropriate settings

5. Tactics for communications

We have created a comprehensive campaign schedule (see Appendix 1), working with our partners to ensure that all activities do not promote silo working, they capitalise on joint working opportunities and identify any gaps in messaging. Below are the tactics we will employ in order to deliver the activities detailed on the schedule.

Proactive communications

Proactive communications will be undertaken across the winter and Christmas period to support the delivery of the winter plan. This utilise print and broadcast media as well as social media, websites, and stakeholder communications channels to inform, promote and change behaviours, particularly around peak times of activity such as bank holidays. We anticipate four themed campaigns, which will be:

1. Promoting Flu Jab
2. Christmas preparations - importance of seeking help early and appropriately before a condition escalates
3. Seek help early
4. Promoting NHS 111 and clinical navigation hub
5. Support appropriate discharge

Supporting partner campaigns

We will support partner campaigns outlined previously. We intend to amplify the messages around how patients can improve their health and wellbeing, with the goal of ultimately reducing attendance at ED as well as the need to access health services.

Collateral and printed materials

There are a variety of printed assets available from NHS England around flu vaccination, Stay Well and self-care, which we will utilise. These will be distributed to health and social care partners across the area, including GP practices and hospital waiting rooms to ensure patients have multiple chances to view our messaging. We will also distribute them to key third sector partners, such as Age UK, who will circulate them to their service users.

Local print is also desirable in order to reflect our local health economy and services. We will identify essential local print particularly around discharge and clinical navigation hub messages that is required.

Digital materials and videos

We will create a range of digital assets, including video clips and social media graphics to accompany our proactive communications work. These assets will be used to increase our reach on social media, and promulgated through partners and targeted organisations. We wish to use these assets , as well as the video assets created last year to promote our key messaging to targeted audiences using Facebook paid for marketing. This would support the reach to groups which are harder for us to reach through normal communications and media routes, such as students.

Supporting GP practices with appointment booking

We will build on the success of 2016/17 and support primary care with outreach workers who will visit practices and support them with appointment booking, calling patients on a pre-approved list and booking appointments onto their system. We will work with practices in advance on the quality of the data and what is required, to avoid spending time contacting patients who were not eligible, or had already received the flu jab at the practice. Using flu data from last year, we will target our support at the practices with the lowest rates of flu jabs last year to make the biggest difference.

Staff engagement

We will support our partner organisations in both health and social care, where appropriate, with their campaigns to vaccinate staff. We will create " toolkits" which our partners can use to cascade messages to front line staff, domiciliary care workers and care home workers in order that they can support the service users who they directly work with.

Voluntary and community sector engagement

We will work to ensure all messages to the voluntary and community sector continue to be cascaded down to their service users. We will work with third sector organisations such as Age UK to educate their voluntary carers and outreach workers so that they can support the people whom they care for to access help appropriately.

Local pharmaceutical committee

We will work with the local pharmaceutical committee to ensure all messages are cascaded down to their customers.

Outreach

We will focus our resources on key outreach events which offer the opportunity to talk to larger groups of the public. We will work with the South East Asian community in relation to the Leicester City Diwali celebrations. We will also work with the three universities and attend their Fresher's Fairs.

Care Homes

We will improve our communications with care homes by developing a more robust route for communications, both with proactive information to support care homes to increase the understanding of how to refer patients appropriately, and when we need to get messages out urgently around pressures on the health system or potential health risks.

Planning for reactive communications

We will work with communications partners across the system to identify the issues which are likely to arise over winter. This would include topics such as high attendance in ED or ambulance handovers. We will draw up a set of media handling protocols for which organisations lead on these issues, as well as key spokespeople for topics and an outline of messaging strategy.

We will also draw up a series of pre-prepared assets for common external topics such as a cold snap or high attendance in ED of frail older patients, which we will be able to distribute as soon as the situation arises.

By having these messages agreed across the system in advance, we will be able to react in a joined up and planned way to the more common reactive queries and occurrences, avoiding last minute responses.

6. Equalities considerations

We have a duty to ensure that the communications and engagement activities reaches out to all people in our diverse communities across LLR.

We will ensure that we communicate with all communities particularly utilising the expertise of relevant voluntary and community sector organisations to raise awareness of how to access care.

We will also reach out to a range of voluntary and community organisations to support communicating with those with protected characteristics and 'seldom heard' groups.

7. Risks

Risks and mitigations will be managed through the urgent and emergency care risk register. Risks around communications, engagement and marketing will be fed into overall risk log.

Communications and engagement risks will be identified and regularly reviewed and assessed throughout mobilisation and mitigating actions put in place to respond to issues.

Risk	**Mitigation**
Warmer weather leads to decreased sense of importance of winter planning in the minds of the media and general public	Better understanding of upcoming weather patterns through the Met office. Communications to be tailored to take account of weather, rather than using generic cold weather messaging
National negative media coverage of NHS 111 leads to lack of confidence in the local service and new models of care	Being prepared to respond to media queries quickly with positive information about 111 locally and the difference that clinical navigation hub makes. Identification of clinical leads at NHS 111 who are media trained and supporting them to respond to media interest.
When the system comes under pressure we will become reactive and talk about "Don't come to A&E", which inadvertently then increases attendance	Planning of responses on key pressure issues such as high attendance so that we can quickly issue targeted relevant messages to encourage appropriate attendance at alternative services. Agreement across the system that we will encourage appropriate attendance rather than try to discourage inappropriate attendance
Difficult to communicate with Care Homes quickly	Explore routes of communications with care homes through working with partners in social care as well as the care homes sub group.

Communications to General Practice are sent out reactively which cause unease and act as a barrier to collaborative working	Work with general practice to pre-plan messages issued wherever possible. Involving primary care and working with the Urgent Care clinical lead in order to improve messaging type and routes
Campaigns fatigue and competing messages – confusing the media and overwhelming the public	Urgent care communications group to discuss interdependency of campaigns to ensure they are delivered in a joined up manner where appropriate.

8. Budget and staff resources

The host CCG for Urgent and Emergency Care is West Leicestershire CCG. For communications, engagement and marketing support the CCG contracts with Midlands and Lancashire Commissioning Support Unit. Therefore, costs for most staff resources are covered for many of the key areas of action identified in the communications, engagement and marketing plan. However, marketing collateral costs are an additional cost, as will be the outreach costs to support relevant GP practices to reach out to appropriate patients.

Outlined below is the projected budget required for full delivery of this plan in order to support winter pressures:

- Support of flu vaccination promotion £13,000
- Support of online marketing (paid for) £2,000
- Support of collateral and general marketing £8,000

Further conversations are needed to assess appropriate methods of funding across the health system.

9. Schedule

Outlined below are the key actions will be undertaken between September and March 2017 to support winter pressures. We have identified activities related to specific proactive campaigns and general activities.

When	*Stakeholder/ group/ Audience*	*What*	*What does good look like*	*Lead*	*Status/Update*
September – October	All audiences	**Proactive campaigns – Flu jab** Schedule of press releases with video assets to remind people to get their flu jab supported with supporting social media campaign content. Working with voluntary and community organisations to support the dissemination of messages to those in our target groups, particularly the harder to reach groups Working with LPT to empower staff to act as ambassadors for target groups including older frail and LTC. Engagement and regular content with media to drive coverage of messaging Targeted work with south east Asian community to promote messages through Diwali celebrations Toolkits to health and social care partners and voluntary and community sectors to cascade messages to front line staff, domiciliary care workers and volunteer workers Support with social media and website content – held centrally on the LLR Stay Well website	Target groups aware of importance of flu jab Support the LLR winter plan with the goal of increasing the overall vaccination rate across LLR to 75% 3 press releases on flu related topics with 2 instances of coverage per release in print and broadcast media Evidence of advertising messages on Diwali screens	CCGs and health and social care partners	
November – December	All audiences	**Proactive campaigns – Christmas preparations** Schedule of press releases to remind people of alternatives to primary care over Christmas and filling repeat prescriptions early. Early distribution of GP opening hours to media outlets, targeting “ultra-local” media / parish council newsletters / etc. Working with voluntary and community organisations to support the dissemination of messages to those in our target	Awareness in local communities of GP opening hours and the preparations they need to make for Christmas period Low numbers of calls to NHS 111 regarding GP closure / repeat prescriptions	CCGs and health and social care partners	

		groups, particularly the harder to reach groups. Working with our PPG members to disseminate messages further into their local area. Support with social media and website content – held centrally on the LLR Stay Well website	3 press releases over campaign period with 2 instances of campaign coverage in print and broadcast media per release.	
January – February	All audiences with a focus on frail and older	**Proactive campaign – Seek help early** Schedule of press releases with video assets targeting people with a condition which may deteriorate quickly in winter such as those with respiratory illness. Schedule of press releases with video assets aimed at informing the wider public about conditions which can escalate quickly and the early warning signs. Working with voluntary and community organisations to support the dissemination of messages to those in our target groups, particularly frail and older. Engagement and regular content with media to drive coverage of messaging Toolkits to health and social care partners and voluntary and community sectors to cascade messages to front line staff, domiciliary care workers and volunteer workers Support with social media and website content – held centrally on the LLR Stay Well website	Informed public understanding the appropriate routes to access urgent care before they become an emergency case 2 press releases with 2 instances of coverage in print and broadcast media	CCGs and health and social care partners
October - February		**Proactive campaign – NHS 111 and clinical navigation hub** Schedule of press releases with video assets to share good results and inspire confidence in 111 service Inclusion of positive 111 references in all other campaign media	Informed public understanding the benefits of NHS 111 locally 2 press releases with 2 instances of coverage in print and broadcast	

	Working with voluntary and community organisations to support the dissemination of messages Engagement and regular content with media to drive coverage of messaging Toolkits to health and social care partners and voluntary and community sectors to cascade messages to front line staff, domiciliary care workers and volunteer workers Support with social media and website content – held centrally on the LLR Stay Well website	media 2 x toolkits distributed to partner organisations and evidence they have been used
	Proactive campaign – Discharge Schedule of press releases to support the campaign messages Working with UHL to discuss routes of communication to staff on words and supporting information to patients regarding discharge options Exploring the potential benefits of collateral for patients to explain the benefits of early discharge Working with voluntary and community organisations to support the dissemination of messages Engagement and regular content with media to drive coverage of messaging Toolkits to health and social care partners and voluntary and community sectors to cascade messages to front line staff, domiciliary care workers and volunteer workers Support with social media and website content – held centrally on the LLR Stay Well website	Informed public understanding the benefits early discharge 1 press release with 2 instances of coverage in print and broadcast media 1 x toolkits distributed to partner organisations and evidence they have been used

September - February	All audiences	**Press and public relations** Meetings and/or regular communications established with journalists to build on relationships, drive positive coverage and mitigate negative coverage around system pressures. Identify different topics of interest – case studies with drivers, carers, patients. Collate and produce proactive press releases throughout campaigns to generate maximum coverage through print, radio and TV. Create video information pieces through the campaign work and promote via social media. Establish and agree key media spokespeople from our own and partner organisations, based on campaigns and key winter topics and ensure they are confident and well briefed in undertaking media interviews Work with other CCG to target appropriate local magazines and newsletter with relevant articles and features, including patient newsletters and local parish councils	Proactive coverage across three campaign topics on TV, print and radio Media protocols for proactive and reactive communications agreed across organisations	CCG
September - February	All audiences	**Website and social media** Develop ongoing schedule of online web and social media content through the duration of the winter to engage and appeal to different audiences Collate social media plan to further promulgate messages Distribute to partners to form links to CCGs website and maximise number of hits Create video information pieces and promote via social media	Awareness online of key messages 2 x video clips per month to support campaigns Consistent winter messaging across all partner sites linking to Stay Well LLR website	CCG

November (budget permitting)	Over 65s Chronic Respiratory Conditions	**Supporting member practices to book flu jabs** Identification of practices with lowest uptake of flu jab to population ratio. Outreach workers to visit individual member practices and support calling target groups to book flu appointments	Improved ratio of flu jab / target population in participating practices Increase from 20 to 30 practices supported through this route	CCG
October	Health and Social Care partners Voluntary sector	**Collateral and printed materials** Distribute printed assets from NHS England to health and social care partners across the system for display in GP practices, hospital waiting rooms and other health and social care settings. Distribute printed assets from NHSE to Age UK and other key voluntary groups working with frail and older people to pass on directly to their service users	Well informed local people aware of new service Confirmed distribution from 3 x larger voluntary community providers	CCG
August and September	Health professionals	**Staff engagement** Work with Alliance, LPT, UHL and council partners to support their campaigns to vaccinate staff. Cascade of information through partners to frontline staff and domiciliary care to support them to deliver our messages directly to service users	Well informed staff aware of importance of flu jab and other winter messaging and acting as ambassadors to amplify our messaging Evidence of campaign messages being delivered directly to staff	
August and September	Care homes	**Care Home Staff** Work with the care home sub group to establish new routes for communications with care homes Regular communications and clear information to care homes regarding winter messaging and appropriate routes of referral into urgent care services.	Well informed care homes staff aware of referral routes for their residents who need urgent care over winter Agreed routes of communication established with care homes in city & county	CCG

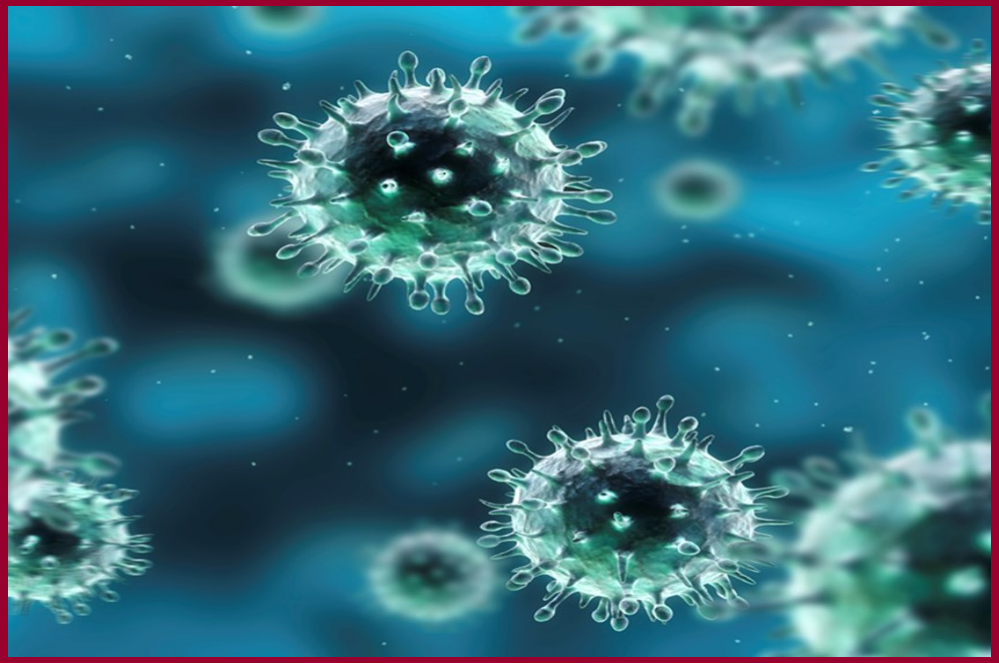
September - February	Students	**Student engagement** Work with Leicester, DeMontfort and Loughborough Universities to reach students and staff Continue training for security staff, campus wardens and other supporting staff at the universities in collaboration with 111 so they can direct students appropriately to services. Outreach workers to attend Fresher's Week and pass on messages about appropriate attendance Work with staff to disseminate messages to students regarding appropriate attendance	Well informed staff and students aware of appropriate ways to access urgent care Attendance at 3 x freshers events
September - February	Voluntary and community sector workers	**Voluntary and community sector** Attend the VAL Health and Social Care Forum to engage with voluntary and community staff and inform them of appropriate routes to access care so they can pass on the messages to staff. Cascade messages through VAL to voluntary and community sector workers to pass on to the groups they work with, particularly the hard to reach groups. Work with Age UK to build relationship further to increase our reach with frail older people in our community Work with ELR CCG and Council mental health project to identify opportunities for urgent care communications to be cascaded through new mental health providers Work with LC CCG to identify route to cascade messages through the voluntary sector to the parents of the 1-5s.	Informed voluntary sector able to act as ambassadors for key messages following attendance at 1 x forum Evidence of articles being published in voluntary sector newsletters Agreed routes of communication for Age UK / mental health / parents of 1-5.

	Proactive campaign – partnership working on other LLR campaigns	
	Cascade partner campaign messages through appropriate routes Join up campaigns where appropriate to ensure maximum impact	Campaigns working together to deliver system goals.

Public Health England

NHS England

Flu and Vaccination Programmes- Leicester City



Chloe Leggat, Screening and Immunisation Co-ordinator, Leics., Lincs., Northants 2017

Public Health England

NHS England

What is flu?

Illness caused by a virus – 3 main types, many sub-types (strains)

Can affect anyone - for most people influenza infection is just a nasty experience but for some it can lead to more serious illnesses

The most common complications of influenza are:

bronchitis (an infection of the bronchi - the main airways of the lungs)

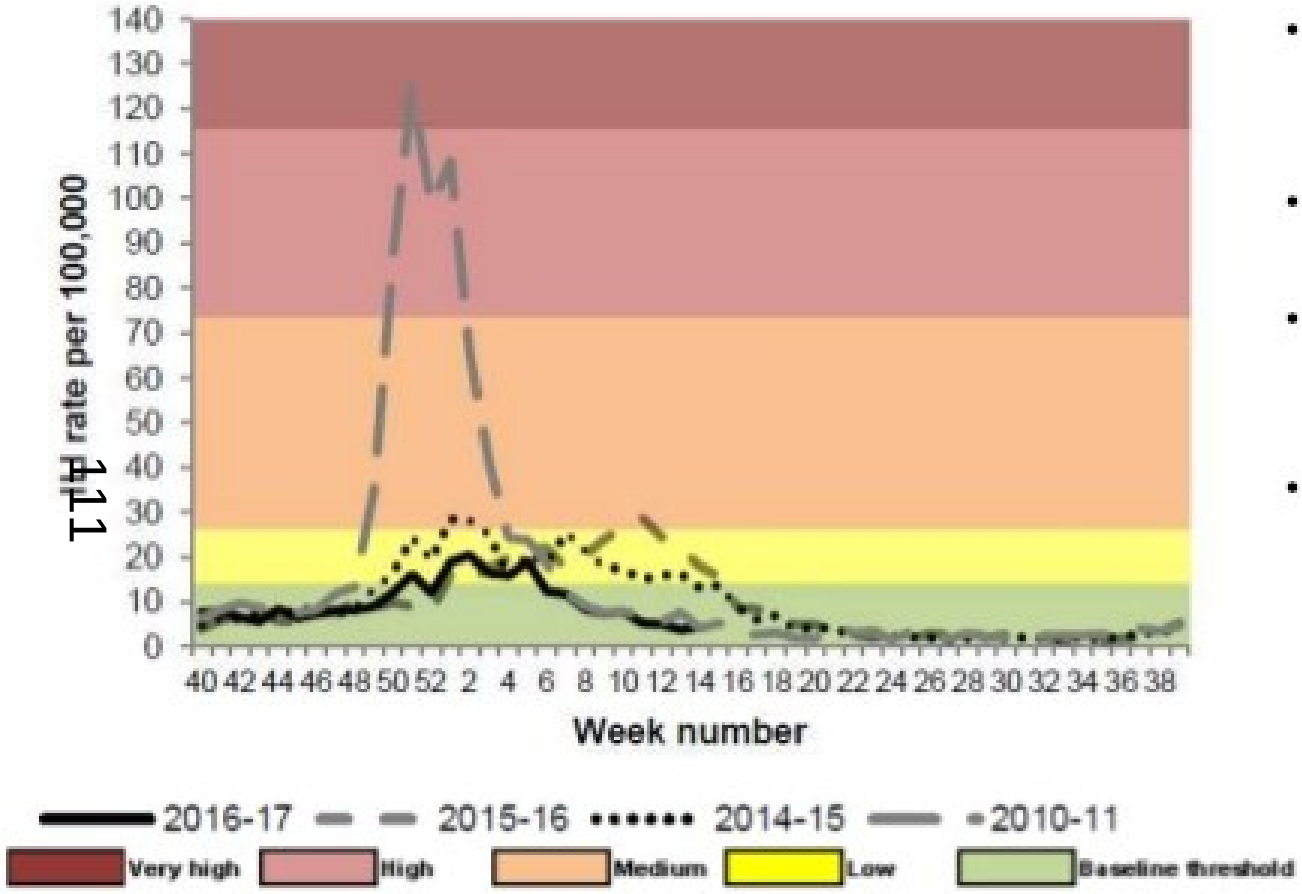
bacterial pneumonia (an infection of the smaller airways)

children often get otitis media (an infection of the middle ear)

These illnesses may require treatment in hospital and can be life threatening especially in the very young, the elderly, in pregnancy, and to those with underlying illnesses

Huge pressure on NHS services – GP and A&E attendance, hospital admissions

Flu epidemiology



Weekly all age GP influenza-like illness rates for 2016 to 2017 and past seasons, England (RCGP)

- flu activity usually between September to March (weeks 37 and 15)
- impact of flu varies from year to year
- moderate levels of influenza activity seen in 2016/17 season
- biggest impact in older adults, increased numbers of care homes outbreaks and excess mortality seen particularly in the 65+ year olds

high number admissions to hospital and ICU/HDU admissions – although lower than seen in the past two seasons

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Review of burden of flu in children

- average flu season: estimated 0.3% to 9.8% of 0-14 year old children present to a GP with flu
- incidence rates can be markedly higher in the younger age groups
- influenza-associated hospitalisation rates:
  - 83-1,038/ 100,000 children 0-59 months old (highest in <6m)
  - 16-210/100,000 children 5-17 years
- children more vulnerable to infection than adults when exposed
- children with flu contribute to the burden of flu in all age groups because they are more likely to pass on the infection than adults

112

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Screening and immunisation- Section 7a remit

- **all 2 and 3 year olds in primary care (with live attenuated influenza vaccine LAIV)**
- **all primary school children in LLR (with LAIV)**
- **those aged six months to under 65 years in clinical risk groups (detail on next slide)**
- **pregnant women – at any stage of pregnancy - and in each pregnancy**
- **those aged 65 years and over**
- **those in long-stay residential care homes**
- **carers**
- **Frontline health and social care workers – employers' responsibility**

113

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At risk groups

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- **Everyone aged 6 months to <65 years with a serious medical condition:**
- **Chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis**
- **Chronic heart disease, such as heart failure**
- **Chronic kidney disease at stage three, four or five (i.e. more severe)**
- **Chronic liver disease, e.g. cirrhosis, chronic hepatitis B**
- **Chronic neurological disease, such as Parkinson's disease or motor neurone disease, or learning disability**
- **Diabetes (both types, regardless of treatment)**
- **Poorly functioning or absent of the spleen**
- **A weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)**
- **Morbidly obese (defined as BMI of 40 and above)**

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Vaccination

- Annual vaccination required due to unstable (changing) nature of flu viruses
- Resource intensive and challenging, almost year-round work-stream
- Programmes focussed on those who are:
- most likely to get flu
- become seriously ill if they get flu
- mostly likely to spread flu to others
- 2 types of vaccine:
- Live attenuated influenza vaccine (LAIV) – nasal spray (“Fluenz®”): protects against 4 strains, licensed for those aged 2 - <18 years
- Inactivated influenza vaccine - given by injection: for everyone else; several different products, most are trivalent (protect against 3 strains), two of them are quadrivalent (protect against 4 strains) including the one given to children

115

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Flu vaccine uptake rates 2015/16 – 2016/17

	2016/17	2015/16	Uptake ambition 2017/18
Patients aged 65 years or older	**70.5%**	71.0%	**75%**
Patients aged six months to under 65 years in risk groups (excluding pregnant women without other risk factors)	**48.6%**	45.1%	**55%** (maintain higher rates where this has already been achieved)
Pregnant women	**44.9%**	42.3%	**55%** (maintain higher rates where this has already been achieved)
Health care workers	**63.2%**	50.6%	**75%**
Children aged two years old (including those in risk groups)	**38.9%**	35.4%	**40-65%** (eligible children aged 2 to 8 years)
Children aged three years old (including those in risk groups)	**41.5%**	37.7%	
Children aged four years old (including those in risk groups)	**33.9%**	30.0%	

116

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Rationale for vaccinating children against flu

Extension of the seasonal flu vaccination programme to all children aims to appreciably lower the public health impact of flu by:

- **providing direct protection** thus preventing a large number of cases of flu in children
- **providing indirect protection** by lowering flu transmission from children:
  - to other children
  - to adults
  - to those in the clinical risk groups of any age

Reducing flu transmission in the community will avert many cases of severe flu and flu-related deaths in older adults and people with clinical risk factors

Annual administration of flu vaccine to children is expected to substantially reduce flu-related illness, GP consultations, hospital admissions and deaths

117

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Changes for 2017/18

One of the virus strains in the vaccine has been changed (The A/California/7/2009 (H1N1)pdm09-like virus has been replaced by an A/Michigan/45/2015 (H1N1)pdm09-like virus)

The addition of a payment for vaccinating those with morbid obesity (defined as BMI of 40 or above) with no co-morbidities

4 year olds/ children in reception year at school will move to the school aged immunisation service

118

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Vaccination uptake in children

12 Chloe Leggat, Screening and Immunisation Co-ordinator, Leics., Lincs., Northants 2017

2016/17 childhood flu uptake

- All 2, 3 and 4 year olds were offered vaccination through GP surgeries. National uptake increased in all three ages from 2015/16 season:
  - 38.9% for two year olds
  - 41.5% for three year olds
  - 33.9% for four year olds

- 55.4% overall uptake for children in school years 1, 2 and 3
  - 57.6% school year 1
  - 55.4% school year 2
  - 53.3% school year 3

120

Flu vaccine pilot success

In flu vaccine pilot areas (2014/15) where primary school age children were given the nasal spray vaccine we saw:

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94%

Primary school aged children: GP influenza like illness consultation rates 94% lower

74%

Primary school aged children: A&E respiratory attendances 74% lower

93%

Primary school aged children: Hospital admissions due to confirmed influenza 93% lower

59%

Adults: GP influenza like illness consultation rates 59% lower

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Past and present barriers to flu vaccination uptake

Schools

- New service
- School pupil data
- Myths- gives you flu / doesn't work
- Porcine gelatine
- Anti vaccination lobby- letters to heads
- Perceived as minor illness
- Poor strain matching

General practice

- Performance and processes
- Needle phobia
- Myths
- Porcine gelatine (pre school)
- Anti vaccination lobby (social media)
- Perceived as minor illness
- Patient targeting
- Poor strain matching

122

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School flu immunisation activity- LLR

- LPT visited 375 schools and units over 10 weeks
- Offered vaccination to 78,602 children
- Vaccinated 47,464 children
- Uptake LLR 60.39%
- 529 children referred to pharmacy mop-up programme -379 vaccinated

123

Uptake Leicester City

- 102 schools
- 28,420 eligible and offered
- 12,711 vaccinated (46.6%)

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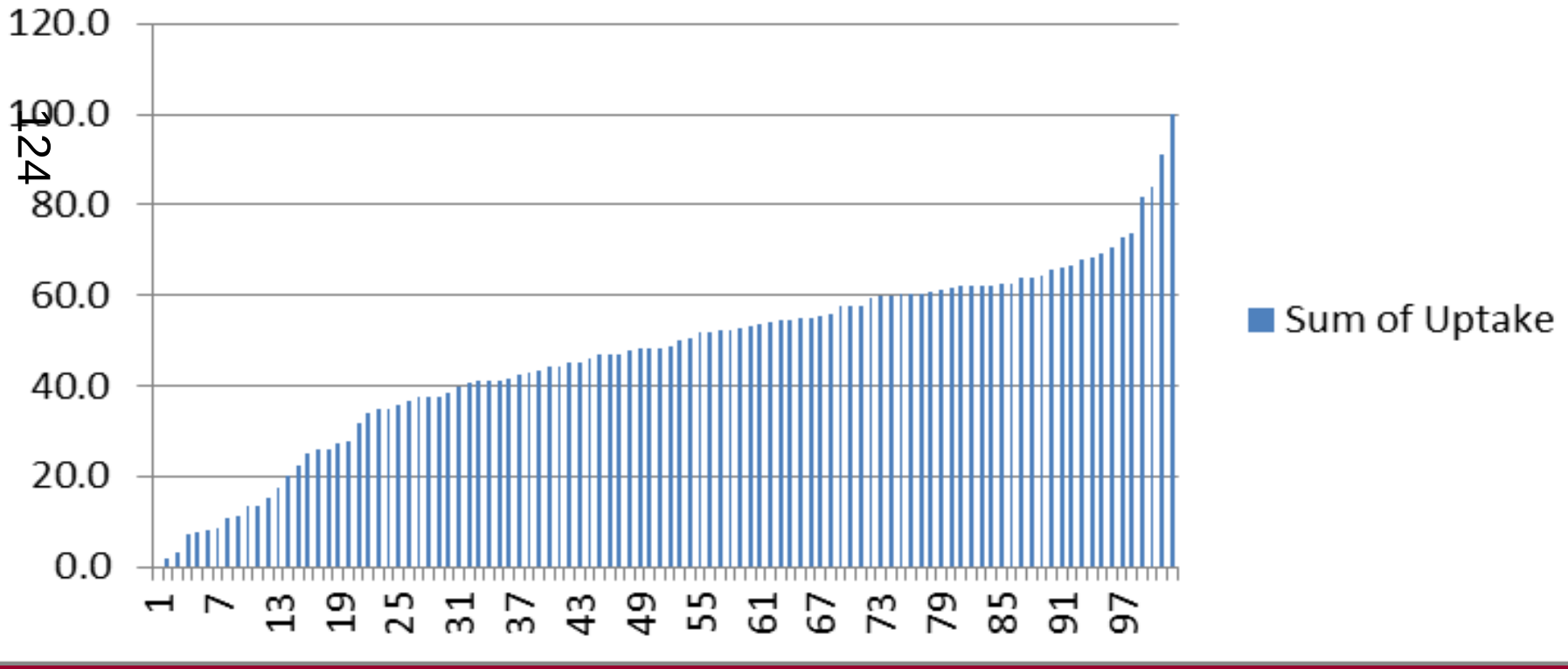
Individual school uptake Leicester City 16/17



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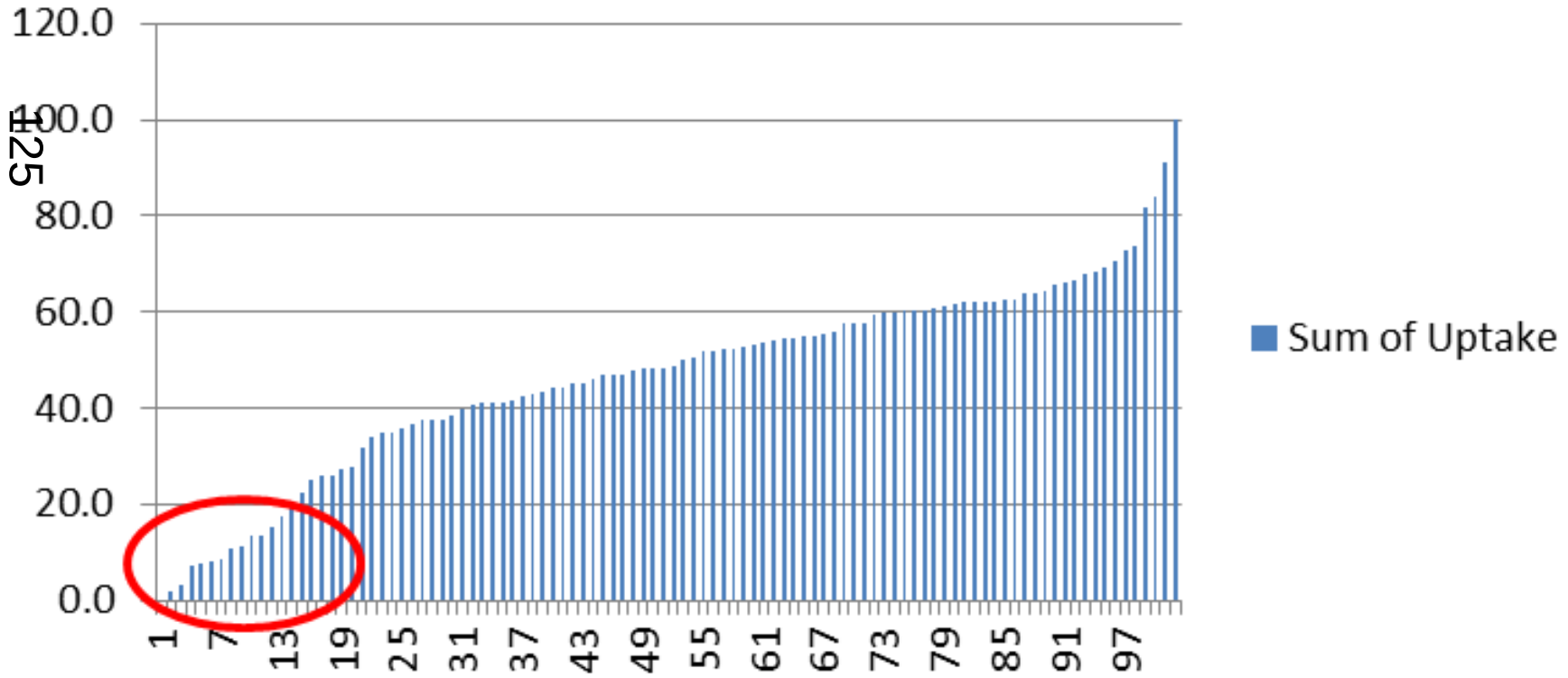
Individual school uptake Leicester City 16/17



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Improving uptake in schools

Steps taken

Early communications

Better planning

Relationships with schools improving

Ofsted

Pharmacy mop up system

Class lists/ census data

Getting better year on year

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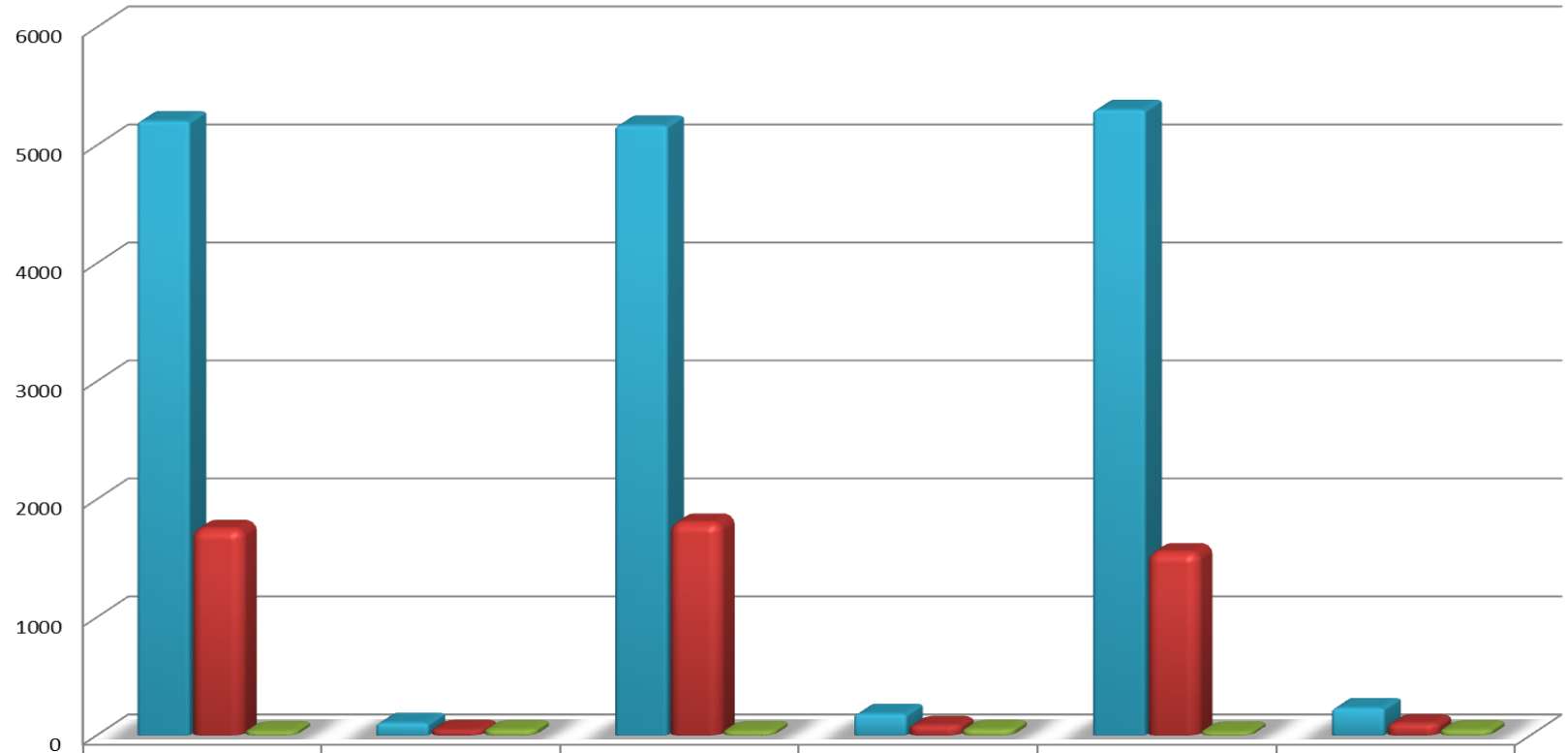
Flu Immunisation in 2,3 and 4 year olds Leicester City GP's 2016-2017



	2 year olds	2 year olds in clinical risk group	3 year olds	3 year olds in clinical risk group	4 year olds	4 year olds in clinical risk group
Patients registered	5205	106	5168	182	5301	232
No. vaccinated	1749	47	1803	84	1552	99
% uptake	33.6	44.3	34.9	46.2	29.3	42.7

127

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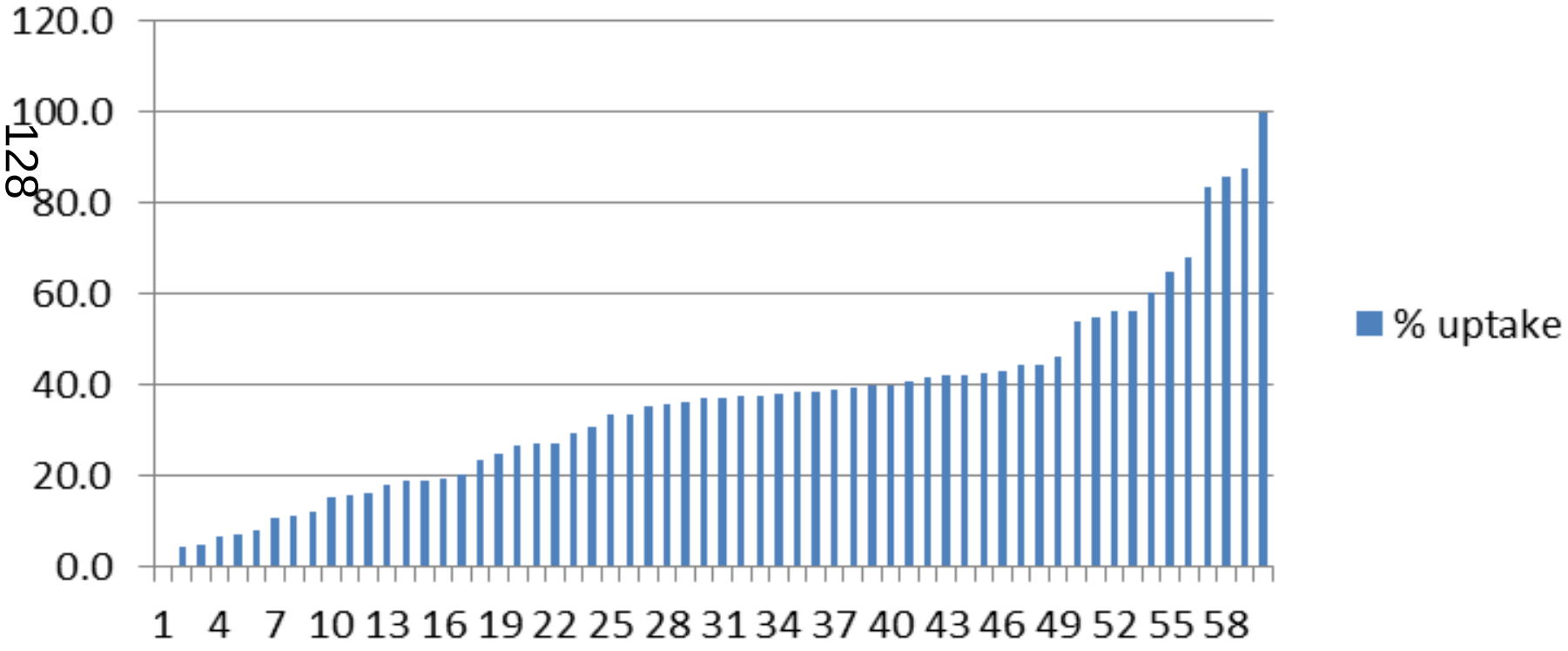
% flu vaccination uptake for 2 year olds in GP practices in Leicester City



128

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Improving uptake in general practice

- Identify lead member of staff
- Thorough planning
- Goal setting- Immform weekly update
- Identify all children
- Invitation – personalised to all children
- Clinics/appointments
- SIT letter to all 2 & 3 year olds
- Flu and pertussis in midwifery

129

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Expected circulating strains

Trivalent vaccines for use in the 2017/18 influenza season (northern hemisphere winter) contain the following:

130

- an A/Michigan/45/2015 (H1N1)pdm09-like virus; (replaces A/California/7/2009 (H1N1)pdm09-like virus)
- an A/Hong Kong/4801/2014 (H3N2)-like virus;

  B/Brisbane/60/2008-like virus.

Quadrivalent vaccines containing two influenza B viruses contain the above three viruses and a B/Phuket/3073/2013-like virus

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Health protection headlines

- Harsh flu season Australia New Zealand A/Hong Kong/4801/2014 (H3N2)- poor immunogenicity in elderly to this strain in the vaccine last year
- Estimated 60% protection in children when vaccinated with quadrivalent vaccine
- H1N1 persistently circulating in India – numerous deaths mostly in western state of Maharashtra and neighbouring Gujarat is the worst affected
- Good mood?
- Time of day?

131

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Supplementary slides

132

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SEVEN ELEMENTS TO RUNNING A SUCCESSFUL FLU CAMPAIGN

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COMMUNICATION

- Tailor your strategy to your organisation
- Mix up your communications channels – Twitter, intranet, email
- Keep staff updated throughout your campaign

BALANCED FLU TEAM

- Include staff from all parts of your organisation
- Get a good skills mix – think communications to clinical
- A diverse team will strengthen your campaign

SUPPORT – ALL HANDS ON DECK

- Have a champion to provide leadership at a senior level
- Seek involvement from the board to the ward
- Get buy-in from management to lead by example

MYTHBUSTING

- Include mythbusting in your communications
- Use clinical evidence for support
- Challenge misconceptions

PEER VACCINATION

- Use peer vaccinators
- Train clinical directors to vaccinate staff
- Utilise staff on adapted working / light duties

ACCESSIBILITY

- Set up a mobile flu vaccination clinic
- Reimburse your staff if they buy their jab externally
- Hold drop-in clinics at staff events

REWARDS

- Use incentives in your campaign
- Incentives don't need to cost a lot – be creative
- A small treat can have a big impact

flufighter

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A leading workforce campaign delivered by NHS Employers

133

Fluenz Tetra® composition 2017/18

Active ingredients:

- A/Michigan/45/2015 (H1N1)pdm09-like virus;
- A/Hong Kong/4801/2014 (H3N2)-like virus
- B/Phuket/3073/2013-like virus
- B/Brisbane/60/2008-like virus

Excipients:

- Sucrose
- Dibasic potassium phosphate
- Monobasic potassium phosphate
- Gelatin (porcine type A)
- Arginine hydrochloride
- Monosodium glutamate monohydrate
- Water for injections

Residues:

- Egg proteins (eg ovalbumin)
- Gentamicin

Image courtesy of AstraZeneca

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LAIV and 'viral shedding'

Some parents have expressed concerns that:

- as the flu vaccine is squirted out of the applicator as a fine mist, the room will be filled with flu vaccine virus, which could infect others
- children who receive the vaccine will actively 'shed' live flu virus for several days or even weeks after vaccination, thus putting others at risk of infection

They should be reassured that:

- the vaccine does not create an external mist of vaccine virus in the air when children are being vaccinated and others in the room should not be at risk of 'catching' the vaccine virus
- administration of the intranasal vaccine delivers just 0.1ml of fluid straight into each nostril and almost all the fluid is immediately absorbed into the child's nose
- although vaccinated children are known to shed virus a few days after vaccination, the vaccine virus that is shed is less able to spread from person to person than natural flu infection
- the amount of virus shed is normally below the levels needed to pass on infection to others and the virus does not survive for long outside of the body. This is in contrast to natural flu infection, which spreads easily during the flu season

135

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Porcine gelatine

- the LAIV contains a highly purified form of gelatine derived from pigs
- gelatine is used in LAIV as a stabiliser - it protects the live viruses from the effects of temperature
- gelatine is commonly used in a range of pharmaceutical products, including many capsules and some vaccines
- some faith groups do not accept the use of porcine gelatine in medicinal products
- there is no other live attenuated vaccine available that does not contain porcine gelatine. The manufacturer of LAIV (Fluenz Tetra®) tested 40 potential stabilisers – gelatine was chosen because without it, stability was significantly reduced
- current policy is that, for universal vaccination of healthy individuals, there is no suitable alternative to Fluenz Tetra®. The purpose of the childhood programme is to interrupt transmission and therefore indirectly protect the whole population. This is best achieved by offering LAIV (Fluenz Tetra®)
- see www.gov.uk/government/news/vaccines-and-gelatine-phe-response for more information on vaccines and gelatine

136

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Increasing flu immunisation uptake among children

Best practice guidance for general practice

Staff responsibilities

- every practice should have **a lead member of staff** with responsibility for running the flu immunisation campaign and all staff should know who the lead person is
- all staff should understand the reason for the programme and have access to PHE resources
- every member of the practice should know their role and responsibilities
- get all staff involved in promoting the vaccine message to parents
- hold regular meetings so that all staff know the practice plan and progress
- include health visitors, midwives, pharmacists and other healthcare professionals linked to your practice in your planning
- use NHS Employers website free resources to put your pictures on a poster (so all staff and parents know who can provide immunisation)

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Increasing flu immunisation uptake among children

Best practice guidance for general practice

Practice goals

- set a higher goal than the previous season
- create computer searches to measure uptake and assess progress towards the goal
- calculate practice income depending on uptake
- advertise the practice goal and have a 'Blue Peter' style 'Totaliser'

Identifying eligible children

- the lead member of staff to **identify eligible children**
- check accuracy of searches and coding to ensure all eligible children are identified
- make sure the correct flu vaccination codes are in your system and that staff are aware –don't let hard work go unmeasured
- create IT system reminders so that opportunistic immunisation happens
- create a system for opportunistic identification of eligible children attending the practice for other clinics or with parents and siblings – use flags or sticky notes to alert staff. Don't send a child away unimmunised

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Increasing flu immunisation uptake among children

Best practice guidance for general practice

Invitation/contacting parents

- **send a personalised invitation** to eligible children – use the parent's and child's names, sign your name at the bottom
- phone calls can be more effective than letters; and try text messages for reminders
- ensure that staff phoning patients have a script but can also answer questions and address concerns
- plan phone calls after 4pm when more working parents might be available
- send letters if telephone contact is not possible
- set a date – invite every eligible child before the end of October
- **be tenacious** – make multiple contacts until child is immunised

139

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Increasing flu immunisation uptake among children

Best practice guidance for general practice

Clinics and appointments

- plan to have completed all routine immunisation activity by Christmas
- use time after Christmas to mop-up unimmunised children, particularly children in at-risk groups. If clinically indicated vaccination can be given up to the end of March
- decide whether you will give timed appointments, run an open access clinic or invite parents to make appointments
- allow online booking for appointments
- consider family friendly clinic/appointment times such as after school 3.30pm to 6.30pm, Saturday mornings, or October half term – consider health fairs or parties – incorporating flu vaccination with other vaccines, health checks, health visitor advice
- create a child friendly environment; including room for pushchairs
- consider other clinics and busy waiting rooms

140

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Increasing flu immunisation uptake among children

Best practice guidance for general practice

Promote the vaccination offer to parents

- ensure every parent has a **personalised invitation** for their child
- display PHE child flu immunisation posters and leaflets in the reception and waiting rooms
- create attractive displays in waiting rooms. Consider posters or banners outside the practice – on a notice board, walls or even on the roof
- place prominent information about the child flu immunisation programme on the practice website
- engage with the local primary school – ask if they can give leaflets to parents with preschool age children and/or display posters on school/parent notice boards
- engage with local pre-school nurseries, children's centres, libraries, toddler groups in your area. Ask staff to put up posters and issue leaflets to parents of children who are 2 years old and older. Highlight the benefits of their children being immunised to these preschool groups and nurseries

141