Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **THURSDAY, 10 OCTOBER 2019**

TIME: **5:30 pm**

PLACE: **Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Commission

Councillor Kitterick (Chair)
Councillor Fonseca (Vice-Chair)

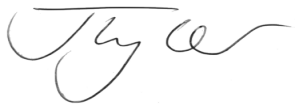
Councillors Aldred, Chamund, March, Dr Sangster and Westley

1 unallocated Non-Group place.

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester



For Monitoring Officer

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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information
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Jason Tyler, Democratic Support on (0116) 454 6359 or email jason.tyler@leicester.gov.uk
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USEFUL ACRONYMS RELATING TO
HEALTH AND WELLBEING SCRUTINY COMMISSION

Acronym	Meaning
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
BCF	Better Care Fund
BCT	Better Care Together
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
CCG	Clinical Commissioning Group
LCCCG	Leicester City Clinical Commissioning Group
ELCCG	East Leicestershire Clinical Commissioning Group
WLCCG	West Leicestershire Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DAFNE	Diabetes Adjusted Food and Nutrition Education
DES	Directly Enhanced Service
DMIRS	Digital Minor Illness Referral Service
DoSA	Diabetes for South Asians
DTOC	Delayed Transfers of Care
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EDEN	Effective Diabetes Education Now!
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
FBC	Full Business Case
FIT	Faecal Immunochemical Test
GPAU	General Practitioner Assessment Unit
GPFV	General Practice Forward View

HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HEEM	Health Education East Midlands
HWLL	Healthwatch Leicester and Leicestershire
ICS	Integrated Care System
IDT	Improved discharge pathways
ISHS	Integrated Sexual Health Service
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LTP	Long Term Plan
MECC	Making Every Contact Count
MDT	Multi-Disciplinary Team
NDPP	National Diabetes Prevention Pathway
NICE	National Institute for Health and Care Excellence
NHSE	NHS England
NQB	National Quality Board
OBC	Outline Business Case
OPEL	Operational Pressures Escalation Levels
PCN	Primary Care Network
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
QNIC	Quality Network for Inpatient CAMHS
RCR	Royal College of Radiologists
RN	Registered Nurses
RSE	Relationship and Sex Education
STI	Sexually Transmitted Infection
STP	Sustainability Transformation Plan
TasP	Treatment as Prevention
TASL	Thames Ambulance Services Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

FIRE / EMERGENCY EVACUATION

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. CHAIR'S ANNOUNCEMENTS

4. MINUTES OF PREVIOUS MEETING **Appendix A (Pages 1 - 30)**

The minutes of the meeting held on 29 August 2019 are attached and the Commission will be asked to confirm them as a correct record.

5. PROGRESS ON ACTIONS AGREED AT THE PREVIOUS MEETING

6. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any Questions, Representations and Statements of Case submitted in accordance with the Council's procedures.

The following 3 questions have been submitted by Mr Robert Ball:

(The government has announced that Leicester Hospitals NHS Trust will receive an investment of £450m to fund a massive development programme. Therefore, local NHS leaders no longer have a case for refusing to allow the public to see their detailed plans).

Question 1, against the Background above:

1. **Will University Hospitals Leicester please clarify the timescale for consultation on the hospital reconfiguration and building programme?**

(University Hospitals of Leicester (UHL) was not successful in getting funding, at this stage - to allow the plan to reorganise hospital services which will involve closing down the General as an acute hospital and moving a range of services from the General and Glenfield to the Leicester Royal Infirmary.

With no funding it's not clear how acute reconfiguration of UHL will proceed. However, any new hospital development need to take into account the UK face a climate emergency and NHS organisations need to take far-ranging action to cut the harmful impact of their activity on the environment.

The NHS is a very large organisation and its activities from travel (5% of vehicles on the road are on NHS related journey's), energy use in buildings and procurement are responsible for 6.3% of England's total carbon emissions, and 5% of total air pollution. This has direct consequences for health and health spending. Increased temperature due to the global climate crisis will lead to morbidity and mortality, for the young and the old. This is urgent and we need to act now).

Questions 2 & 3, against the background above:

2. **When will UHL declared a climate emergency, like the NHS in Greater Manchester - committing to far-ranging action to slash carbon emissions and avert predicted heat-related illness and disease?**

3. **When will UHL develop and agree a plan that will show how the NHS will meet its obligations under the Climate Change Act to achieve net zero carbon emissions by 2050?**

6A RESPONSES AND ANNOUNCEMENT - UHL TRUST

Mr John Adler, Chief Executive UHL Trust, will respond to the Questions submitted and in particular will make a statement about the recent funding announcement.

The UHL Trust's press release on the matter is copied below:

John Adler, Chief Executive of Leicester's Hospitals said: "We are ecstatic to hear that we will benefit from major national capital funding to invest in our local hospitals. This will allow us to fulfil our ambition of creating the local hospitals that our patients and staff deserve and can be proud of".

"This money will allow us to realise a major programme of investment to transform our hospitals and improve the way that we deliver care. The £450m allocated to us will allow us to create:

- *A new Maternity Hospital and dedicated Children's Hospital at the Royal Infirmary*
- *Two 'super' intensive care units with 100 beds in total, almost double the current number*
- *A major planned care Treatment Centre at the Glenfield Hospital*
- *Modernised wards, operating theatres and imaging facilities, and*
- *Additional car parking*

Karamjit Singh, Chairman of Leicester's Hospitals, said: "On behalf of our Trust Board, I would like to say how pleased we are that the need for major investment in our hospitals has been recognised. This success is testament to the hard work of all those involved in developing our plans and to the fantastic support we have had from local stakeholders. I also appreciate the recent visit the Secretary of State for Health, Matt Hancock, made to Leicester in order to see for himself the reasons why we needed this investment."

Notes:

You can find out more about our plans on our website:

https://www.leicestershospitals.nhs.uk/aboutus/building-better-hospitals/

7. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

8. LEICESTER, LEICESTERSHIRE AND RUTLAND URGENT AND EMERGENCY CARE - TRANSFORMATION PLAN

Appendix B (Pages 31 - 118)

Yasmin Sidyot, Acting Director or Urgent and Emergency Care for the LLR CCGs and Rebecca Brown, Chief Operating Officer and Deputy Chief Executive for UHL, will present the Leicester, Leicestershire and Rutland Urgency and Emergency Care vision.

9. UPDATE ON MANIFESTO COMMITMENTS

Appendix C (Pages 119 - 122)

Ivan Browne, Director of Public Health, submits a report which provides an overview of the manifesto pledges which fall under the theme of Health and Wellbeing for discussion.

10. WORK PROGRAMME

Appendix D (Pages 123 - 124)

The Work Programme for the Commission is attached for information and comment.

11. ANY OTHER URGENT BUSINESS

(i) UHL TRUST BRIEFING PAPER

Hospital Close Residences and Jarrom Street Proposed Development

The attached Briefing Note will be considered as an item of urgent business. This is because of the timing of the update and undue delay if consideration was deferred until the next meeting.

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: THURSDAY, 29 AUGUST 2019 at 5:30 pm

P R E S E N T :

Councillor Kitterick (Chair)
Councillor Fonseca (Vice-Chair)

Councillor Chamund
Councillor Dr Sangster
Councillor March

In Attendance:

Councillor Dempster, Assistant City Mayor - Health

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17. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Aldred and Councillor Westley.

18. DECLARATIONS OF INTEREST

No declarations were made.

19. MINUTES OF PREVIOUS MEETING

Further to minute 10, “Primary Care Hub Access at the Merlyn Vaz Health and Social Care Centre”, it was noted that the discussions on how an analysis of patient experiences following the introduction of a hybrid system for accessing services at the Merlyn Vaz Centre could be undertaken had not been held yet.

Further to minute 15, “Work Programme”, it was noted that scrutiny of issues such as education Health Care Plans for children, childhood obesity and children’s mental health services would be undertaken with the Children, Young People and Schools Scrutiny Commission at he January meeting of the

Health and Wellbeing Scrutiny Commission.

AGREED:

that the minutes of the meeting of the Health and Wellbeing Scrutiny Commission held on 4 July 2019 be confirmed as a correct record, subject to the first line of paragraph 12 of minute 10, "Primary Care Hub Access at the Merlyn Vaz Health and Social Care Centre", being amended as follows (new wording in italics):

"~~Sarah Prema~~ *Harsha Kotecha*, *Chair of* Healthwatch, advised that Healthwatch had visited two hubs …"

20. CHAIR'S ANNOUNCEMENTS

No announcements were made.

21. PETITIONS

The Monitoring Officer reported that no petitions had been received.

22. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

Ms Lucy Chaplin submitted the following representation:

"Are health providers aware that by offering mental health support through mainly telephone-based services that phone companies - particularly mobile phone companies - do not inform users that they may have used up contracted minutes and accumulated large phone bills in accessing the support they need?

While it is very helpful to be able to call the crisis team, and other services, it is very difficult to keep track of time. Indeed why should someone who is already so unwell that they need these services have the additional burden of thinking about their phone bill?

Has any part of the NHS looked into this, or discussed the issue with mobile phone companies, as many patients with severe mental health problems are already on reduced income, indeed many are classed as homeless, and cannot afford huge phone bills. When people can't pay the bill their phones are barred by companies, which actually cuts patients off from ALL the support networks they have.

This is like an additional tax, and additional stress, on those who are ill with poor mental health, as is discriminatory.

Responses from the CCG and LPT would be welcome.

I would also ask that the Leicester City Council Health and Wellbeing scrutiny commission agrees to take this up with NHS England and asks that there are agreements with phone companies about making those

telephone services COMPLETELY freephone - in order that already vulnerable people are not faced with huge bills just for accessing the services they need.

Is Leicestershire the only place where this happens?

I've also copied in Keith Vaz as my local MP and Jon Ashworth MP as the shadow Health secretary as they could also take this up nationally.

It is a scandal that while society tries to breakdown the stigma of poor mental health, the telephone companies are making a lot of money from people accessing help, especially when that help is mostly available only via telephone."

On behalf of Leicester City Clinical Commissioning Group, Richard Morris (Director of Corporate Affairs) gave the following response:

"We would like to thank Ms Chaplin for raising these issues. We have spoken with Leicestershire Partnership NHS Trust who have provided the following response:

'Where phone-based support is offered to our patients and service users we want to ensure it is accessible and affordable. Our 24-hour mental health crisis support line, commissioned from our partners at Turning Point, is free to call from landlines and most mobile networks and a call-back service is also offered via email request. Similarly, our suite of ChatHealth support services provide confidential support via a secure text messaging service.

Where individuals are given landline numbers we also aim to ensure they have information about the other options open to them. However, if there is more we can do we will certainly consider it and we are grateful for this helpful feedback. We will be reviewing it as part of our plans to develop of a single central access point as part of our All-Age Transformation programme to transform our mental health and learning disabilities services.'

The local clinical commissioning groups are working with LPT to support them in their plans to transform local services.

We also believe that Ms Chaplin's feedback raises national challenges relating to accessibility and cost of phone lines. This in turn raises potential issues with availability of funding, patient confidentiality and the need to work with phone companies to bring about change. This issue is therefore wider than Leicester, Leicestershire and Rutland and may also affect a broader range of health services. As such we will be raising the matter with NHS England for their consideration."

AGREED:

That the Leicester City Clinical Commissioning Group be asked to

circulate the letter sent to NHS England in relation to this matter, and any response received, to the members of this Commission for information.

23. LEICESTERSHIRE PARTNERSHIP NHS TRUST: UPDATE ON STEPS TAKEN IN RESPONSE TO REGULATORY INSPECTIONS

Angela Hillery, Chief Executive Officer, and Anne-Maria Newham, Director of Nursing (AHPs & Quality), from the Leicestershire Partnership NHS Trust (LPT) gave a presentation providing the Commission with details on the current Care Quality Commission (CQC) position for LPT, assurance around actions that had been taken following recent inspections and the Trust's approach to monitoring and embedding these actions. A copy of this presentation is attached at the end of these minutes for information.

During the presentation, Ms Hillery drew particular attention to the following:

- Full information on the results of the CQC regulatory inspections was available on the LPT's website (www.leicspart.nhs.uk);

- The STEP up to GREAT strategy was the focus for the whole Trust. A director had been assigned to each area of the strategy, and these directors had responsibility and accountability for taking their areas forward. The Programme Management office supported them in doing this;

- Nationally, the use of dormitory accommodation in mental health units was considered unacceptable. The LPT endorsed this view and was trying to find capital funding to eliminate it in the Trust's facilities;

- Staff were at the heart of change, so a number of Change Champions had been recruited across the organisation. Approximately 80 people had volunteered for this role and had provided useful insights in to the organisation culture, what worked and what did not work;

- The CQC had undertaken an unannounced inspection in June 2019 and had identified some encouraging improvements. For example, improvements had been made in recording patients' physical healthcare and monitoring patients with ongoing physical healthcare problems, so mental health services did not just focus on mental health. Fire safety also was much improved, part of which was enforcement of the 'No Smoking' policy. However, most mental health units nationally found this difficult to implement, as people attending these units often were in distress and smoking provided them some relief from this;

- As the waiting list of children and young people waiting for treatment had increased and the demand for neurodevelopment assessment remained high, work needed to be undertaken with the Trust's commissioning partners to improve access to these services and ensure they were appropriate;

- An intensive support team from NHS England had looked at the commissioning and provision of Child and Adolescent Mental Health Services (CAMHS);

- Awarding a rating was not part of the process of the inspection undertaken in June, but the Warning Notice was removed following that inspection; and

- The LPT would have a re-inspection sometime from October or November 2019 onwards, when it was hoped that some improvement would be seen.

Ms Newham assured the Commission that the LPT was not being complacent about this work. It was recognised that the Trust had not worked well co-operatively in the past, but this had been addressed. It also was recognised that the Trust had not provided good responses to complaints in the past, particularly telephone complaints, and this also was being addressed.

Rachel Bilsborough, Divisional Director Community Health with the LPT, stressed that staff on the ground were being fully supported to understand the continual cycle of improvement being undertaken, to ensure that they were aware that these were not one-off improvements and needed to be embedded in the organisation. This was a new approach for the Trust.

Ms Hillery recognised that the Trust had a lot of priorities and it could be hard for staff to navigate through them in order to contribute to the improvements being made. The priorities therefore needed to be simplified, so that all contributions also were clearer. To facilitate this, the complexities of management structures also needed to be made clearer, as did the way in which the various parts of the organisation worked together. There had been some separate attempts to explain individual elements of this, but these had not made it clear how those elements affected the Trust as a whole. The Change Champions therefore were now working with the directors leading change to remedy this.

Michael Smith, Healthwatch, enquired how patient experience was captured and understood pro-actively by the Trust. In reply, Ms Hillery noted that Mark Wightman, Director of Strategy and Communications with University Hospitals of Leicester NHS Trust, was on the LPT Board, which helped improve the Trust's understanding of patient experience. In addition, patient involvement teams from the Trust were visiting communities and trying to ensure that 'harder to see' patients were identified and their experiences captured. This work was ongoing. Ms Newham stressed that this needed to be done throughout the Trust, as it was a core area to which the Trust needed to give attention.

In response to an enquiry from Mr Smith regarding whether district nursing was a stress area, Ms Bilsborough explained that district nursing services had been inspected by the CQC in 2018 and had been categorised as a Good component of community services.

Members expressed some concern that ligature risks had been highlighted as

an area needing attention for a number of years. Ms Newham and Ms Hillery explained that the service was not necessarily missing ligature risks, but as environments changed, (for example, through works to buildings), patients found different ways in which to use fixed and non-fixed ligatures. There had been no fixed ligature incidents in the Trust for a number of years, but continual audits of premises were undertaken and external advice taken, including from other trusts. The CQC had identified some potential ligature points, such as radiators positioned away from walls, but welcomed the plans that had been produced for each ward identifying all points of concern.

Members raised concerns that problems at the Bradgate Unit had been known about for some time, but did not appear to have been addressed before now. It therefore was questioned whether the LPT could be confident of getting funding needed and improving the service rating. Ms Hillery explained that the Sustainability and Transformation Partnership and the Better Care Together programme agreed priorities for the population, but the LPT had to develop the business case for this expenditure. This then had to receive system support for the work to be identified as a priority, followed by approval from the system partners. This funding bid would be separate from bids for other projects or programmes.

The business case for funding for improvements to the Bradgate Unit was being prepared and it was anticipated that the LPT would consider it in September, following which it could be shared with other partners. Other trusts had reduced the number of beds available in order to create single accommodation, but beds in Leicestershire already were under significant pressure, which was an important consideration. It was noted that it could take some time to acquire the necessary funding, so clear plans also were needed for the interim period.

The Commission enquired how the Trust approached equalities, particularly for women. In reply, Ms Hillery explained that the LPT had a very good champion and lead on this, who was assessing what work was being done in this area. Work also was being done with NHS national teams, such as the Race Equality team, to identify any further action that could be taken. An update on progress with this could be given to the Commission in due course.

The Commission noted that the LPT was working in partnership with Northamptonshire Healthcare NHS Foundation Trust (NHFT), having a shared Chief Executive. Ms Hillery explained that this was a “buddy” relationship. When NHS Improvement (NHSI) felt that a trust needed support, a near-by trust with a Good or Outstanding rating was asked to provide “buddy” support. The LPT had been approached before the support was put in place to ensure that it was comfortable with the arrangement.

Although a shared Chief Executive role provided the infrastructure for support for the LPT, but care was taken to ensure that this was not to the detriment of the NHFT. Ms Hillery stressed that the “buddy” arrangement was not a take-over by NHFT or a merger of the two trusts, although it was a formal arrangement. NHSI provided some resource towards backfilling time in relation

to the joint Chief Executive role if needed and the regulators would require reasons to be given if either party withdrew from the arrangement.

As an example of the type of work now being undertaken, Ms Newham noted that the LPT and the NHFT had worked together on nursing, enabling ideas to be shared without having to go through development processes already undertaken by either trust.

It was noted that the current "buddy" arrangement was for 12 months. Monthly monitoring was undertaken to ensure that learning was happening and a yearly review, based on the financial year, would be undertaken to ensure that the arrangement was making a difference. During this time, work with other trusts would continue, such as that on reducing CAMHS waiting lists, and a CQC inspection was anticipated during the partnership period.

Ms Hillery explained that the LPT needed more robust governance. Her experience from other organisations was that it took approximately three years to move to an Outstanding rating, although a Good rating could be achieved in the interim. As this involved a change in culture, it would not be an easy change to make, but the Board had been very receptive to changes and suggestions made.

Tim Sacks, Chief Operating Officer at East Leicestershire and Rutland Clinical Commissioning Group, emphasised that change would take time, but he also noted that very real change and engagement already had taken place, which was a welcome start to the process. Tamsin Hooton, CCG Director Lead for Community Services Redesign, agreed with this, noting that work with nurses was key to the process and had started straight away.

AGREED:

1) That the presentation be received and noted;

2) That the improvements made to date be welcomed;

3) That the Leicestershire Partnership Trust be asked to provide:

    a) an update on its work on equalities at an appropriate time;

    b) a report at the end of 2019 on progress with the redevelopment of the Bradgate Unit, this report to include the design of accommodation at the Unit and the business case for, and progress with, the acquisition of the funding required; and

    c) information on why some service areas had not been rated during Care Quality Commission regulatory inspections.

4) That the Leicestershire Partnership Trust be asked to present for scrutiny by this Commission at the appropriate time details of any further changes and/or improvements made in response to Care

Quality Commission regulatory inspections.

24. LEICESTER, LEICESTERSHIRE AND RUTLAND 2019/20-2023/24 PRIMARY CARE STRATEGY

The Leicester, Leicestershire and Rutland 2019/20-2023/24 Primary Care Strategy was submitted by the Leicester City, West Leicestershire and East Leicestershire & Rutland Clinical Commissioning Groups (CCGs).

Tim Sacks, Chief Operating Officer at East Leicestershire and Rutland Clinical Commissioning Group, explained that the CCGs had been asked to produce the Strategy, to show how primary care practice would be driven forward, including how it was envisaged Primary Care Networks (PCNs) would work together and impact on the functions of CCGs. This therefore was a high-level plan, from which an operational plan would be developed.

The Strategy would be delivered through the PCNs, but meetings to discuss how this would be achieved had only just started, so it was anticipated that it would take time to implement the Strategy. Directors across the three organisations were taking the lead on portfolios within the Strategy to ensure their delivery.

To facilitate this, new funding was being provided, which included funding for the PCNs and for 12 or 13 additional clinical staff. Initial funding was for five years and it was hoped that during the first year funding would have been accessed, staff appointed and trained, and patients would be seeing improvements in access and care. Government guidance indicated that funding would only be released when the additional clinical staff had been employed. There also had been an increase in funding for GP practices this year, with an additional 1.5% being provided for core practice services.

The Commission expressed some concern that structures were being funded, not services. In reply, Mr Sacks explained that the roles in PCNs were very specific, so with the additional staff delivering other services more time was available in practices for providing core services.

It was stressed that the differences between PCNs, (for example, in demographics and resources), needed to be taken in to account. Services therefore needed to be locally responsive and to address the concerns of patients in each area, so would be commissioned accordingly. Practices could ask to move between PCNs, or they could be expelled from a PCN, which could change the resources and demographics of those PCNs and it was anticipated that there would be some movement over time.

Improvements in primary care would be determined through analysis of data by NHS England and the establishment of local benchmarks. The three basic aims of improving care, access and outcomes had been set by the CCGs and would be achieved through delivery in the seven key contract areas. At present, performance indicators for these had not been created, so work was underway to establish the base line. Risk stratification scores and national

standards of care also would be used to direct service delivery and improvement. Progress with the Strategy was monitored through the national workforce survey, which was held every three months and to which all practices were required to respond.

This structure meant that it was possible that improvements would not be reflected in patient surveys during the first year, but it would be disappointing if improvements were not seen in the second year.

Michael Smith, Healthwatch, stressed that patients' experience of visiting GPs was an important part of this and Healthwatch would know quickly if improvements were being made, (for example, if greater, and more timely, access to GPs was available). He suggested that monitoring the use of primary care hubs could be an indicator of such improvements, as the improvements described should reduce the need for people to use the hubs.

Concern was expressed that as the number of PCNs increased, so did the possibility of privatising services if users' needs were not being met. In reply, Mr Sacks explained that GP practices in PCNs still had their own independent contracts with the NHS. The PCN contract was an addition to this, but could mean that service delivery had to change to enable the practices to work together in different ways through the PCNs.

During discussion on the Strategy, the Commission noted that social prescribing was a way of supporting GPs in relation to patients' non-clinical needs through prescribing things such as swimming sessions. In order to maximise opportunities for this, consideration needed to be given to how health organisations and local authorities worked together.

The Commission noted that, although a priority in relation to personal health budgets was to work with people with frailties, these people could be reticent to take up these budgets. In reply, Mr Sacks explained that there were defined markers for frailty, but a personal health budget was a choice, so people did not have to have one and did not receive a lesser service if they chose not to have one.

Members also expressed concern that the target of recruiting 30 GPs from overseas in the next five years appeared to lack ambition. It was noted by Mr Sacks that reference to this in the Strategy related to relocation costs for 30 GPs, not pay, and funding was only for 30, so any more would have to be funded by the CCGs. However, Richard Morris, Director of Corporate Affairs at Leicester City Clinical Commissioning Group, noted that the increase in GPs from abroad coming to Leicester in recent years was higher than the national average, as a result of ongoing work to encourage GPs to consider moving to the city. Mr Sacks also advised that more newly qualified GPs who trained in Leicester, Leicestershire and Rutland stayed in the area than the national average, but many GPs working in these areas were doing fewer clinical sessions.

Mr Smith asked that consideration be given to consulting on the different parts

of the Strategy whenever possible, as this helped to build public trust. Mr Sacks advised that this was done, and would continue, as engagement was considered to be very important.

Members were reminded that information on attendance statistics at hospital Accident and Emergency services had been circulated following the last meeting of the Commission, (minute 10, "Primary Care Hub Access at the Merlyn Vaz Health and Social Care Centre", referred). These statistics are attached at the end of these minutes for information.

Mr Morris noted that the number of attendances at the Accident and Emergency department by people aged 21-25 were consistent with expectations in a city like Leicester. Tamsin Hooton, CCG Director Lead for Community Services Redesign, explained that these numbers partly reflected the number of young people in the city due to it having two universities, but they also were partly due to people choosing to go to Accident and Emergency services, rather than seeking alternative assistance. Work therefore needed to be done on encouraging them to deflect to other services where appropriate.

Some GP practices had low presentation rates, with more of their patients using Accident and Emergency services. This could be for a number of reasons. For example, it was known that one practice in the city with low presentation rates had the highest number of registered patients living in care homes in the city and these residents often were taken to the hospital Accident and Emergency department as a first choice destination.

It was noted that homeless people could register with a GP practice, but nationally there were problems in encouraging them to do so. Homeless people therefore tended to present in high numbers at Accident and Emergency services, but locally Inclusion Healthcare was rated excellent and was very pro-active, including walking round the streets with clinical staff and having conversations with homeless people about their health.

AGREED:

1) That the Leicester City, West Leicestershire and East Leicestershire & Rutland Clinical Commissioning Groups be asked to provide the Commission with:

    a) a review of progress with implementing the Leicester, Leicestershire and Rutland 2019/20-2023/24 Primary Care Strategy early in 2020, this review to include information on funding and expenditure; and

    b) information on the work being done to deflect people from using hospital Accident and Emergency services when appropriate; and

2) That Healthwatch be asked to provide the Commission with a review of progress it identifies in the implementation of the Leicester, Leicestershire and Rutland 2019/20-2023/24 Primary

Care at the same time as the review requested under 1a) above is presented to the Commission.

Councillor Dr Sangster left the meeting during discussion on this item.

25. COMMUNITY SERVICES REDESIGN - FUTURE MODEL OF CARE, IMPLEMENTATION AND NEXT STEPS

The Leicester, Leicestershire and Rutland Clinical Commissioning Groups (CCGs) submitted a report describing the Community Services Redesign project to date. The report set out the future model that the CCGs would commission, describing what impact that would have on the care people received and what that would mean to other parts of the health and care system in Leicester, Leicestershire and Rutland. The report also outlined the next steps in the CCGs' work on community health services.

Tamsin Hooton, CCG Director Lead for Community Services Redesign, introduced the report, making the following points:

- Adult community health services in Leicester, Leicestershire and Rutland were being reviewed as they had not been commissioned to work with other health care providers in a way that was consistent with how health care would be provided in the future;

- Some of the perceived deficits it was hoped to address included services for people in crisis and the capacity of community nursing services;

- A new model of care had been developed, based on feedback, which showed that a lot of services were not seen as being joined up;

- A new model of home-based care had been designed, comprising of three parts: neighbourhood community nursing and therapy services, Home First services and Locality Decision units;

- As part of this, investment was being made in greater GP capacity through Primary Care Networks;

- The key change in the first phase of introducing the new model would be the reorganisation of teams within the Leicestershire Partnership NHS Trust (LPT) by the end of 2019 and increasing capacity through to early 2020;

- A system transformation working group had been established and included various partners, such as University Hospitals of Leicester NHS Trust (UHL); and

- The success of the redesign would be assessed by a steering group comprised of various partners looking at the impact that the redesign had on people's experiences, including whether they were able to stay at home, and the impact on community hospitals.

Rachel Bilsborough, Divisional Director Community Health with LPT, advised the Commission that the redesign was being co-produced by health care professionals, Healthwatch and patients, carers and users. Service users would be the same people as previously and they would have the same needs, but the care received would be changing under the redesign. The LPT Board would consider the proposals on 30 August 2019.

Members noted that the service already had a strong relationship with the City Council and this would be built on through the redesign, but Council staff would remain working for the Council. Ms Hooton also noted that the City Council's Adult Social Care service had been very engaged in the redesign of Community Services, helping with things such as the testing of new models.

The Commission noted that a significant workforce challenge would be in the number of therapy staff employed, as this currently was lower than national averages. In addition, integrating therapy services and acute social care could be problematic, as people were being discharged to go home for assessment to be undertaken there, but therapy services had not yet moved to that model.

Retention of staff was a problem in some parts of the city. This also was affected by the national shortage of Band 5 registered nurses and problems regarding the supply of newly qualified nurses, the latter relating at least in part to changes in the number of training places available and the availability of bursaries. Suggestions of how people could be incentivised to work in the city, or assistance with doing this, therefore would be welcome.

It was noted that District Nurses often had problems parking near homes they were visiting. This could be problematic, as they often had to carry equipment in to the homes. The Commission noted that a scheme allowing parking in restricted areas for people in this situation had been tried previously, but had not been successful. However, it was suggested that discussions on possible options for such a scheme could be held.

Members noted that consultancy support had been provided by Deloitte. This had been sourced by NHS England and offered as a support package to work on some areas of the service redesign. Funding also was provided by NHS England. Deloitte's involvement in this work had now ended.

The Commission recognised that this was an evolving service model, but queried how it would be assessed whether the new service design was successful. In reply, Mr Sacks explained that a set of outcomes had been identified, but some of these were reliant on other organisations, such as social care performance indicators.

AGREED:

1) That the Scrutiny Policy Officer be asked to liaise with members of this Commission to establish a small "task and finish" group to consider how parking problems being experienced by Community Services providers can be addressed; and

2) That the Leicester, Leicestershire and Rutland Clinical Commissioning Groups be asked to report back to this Commission in one year on how the redesigned Community Services are evolving.

26. WORK PROGRAMME

AGREED:

The work programme for the Commission be received and noted.

27. CLOSE OF MEETING

The meeting closed at 8.15 pm

Leicestershire Partnership
NHS Trust

Health & Wellbeing Scrutiny Commission

LPT: Update on steps taken in response to regulatory inspections

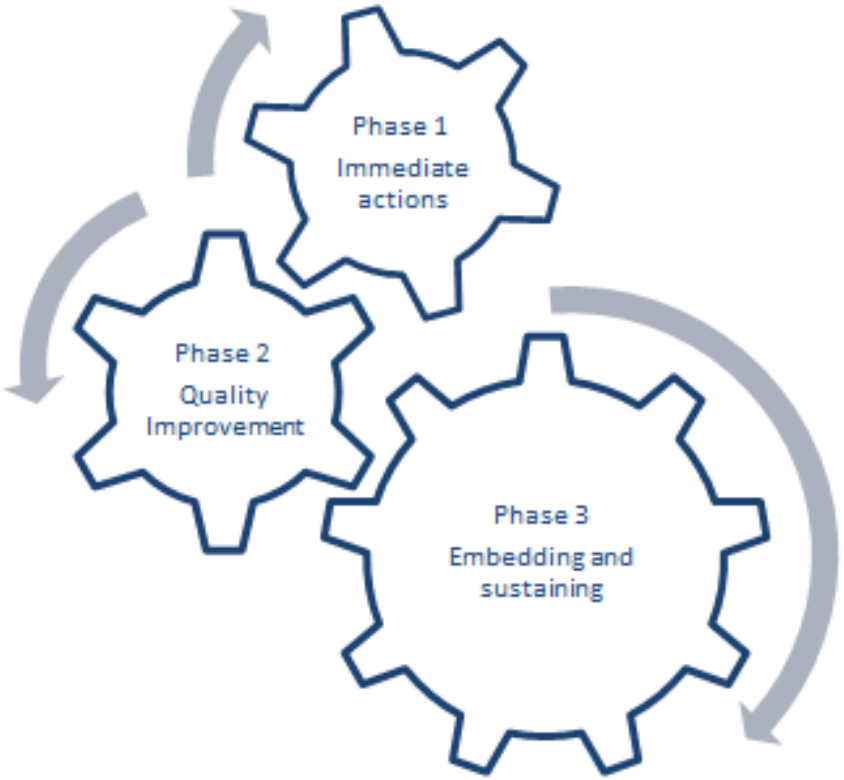
15

Minute Item 23

WeAreLPT
compassion respect
integrity trust

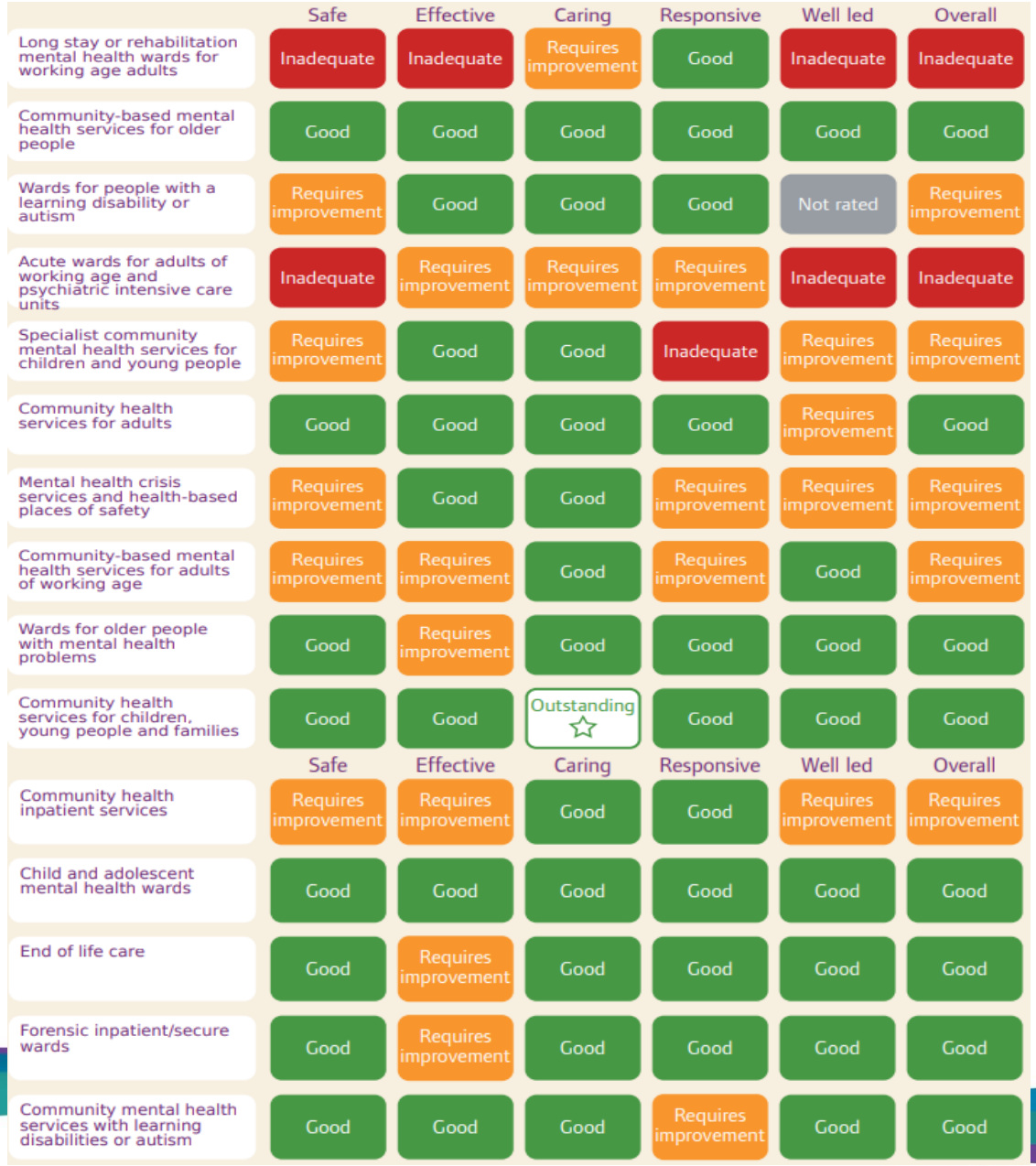
www.leicspart.nhs.uk

Approach for responding to regulatory inspections



CQC Warning Notice – Key Areas

1. Access to services – waits for CAMHS
2. Mixed sex accommodation issues
3. Environment including ligatures
4. Fire safety including smoking
5. Medicines management
6. Seclusion
7. Care planning – physical care/risk assessments
8. Governance / Learning



	Safe	Effective	Caring	Responsive	Well led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Inadequate	Requires improvement	Good	Inadequate	Inadequate
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Wards for people with a learning disability or autism	Requires improvement	Good	Good	Good	Not rated	Requires improvement
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Specialist community mental health services for children and young people	Requires improvement	Good	Good	Inadequate	Requires improvement	Requires improvement
Community health services for adults	Good	Good	Good	Good	Requires improvement	Good
Mental health crisis services and health-based places of safety	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Community-based mental health services for adults of working age	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Wards for older people with mental health problems	Good	Requires improvement	Good	Good	Good	Good
Community health services for children, young people and families	Good	Good	Outstanding ☆	Good	Good	Good
	Safe	Effective	Caring	Responsive	Well led	Overall
Community health inpatient services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Forensic inpatient/secure wards	Good	Requires improvement	Good	Good	Good	Good
Community mental health services with learning disabilities or autism	Good	Good	Good	Requires improvement	Good	Good

Identified essentials for success

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Bradgate Unit

New flooring, windows and lighting

Improvements to medication disposal, labelling and the management of controlled drugs

Staff and patient involvement

Change Champions

Freedom to speak up partners

Involvement Centre

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Our progress to date

CQC re-inspection report (9th August 2019)

Unannounced inspection in June 2019 to follow up on enforcement action issued after the last core service inspection dated November 2018

Key identified improvements;

- Significant improvement has been made to the environments at most wards.
- There were improvements in ligature risk assessments.
- Improvement in recording patient's physical healthcare, monitored patients with ongoing physical healthcare problems, and maintained privacy and dignity.
- Improved medicines management, this includes the labelling, disposal, reconciliation and ward level audit.
- Some improvements addressing no smoking policy at the Bradgate Mental Health Unit.
- Fire safety is much improved.
- Some improvement in seclusion documentation and new paperwork introduced.
- Significantly reduced waiting times for children and young people waiting for assessment.

Our progress to date

Actions still to do

- Further improvement to environments at Bradgate Mental Health Unit needed.
- Pharmacy oversight in medicines management needs strengthening.
- Quality of recording seclusion requires further improvement.
- Waiting list of children and young people waiting for treatment has increased. Demand for neurodevelopment assessment remains high.

Support and Scrutiny

Buddy Relationship with NHFT

Infection Prevention Visit

External Reviews

1. Governance

2. Learning from SIs

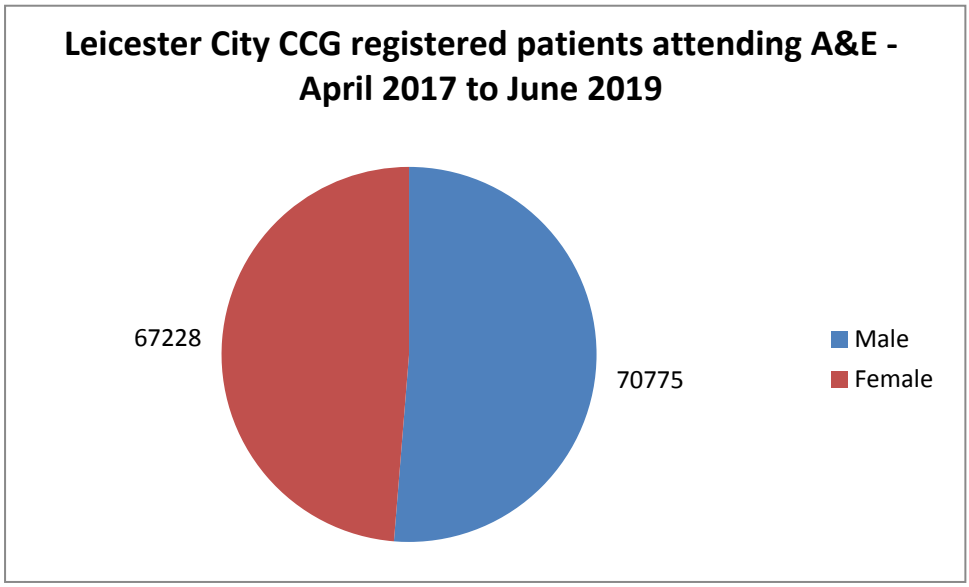
Intensive Support Team from NHSEI

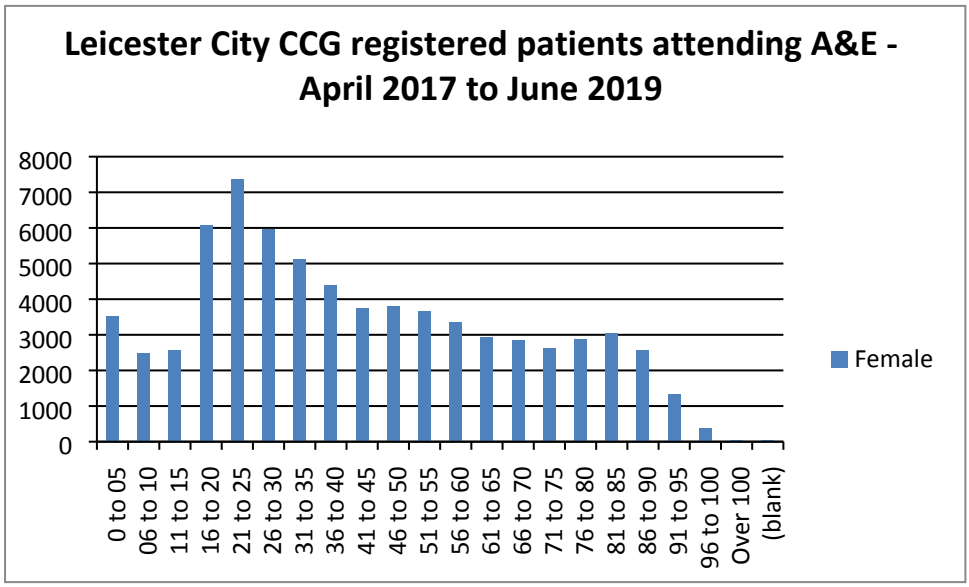
Questions?

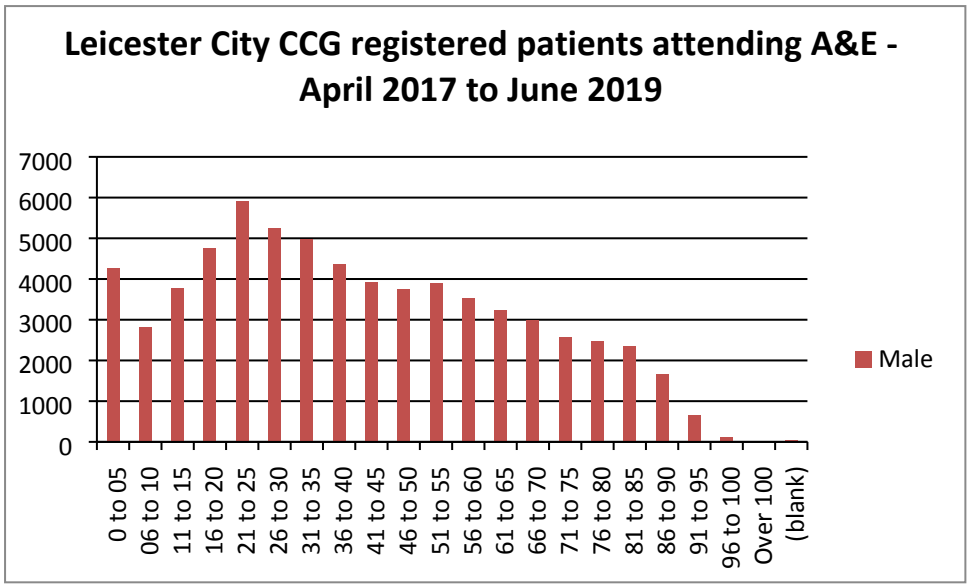
UPDATE ON ACTIONS FROM LEICESTER CITY HEALTH SCRUTINY COMMISSION

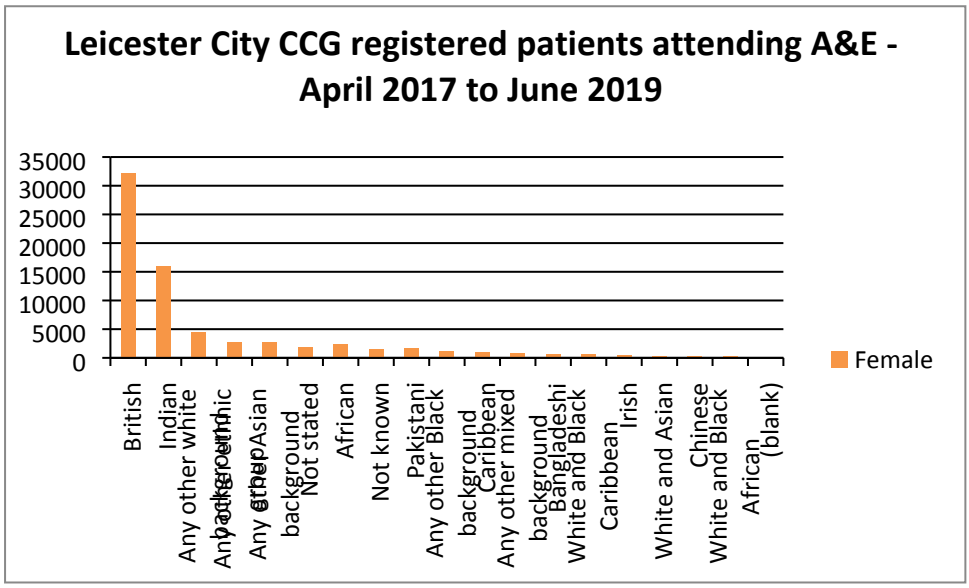
PRIMARY CARE HUB ACCESS AT THE MERLYN VAZ HEALTH AND SOCIAL CARE CENTRE

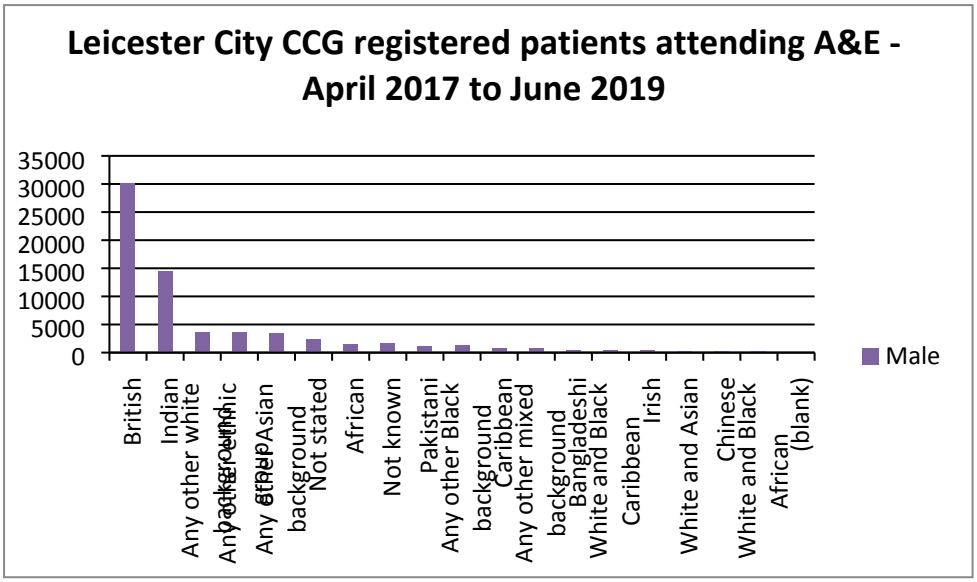
1. **Demographic profiling of Leicester City CCG registered patients attending A&E – April 2017 to June 2019**






Leicester City CCG registered patients attending A&E - April 2017 to June 2019
7000
6000
5000
4000
3000
2000
1000
0
0 to 05
06 to 10
11 to 15
16 to 20
21 to 25
26 to 30
31 to 35
36 to 40
41 to 45
46 to 50
51 to 55
56 to 60
61 to 65
66 to 70
71 to 75
76 to 80
81 to 85
86 to 90
91 to 95
96 to 100
Over 100
(blank)
Male


Leicester City CCG registered patients attending A&E - April 2017 to June 2019
35000
30000
25000
20000
15000
10000
5000
0
British
Indian
Any other white background
Any other Asian background
Not stated
African
Not known
Pakistani
Any other Black background
Any other mixed background
Bangladeshi
White and Black Caribbean
Irish
White and Asian
Chinese
White and Black African
(blank)
Female



Leicester City CCG registered patients attending A&E - Weighted attendance (12 month average) per 1000 patients

Attendance at A&E	Average weighting
GP Practice	
INCLUSION HEALTHCARE	126.72
LEICESTER CITY ASSIST PRACTICE	40.68
THE PRACTICE BEAUMONT LEYS	40.57
BOWLING GREEN STREET SURGERY	38.22
THE HEDGES MEDICAL CENTRE (SA BAILEY)	34.03
THE SURGERY @ AYLESTONE	33.73
HOCKLEY FARM MED PRACT (A NANA)	33.42
WESTCOTES GP SURGERY (ONE)	32.95
PASLEY ROAD HEALTH CENTRE (G SINGH)	31.59
WESTCOTES GP SURGERY (TWO)	31.20
THE PARKS MEDICAL CENTRE (B HAINSWORTH)	31.19
PARKER DRIVE SURGERY	30.97
SAFFRON GROUP PRACTICE	30.96
BEAUMONT LODGE MEDICAL PRACTICE	30.37
WESTCOTES MEDICAL CENTRE	30.28
ST PETER'S MED CENTRE (MANSINGH & MEHRA)	30.27
THE WILLOWS MEDICAL CENTRE	30.11
HERON GP PRACTICE	29.55
ST ELIZABETH'S MEDICAL CENTRE (JA WOOD)	29.25
ASQUITH SURGERY	28.81
WILLOWBROOK MEDICAL CENTRE (JG ASTLES)	28.04
EAST LEICESTER MED PRACT(S LONGWORTH)	27.88
GROBY ROAD MEDICAL CENTRE (ID PATCHETT)	27.85

PASLEY ROAD HEALTH CENTRE (TK KHONG)	27.62
OAKMEADOW SURGERY (RA LEACH)	27.31
MERRIDALE MEDICAL CENTRE (RP TEW)	27.19
SHEFA MEDICAL PRACTICE	27.01
RUSHEY MEAD HEALTH CENTRE	26.89
BRANDON STREET SURGERY	26.75
COMMUNITY HEALTH CENTRE (ZS OSAMA)	26.55
HUMBERSTONE MEDICAL CENTRE (IP JONES)	26.12
FOSSE FAMILY	26.03
HIGHFIELDS SURGERY (R WADHWA)	25.84
FOSSE MEDICAL CENTRE (GK SHARMA)	25.55
DR S SHAFI	25.48
AL-WAQAS MEDICAL CENTRE	25.26
AYLESTONE HEALTH CENTRE	24.66
HEATHERBROOK SURGERY (RP ARCHER)	24.19
THE PRACTICE-SAYEED	24.19
THE CHARNWOOD PRACTICE	24.11
WALNUT ST MED CTR (LEICESTER MED GROUP)	23.94
WESTCOTES HEALTH CENTRE (RL HAZELDINE)	23.82
JOHNSON MEDICAL PRACTICE	23.63
HIGHFIELDS MEDICAL CENTRE	23.51
NARBOROUGH ROAD SURGERY	23.49
EVINGTON MEDICAL CENTRE (C KUMAR)	23.39
DE MONTFORT SURGERY	21.30
CLARENDON PARK ROAD HEALTH CENTRE	21.11
AR-RAZI MEDICAL CENTRE	19.64
EAST PARK MEDICAL CENTRE (RP PANDYA)	19.57
SPINNEY HILL MEDICAL CENTRE	19.28
BROADHURST ST MED PRACT (KS MORJARIA)	19.11
DOWNING DRIVE SURGERY (AJJ BENTLEY)	19.07
DR B MODI	18.25
DR R KAPUR & PARTNERS	18.05
DR GANDECHA & PARTNER	17.62
VICTORIA PARK HEALTH CENTRE	16.18

A note of caution should be applied when interpreting the above data, with the following caveats noted:

(i) Patient demographics vary across each practice

(ii) Practices with a high proportion of patients with multiple complex long term conditions, or care home patients, may expect to see higher A&E attendances

(iii) Practices which are closer to A&E tend to be slightly higher users of the service

(iv) The two practices with the highest use of A&E services are managed by Inclusion Healthcare - which look after homeless and the asylum seeker patients.

Leicester, Leicestershire and Rutland Urgent and Emergency Care Transformation Plan

Introduction

1. The Leicester, Leicestershire and Rutland Urgency and Emergency Care vision is to create a health and care system that provides responsive, accessible person-centred services as close to home as possible. It will be a model in which services will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement through integrated health and social care services that exploit innovation and promote care in the right setting at the right time. Patients and staff will be supported by responsive technology. As well as acute care and community services, Primary Care Networks (PCNs) and general p ractice have a pivotal role to play in this ambition.

2. In order to meet important and significant targets and deliver safe, high quality, cost effective care for patients in Leicester, Leicestershire and Rutland (LLR), local health and social care partners have agreed an Urgent and Emergency Care Transformation Plan. This sets out plans to deliver our LLR vision for Urgent and Emergency Care. Within this we have set our priorities into the following key work programme areas:

    - Integrated Urgent Care
    - Ambulance
    - Urgent Treatment Centres
    - Hospitals
    - Reduce Length of Stay
    - Digital.

<u>Integrated Urgent Care</u>

3. Key national priorities to be delivered in 2019/20 for Integrated Urgent Care are to ensure that more than 50% of patients who call NHS111 receive clinical input into their call, for example speaking to a nurse, and that at least 40% of patients who need a face to face consultation are electronically booked into an appointment.

4. Local priorities are to deliver increased clinical assessment of low acuity 999 calls, and to develop a consistent specification and offer across the LLR Integrated Urgent and Emergency Care tiers of care model to deliver consistent access to Same Day Emergency Care (SDEC).

<u>Ambulance</u>

5. National priorities for this year related to ambulances are to deliver a safe reduction in ambulance conveyances, increase sharing of patient information and improve efficient handover of care. Patient information will be electronically shared when patients are transferred to hospital, ensuring that ambulance crews are able to transfer patients into a hospital setting and provide the information to hospital staff within 30 mins of the ambulance arriving at the hospital.

Urgent Treatment Centres (UTC)

6. There is a national priority for Urgent Treatment Centres to meet a number of standards set by NHS England. These currently apply to three sites in LLR.

    - Loughborough Urgent Care Centre
    - Oadby Urgent Care Centre
    - Merlyn Vaz Health and Social Care Centre.

7. Urgent treatment centres (UTCs) are GP-led, open at least 12 hours a day, every day, offer appointments that can be booked through 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments people attend A&E for. It is anticipated that UTCs will also ease the pressure on hospitals, leaving other parts of the system free to treat the most serious cases.

Hospitals

8. In 2019/20 it is expected that for hospitals a frailty service will be provided 70 hours a week, and that all trusts will provide Same Day Emergency Care (SDEC) services 12 hours a day/7 days a week. SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

9. Local priorities include reducing readmissions, and carrying out "perfect ward" multiagency discharge events. These are where a number of partners are involved, bringing a team together to manage a day and capture lessons learnt, implementing the required improvements and sharing information across the teams.

Reduce Length of Stay

10. The key national priorities to be delivered in 2019/20 are for a care home bed state tracker to be in place, delivery of reduced delayed transfer of care (DTOC), and delivering a 40% reduction in hospital long stays.

11. The local priorities are to enhance health in care homes, increase the number of assessments that are carried out to discharge patients efficiently, increase the use of the *Discharge to Assess* home pathway, ensure multidisciplinary/multi-agency discharge teams are in place to embed culture and behaviour, have in place appropriate systems to monitor patient flow, and deliver early discharge planning.

Digital

12. Key this year is the requirement for Urgent Treatment Centres to have the capability to book patients into other services. Others include the requirement for increased numbers of patients to be sharing extended summary care records (e-SCR), and A&E pharmacies to have access to either the Summary Care Record or local care records.

13. Local priorities to be delivered include NHS 111 booking into face to face appointments, record sharing between health and social care, digitisation of care homes, and East Midlands Ambulance Service (EMAS) having the ability to be able to share patients' records electronically.

14. A further six priority areas were identified through LLR system-wide Multi-Agency Admission Avoidance (MAAD) events carried out in February and March 2019.

15. The MAAD events helped provide an understanding of the level and type of demand that is coming into LLR emergency services. From this we have pinpointed particular areas of pressure where focussed actions are required to improve performance.

16. Through this process a number of actions were identified, some of which were short term and some that require a longer term focus. LLR will aim to support accelerated implementation of the highest priority scheme, based upon achievability and impact. These have been incorporated into the LLR Transformation Plan.

17. The six key areas are:

    - Primary Care (part of demand management work)

    - Reduce A&E attends, particularly the 18-25 age group

    - Mental Health: use of Clinical Navigation Hub will provide an improved clinical assessment for patients accessing the urgent care system via 111 and 999, to support telephone triage and assessment, access into crisis team and frequent attenders)

    - Reducing readmissions: Post Discharge Support role (Care coordinator) and frequent flyers

    - Redirection of ambulance conveyance into alternative pathways: same day access into chest pain clinic, mandated conveyances to LUCC, Implement pathways to redirect conveyance straight to CDU, Access to Service Information (MiDos)

    - Reducing care home admissions: Accelerate Health in Care homes plan, frequent flyers.

STP: Leicester, Leicestershire & Rutland

Urgent & Emergency Care Transformation Plan

Year: 2019/20

Version: v2.0

Amendment History:

Version No:	Date:	Amendment History:
1.0	27/06/2019	Initial Draft – Yasmin Sidyot
2.0	02/08/2019	Final - Yasmin Sidyot

Report produced by:

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Approvals

This document has been approved by:

Approving Body/ Board	Locality	Approval date for original plan
LLR AEDB	LLR	17/07/2019
LLR Executive Leaders	LLR	05/07/2019
LLR CCB	LLR	22/07/2019
3 LLR CCGs Governing Bodies	LLR	Aug 2019

Distribution

This document has been distributed to:

Distributed To	Distributed by/When	Paper or Electronic
AEDB Members	**Yasmin Sidyot**	**Electronic**
Project and Programme Leads	**Leena Tailor**	**Electronic**

Contents

Executive Summary

Activity is rising across the whole urgent care system nationally and in LLR. Interventions are needed to manage and contain growth, in particular growth in ambulance activity and ED attendances. UHL ED attendances have risen year on year by 4.7%. Primary care is continuing to see a rise in the numbers of attendances in 18/19 there has been a 40% increase in the number of patients referred to ED compared to 17/18. As well as costing more to the LLR health economy, rising attendances cause increased pressure on UHL and result in reduced flow, longer waiting times and poor patient experience. Demand for EMAS services is also expected to rise significantly in the next two years. As well as the cost to the LLR health economy of rising growth, there is a negative impact on performance. Whilst front line staff continues to work increasingly hard to deliver effective services, growth in all parts of the urgent care system has resulted in significant challenge to meeting national and local standards.

In September 2018 the Carter Review into unwarranted variation in NHS ambulance trusts indicated that if more patients were treated at the scene by paramedics or were better assessed over the phone when dialing 999 — avoiding the need for an ambulance when it is safe to do so — the NHS could treat patients closer to home and reduce unnecessary pressure on emergency departments (EDs) and hospital beds.

More recently, the Long Term Plan challenges the NHS to reduce pressure on emergency hospital services by expanding and reforming urgent and emergency care services, including the following key objectives for 2019/20:

- To support patients to navigate the optimal service 'channel', we will embed a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services from 2019/20
- Fully implement the Urgent Treatment Centre model by autumn 2020 so that all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111
- Implement the recommendations from Lord Carter's report on operational productivity and performance in ambulance trusts, ensuring that ambulance services are able to offer the most clinically and operationally effective response
- Implement a comprehensive model of Same Day Emergency Care, providing SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20
- Provide an acute frailty service for at least 70 hours a week, working towards achieving clinical frailty assessment within 30 minutes of arrival
- Embed the Emergency Care Data Set (ECDS) into UTCs and SDEC services from 2020 to help us better understand the needs of patients accessing ED
- Further reduce DTOC, in partnership with local authorities

In order to meet these targets and deliver safe, high quality, cost effective care for LLR patients, local health and social care partners have agreed a UEC 2019/20 Transformation Plan through which we set out our plans to deliver our LLR vision for Urgent and Emergency Care. We have set our priorities into the following key work programme areas:

- Integrated Urgent Care
- Ambulance
- Urgent Treatment Centres
- Hospitals
- Reduce Length of Stay
- Digital

1. Background/Context

The LLR Vision for Urgent and Emergency Care

The LLR UEC STP vision is to create a health and care system that provides responsive, accessible person-centred services as close to home as possible. It will be a model in which services will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services that exploit innovation and promote care in the right setting at the right time. Patients and staff will be supported by responsive technology. As well as acute care and community services, Primary Care Networks (PCNs) and General Practice have a pivotal role to play in this ambition.

We will develop Same Day Emergency Care (SDEC) services both in hospital and in the community. In this way, we can better manage patients with long term and complex conditions reducing and better managing the demand on the Emergency Department (ED) at acute hospitals and ambulance services. Enhanced clinical assessment and navigation is a central part of the new integrated urgent care offer, so that we can direct patients into the most appropriate care setting based on need. We believe that a fully integrated IUEC system with consistency of access, allowing for local variation in the needs of patients across LLR, will make it easier for patients to navigate our system and use alternatives to acute services where appropriate.

The LLR vision is supported by the NHS Long Term Plan. Our 2019/20 Transformation Plan will ensure delivery of all the 2019/20 targets and will also position the LLR UEC system in readiness for delivery of future ambitions.

Background and Context

LLR has been an Urgent and Emergency Care Vanguard since 2015, enabling the development of a sophisticated 24/7 integrated urgent care (IUC) model that ensures seamless care of patients who enter the urgent care system. Key to the delivery of IUEC is a 24/7 telephone based clinical assessment model which supports interoperability with the wider IUC system, electronic record sharing, appointment booking, referrals and prescriptions.

These improvements have resulted in fewer ambulances dispatched and fewer patients being directed to attend ED via 111, as well as patients receiving health care closer to home. Therefore LLR already meets the requirement to **embed a single multidisciplinary Clinical Assessment Service (CAS) within 111/out of**

hours and meets the national IUC Service Specification standards.
LLR also currently has three designated Urgent Treatment Centres, providing a key element of IUC and forming a key part of our model developed in 2018.

However, we recognise that to **fully implement the Urgent Treatment Centre model by autumn 2020**, we need to review, define, improve and expand our IUEC offer.

Current Performance challenges
Overall in LLR we have seen an increase in the demand for acute services with a significant rise in A&E attends non-elective admissions and growth in ambulance activity. Although the ambulance service has maintained a good non-conveyance rate of 42%, overall activity has continued to increase which has then impacted on the overall performance. UHL performance against the national 4 hour standard has not been met with a system performance of 75.1% UHL and 82.6% LLR (national ranking 103) in March 2018/19.

In addition LLR performance against the ARP standards were not met in 2018/19 for C3 and C4 in particular. Overall Ambulance Handover delay (AHD) performance during 2018/19 improved from 2017/18. However during times of high demand and pressure on the system AHD performance standards are not met. 80% of all ambulance handovers were achieved within 30 minutes.

Demand for NHS 111 and out of hospital services such as Loughborough Urgent Care Centre have also seen an increase during 2018/19 and this trend is continuing into 2019/20. During February and March 2019 the LLR system undertook Multi-agency admission avoidance events (MAAD) to undertake a system review of understanding the level and type of demand that is coming into our emergency services and pinpointing particular areas of pressure where focussed actions are required to improve performance. Through this process a number of actions were identified some of which were short term and some that require a longer term focus. We will aim to support accelerated implementation of the highest priority scheme, based upon achievability and impact. These have been incorporated into the LLR transformation plan.

The six key areas are:

- Primary Care
- Reduce A&E attends 18-25 group
- Mental Health
- Reducing readmissions
- Redirection of ambulance conveyance into alternative pathways
- Reducing care home admissions

Our key objectives during 2019/20 are to:

- **Deliver improvements in performance in our 4 hour standard** – through improving flow and better management of demand through our acute services
- **Eliminate ambulance handover delays** – through implementing escalation protocols that support partnership working, implementing conveyance direct into pathways such as CDU, LUCC and community based step-up services
- **Improve responsiveness of services** – implementing the recommendations from the Carter Review in order to improve the ARP performance of EMAS, increasing non-conveyance through the implementation of the CAT 3&4 redirection into Clinical Navigation Hub to better manage low acuity demand
- **Reduce the demand on our acute ED service** – developing in and out of hospital same day emergency care (SDEC) pathways, improving access to extended primary care, use of digital technology that supports reducing demand on secondary care services, improving post discharge support to reduce readmissions and working with PCN development to deliver full extended primary care cover during 2019/20
- **Maintain the delivery of DTOC and achieve the standards for reducing long stay patients –** continue to implement and embed the High Impact change Model for Discharge and deliver on Red to Green and SAFER as a consistent approach across all wards at UHL and community hospitals.

Despite the challenges LLR have seen considerable improvements and success in a number of areas. During 2018/19 the LLR system has significantly reduced the number of patients whose discharge from hospital is delayed. In LLR we have achieved the standards for reducing delayed transfers of care (National DTOC Rate 10.2) and a significant improvement in delivering a reduction in the overall number of long stay patients in an acute inpatient care setting. (March 18/19 Stranded patients 14-20 day 102 patients from a target of 100 patients.) Furthermore by the end of 2018/19 less than 5% of patients underwent their CHC assessment in an acute care setting. These successes have been achieved through the delivery of a comprehensive LLR discharge plan that has been based on the delivery of the High Impact Change Model for discharge. Through the delivery of this model we have:

- Implemented an Integrated Discharge Team comprising of nurses, therapists, social workers and discharge support co-ordinators – supporting front door and base wards
- Implemented Trusted Assessment Model between Acute and community services and adult social care teams
- Implemented trusted assessor model for care homes – this includes the red bag scheme
- Implemented discharge to assess model across LLR – which better support the safe transition of patients out of hospitals

Furthermore LLR has led the development locally of digital solutions to support patient care and access such as:

- Direct electronic booking into services
- Early adoption of the Emergency Care Data Set (ECDS) at LRI ED
- Implementation of NHS.net mail with a cohort of care homes in LLR
- NHS 111 online

However there is still some way to go in order fully utilise and embed the digital solutions available that can enhance patient care. In LLR we aim to:

- Have NHS 111 booking patients into same day access for GP Practices across LLR (currently West Leicestershire have this fully implemented)
- Implement NHS.net mail across 50% of our care homes in LLR
- Pilot and test use of SystmOne Care home module for care homes so that they can access care plans for residents in their care
- Embedding the Emergency Care Data Set (ECDS) into UTCs and SDEC services from 2020 to help us better understand the needs of patients accessing ED.

Our Digital priorities section further details our plans on how we aim to utilise digital solutions available to us to enhance patient care.

In order to meet the demands of the Long Term Plan there is significant organisational change taking place within the LLR health economy. The three LLR CCGs recently appointed a single Accountable Officer and are formally considering significant governance changes to try to bring decision making closer together, focussing on the role of the strategic commissioner at system/place/neighbourhood levels. At the same time system partners are working together to ensure success within an Integrated Care System (ICS). These developments bring both opportunities and challenges as the LLR health economy adapts and changes to meet the demands of the changing health landscape and the Long Term Plan.

Furthermore with the development and implementation of Primary Care Networks (PCN) there is a significant role for PCNs in shaping and supporting the development of out of hospital SDEC services, in particular access to diagnostics. However there is significant work that needs to be done to develop PCNs in order to support the work programme. The LLR Primary Care Strategy details the priorities and key actions from a UEC perspective.

Workforce is a significant challenge to delivery in all areas of the 2019/20 UEC Transformation Plan and we will work closely with our system partners to complete and refresh the draft UEC workforce plan that was initiated in 2018.

2. **Governance of the Programme**

The LLR A&E Delivery Board (AEDB) brings together on a monthly basis the local statutory organisations to oversee the development, agreement and implementation of the UEC Transformation Plan. The AEDB provides a multi-agency forum for planning, discussion and oversight of the delivery of integrated urgent care services resulting in improved A&E performance delivery. It is the senior executive group for the delivery of improvement across the LLR Urgent & Emergency Care system, and members represent their organisations in holding others to account for delivery of agreed actions. The Board is the STP programme lead for Urgent & Emergency Care for LLR. Our clinicians are engaged directly into the work of the Delivery Board either directly or through the working groups such as Integrated Urgent & Emergency Care group, Demand Management Group, Clinical Ideas Factory group Engagement takes place on a weekly/monthly basis. Clinical colleagues both lead the development and/or co-design developments/interventions to support improvements. AEDB will also agree relevant performance metrics and receive performance reports to measure progress and identify variance from plan, to ensure that performance improvement is in line with agreed milestones and targets and agree recovery actions where performance does not match plan.

The Board is chaired by the Chief Executive Officer of University Hospitals of Leicester. Vice Chair is provided by the West Leicestershire CCG Accountable Officer. SRO Director Support is provided by the Director of UEC.

Reporting into AEDB are three key groups which provide recommendations to AEDB and are responsible for the implementation of the work programme of the LLR UEC transformation plan.

These are:

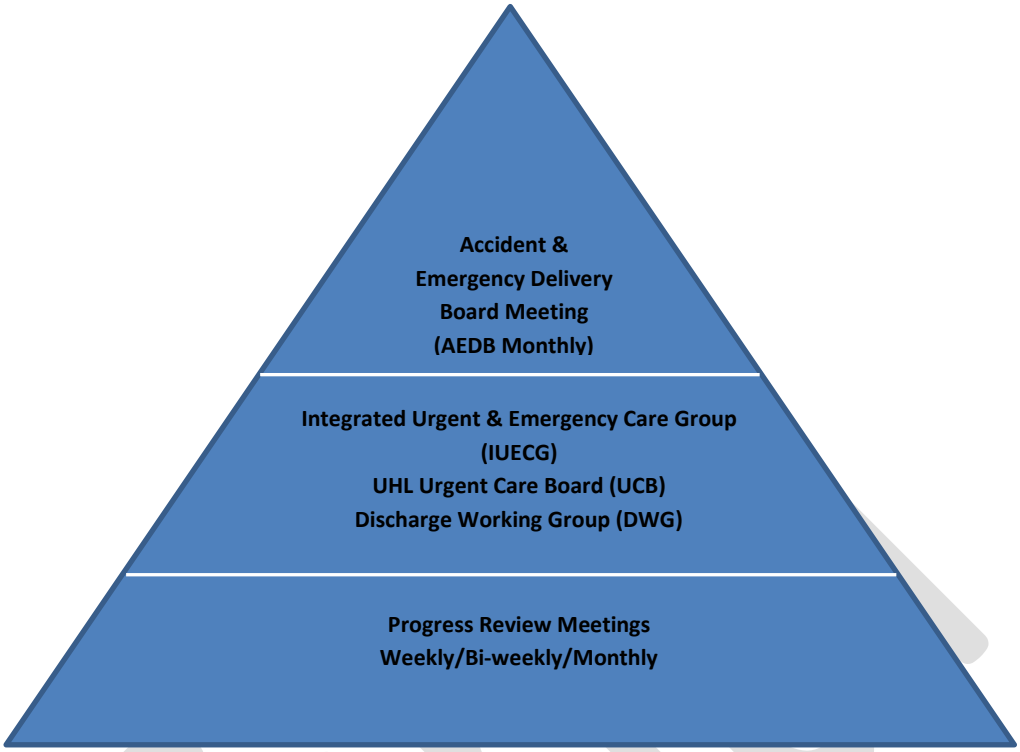
- Integrated Urgent and Emergency Care Group (fortnightly)
  Focus: Integrated Urgent Care and Urgent Treatment Centres Priorities

- UHL Urgent Care Board (Monthly)
  Focus: Ambulance and Hospitals Priorities

- Discharge Working Group (Monthly)
  Focus: Reduce Length of Stay and Digital Priorities

The management of the urgent and emergency care across LLR has been identified as a key priority and as such we are committed to supporting the work required to deliver the implementation of the plan.

In addition, a number of task and finish groups report into the above three groups, for example LLR SDEC Task and Finish Group, which reports to Integrated Urgent and Emergency Care Group. Please see Appendix A for a detailed governance chart. The diagram below illustrates high level governance.



Stakeholders

Stakeholders and partners in the delivery of the 2019/20 UEC Transformation Plan include:

- LLR Clinical Commissioning Groups (CCGs)
- University Hospitals of Leicester (UHL)
- East Midlands Ambulance Service (EMAS)
- Thames Ambulance Service Ltd (TASL)
- Regional EMAS and 111 commissioners – Hardwick CCG and other regional partners
- DHU Healthcare
- Leicestershire Health Informatics Service (LHIS)
- Care Homes (nursing and residential)
- Leicestershire Partnership Trust (LPT)
- Leicester City Council
- Leicestershire County Council
- Rutland County Council
- GPs and Primary Care Networks
- Healthwatch

Public involvement development

The CCGs will use existing public involvement tools/channels to influence the development of the plan. Health representatives sit on a number of UE workstreams. We will also use evidence from a series of Healthwatch focus groups to evaluate winter messaging to determine our approach to communication with the public.

We will establish an LLR – wide communications and engagement network to develop the detailed delivery plan, including all NHS organisations, NHS111, Healthwatch and local authorities. The lead for the network also sits on the LLR Local Resilience Forum to ensure we are linked in and respond to the broader events that can impact on demand for Urgent and Emergency services e.g. severe weather.

The communication network is also connected to the escalation process in terms of A&E demand to ensure we respond to the need for public information.

Public Involvement - delivery

The CCG will take a targeted approach to its communications and engagement on urgent and emergency care, as in previous years. Specifically this will involve:

- An evidence – based approach to communications using A&E attendance data to focus on particular groups of service users and conditions
- This year the focus will be on 18 – 25 year olds and in particular exploiting the links established with the three universities in LLR. This will involve outreach work with identified university staff who can direct students to the most appropriate service following awareness raising sessions
- We will again target large employers as a way of amplifying local the national messages with employees. This will involve outreach work and briefing employer HR teams on services for cascading to colleagues
- Using our well established links with the voluntary and community sector we will provide communications packs to help spread the message locally
- We run appropriate supporting campaigns e.g. in particular we will participate in self-care week
- We will work with local Patient Participant Groups (PPGs) to support us to ensure public information is available at practice level and to ensure campaigns e.g. flu are delivered at practice level

3. Process for monitoring and reporting

Project and Programme Management

Project and programme leads meet regularly with SROs to update on progress, risk and issues. SROs are ultimately responsible for the delivery of projects. In addition project leads meet informally on a regular basis with the LLR UEC PMO and Delivery Manager to ensure that progress against the overall UEC programme is monitored and understood. Progress against the plan is reported and discussed at the relevant working group, for example Discharge Working Group.

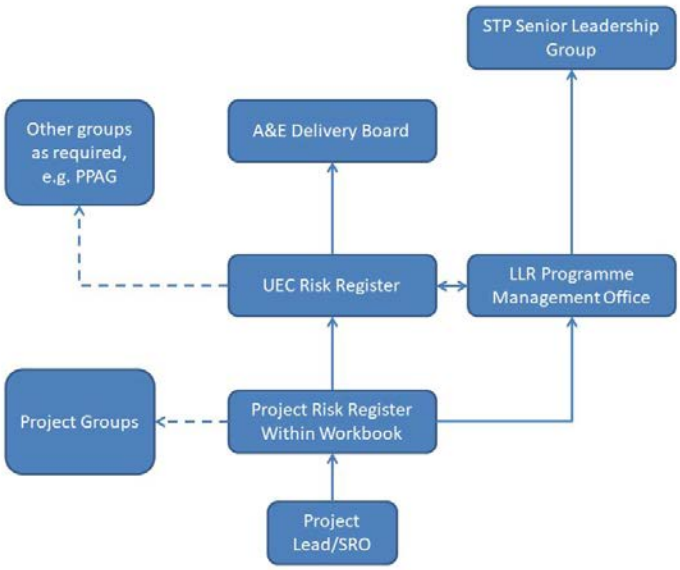
Formal monitoring of projects and the overall UEC transformation programme is reported within a programme workbook, which is completed monthly by project leads and submitted to the LLR PMO team. The workbooks contain PID and business case as well as information on progress against key milestones, project plan, risks and issues and, where relevant, financial information. Before submission to the PMO workbooks are reviewed internally by the UEC PMO and Delivery Manager and approved by the relevant SRO. Following submission PMO leads meet monthly with project leads to review progress and provide further clarity where required. Highlight reports containing key progress, risks, issue and high level finance are presented to the STP Senior Leadership Group.

Risk and Issue Management

Project leads identify risks and issues on an as-and-when basis and maintain a live risk register which forms part of the project workbook. These are agreed with the SRO. Key risks form part of the STP highlight report. Risks are reported using the following format and are reviewed/actions updated by project leads at least monthly.

Risk Number	Risk Description: describe the cause (hazard), and effect (risk)	Original Likelihood Score	Original Impact Score	Original Risk rating	Risk Level	Date Added to Risk Register	Mitigating Actions/Controls Required	Responsible Person	Reviewed Likelihood Score	Reviewed Impact Score	Reviewed Risk rating	Risk Movement from last assessment ◄►/▼/▲	Risk Status	Date Reviewed
CNH005	**CAUSE** Adequate IM&T not in place **EFFECT** Unable to transfer calls from EMAS to DHU, delay to project & benefits reduced.	4	4	16	Significant	08.01.19	(1) LHIS have initiated IM&T review and existing work taking place within EMAS to be aligned to CNH needs. (2) The project now confirmed to align to IM&T STP strategy and has access to funding stream.	Yasmin Sidyot	3	2	6	◄►	open	05/06/2019

UEC Risk Register may also be shared with the relevant project group if appropriate. Otherwise, risks are reviewed and captured for the UEC Risk Register as part of the monthly workbook submission. The UEC Risk Register is reported monthly at AEDB but risks are also reported and escalated as required at key meetings for example Provider Performance and Assurance Group. The diagram below illustrates how risks are escalated.



In addition to the workbooks a detailed presentation focused on one area per month is provided by SROs to AEDB. Key risks or issues for escalation are highlighted on the AEDB presentation are raised and discussed. Following this the workbooks and UEC risk register are updated.

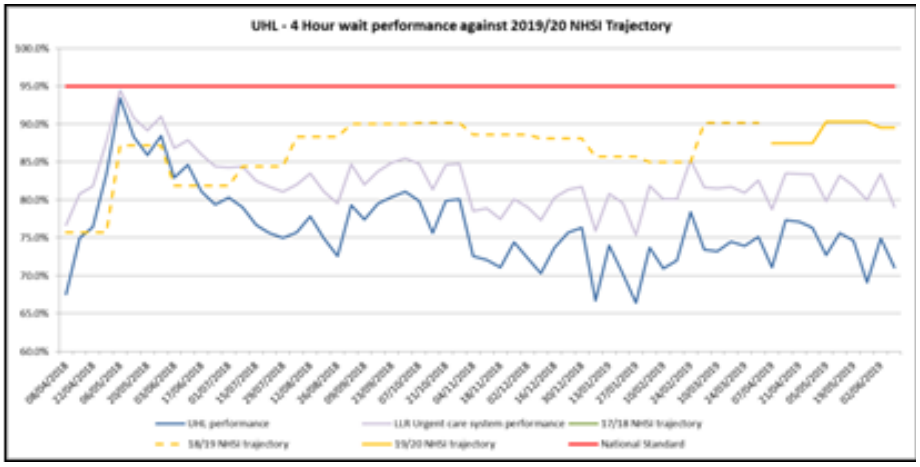
Monitoring of progress and tracking performance

In LLR we have developed our service heat map which enables the system to have an overview of the overall performance of the system and keep a track of impact of interventions and early recognition of over performance or challenges including risks at a system level. This report is reported to AEDB and Integrated Urgent Care Group. Below is an example of our heat map:

4. Monitoring the UEC Programme Plan

Please find below trajectories for the following standards:

4 Hour A&E Performance Trajectory for LLR



19/20 Trajectory

Month	National Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
UHL ED 4 hr	95%	83.1%	86.9%	85.8%	83.9%	84.1%	85.1%	83.8%	82.4%	81.2%	77.7%	82.5%	82.8%
UHL/LLR ED 4hr wait	95%	87.5%	90.3%	89.5%	88.3%	88.4%	88.6%	87.5%	86.2%	85.3%	84.0%	87.1%	87.4%

Ambulance Handover

19/20 - Trajectory (updated 15th May 19)

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Arrivals (CAD)	5893	5662	5429	5506	5393	5532	6089	6130	6241	6108	5518	6194
Handover delays 15-30 mins CAD	1879	2222	2295	2477	2466	2644	2888	2960	2769	2616	2236	2455
Handover delays 30-60 mins CAD	728	550	393	340	288	170	142	0	310	569	399	402
Handover delays 60+ minutes CAD	263	110	45	0	0	0	0	0	0	0	0	0

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% Handover delays 15-30 mins (CAD)	31.9%	39.2%	42.3%	45.0%	45.7%	47.8%	47.4%	48.3%	44.4%	42.8%	40.5%	39.6%
% Handover delays 30-60 mins (CAD)	12.4%	9.7%	7.2%	6.2%	5.3%	3.1%	2.3%	0.0%	5.0%	9.3%	7.2%	6.5%
Handover delays 60+ minutes CAD	4.5%	1.9%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Ambulance Handover Performance

19/20 - Trajectory

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Arrivals (CAD)	5458	5662	5429	5506	5393	5532	6089	6130	6241	6108	5518	6028
Handover delays 15-30 mins CAD	1999	2222	2295	2477	2466	2566	2666	2431	2448	2616	2236	2455
Handover delays 30-60 mins CAD	665	550	393	340	288	278	289	455	420	569	399	402
Handover delays 60+ minutes CAD	235	110	45	0	0	0	0	0	0	0	0	0

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% Handover delays 15-30 mins (CAD)	37%	39%	42%	45%	46%	46%	44%	40%	39%	43%	41%	41%
% Handover delays 30-60 mins (CAD)	12%	10%	7%	6%	5%	5%	5%	7%	7%	9%	7%	7%
Handover delays 60+ minutes CAD	4%	2%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Long Stay Patients

UHL SUPER STRANDED (21+ days)
TRAJECTORY - ADULTS

TARGET:
135

Month	Mar -19	Apr -19	May -19	Jun -19	Jul-19	Aug -19	Sep -19	Oct -19	Nov -19	Dec -19	Jan-20	Feb -20	Mar -20
Patients 21+ days	172	152	162	151	166	161	152	147	143	149	156	143	135

DTOC – BCF guidance just released and now awaiting technical guidance to setting trajectories from NHSE/I

NHS111 Standards

	Target	18/19 Outturn	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD / Mean
Call Handling															
Total Calls Answered		88.00%	90.1%	84.4%	86.4%	83.1%	82.6%	86.2%	85.2%	85.0%					85.3%
Calls Answered within 60 seconds %		76.80%	94.3%	86.9%	90.5%	90.7%	90.5%	96.2%	96.3%	96.6%					92.8%
Calls abandoned after 30 seconds	<4%	5.60%	1.2%	2.7%	2.5%	2.0%	1.9%	0.9%	0.9%	0.7%					1.6%
Average Answer Time (seconds)	<27 secs	00:00:34	00:00:11	00:00:21	00:00:16	00:00:17	00:00:16	00:00:08	00:00:08	00:00:07					00:00:13
Final Disposition															
Emergency Ambulance dispatch	≤ 9%	13.1%	15.8%	16.3%	14.9%	15.3%	14.4%	14.3%	12.8%	13.4%					14.7%
Attend A&E	≤ 8%	5.2%	5.8%	5.8%	5.9%	6.3%	6.2%	6.7%	6.8%	6.9%					6.3%
Attend Primary Care	≥ 55%	59.0%	55.5%	57.3%	59.6%	57.9%	59.0%	58.5%	60.1%	59.3%					58.4%
Self Care	≥ 17%	16.0%	18.1%	17.1%	15.6%	16.1%	16.4%	16.4%	16.0%	16.0%					16.5%
Triage Rate															
Answered calls that are triaged	80%	92.4%	90.9%	90.5%	91.7%	90.5%	93.3%	93.3%	94.5%	93.9%					92.3%
Warm Transfers															
Calls either warm transferred or called back within 10 mins	≥ 50%	49.3%	57.6%	57.7%	60.5%	58.6%	58.9%	56.8%	59.0%	61.7%					58.9%
Warm Transfers to clinician when required	n/a	41.0%	22.0%	16.4%	18.1%	17.2%	14.3%	16.3%	18.5%	16.9%					17.5%
Person called back within 10 minutes	n/a	26.7%	20.3%	12.3%	22.3%	19.1%	21.2%	21.8%	25.1%	21.1%					20.4%

SDEC Standards

UHL have confirmed that they are already meeting the standard for 100% of trusts are providing Same Day Emergency Care (12 hours day / 7 days week) by September 2019

UHL current performance stands at a minimum of 34% against the standard of delivering 30% reduction in non-elective admissions from SDEC. We are working with UHL to develop a more ambitious trajectory of achieving 40% reduction in Non-elective admissions by March 2020. We are working with the national accelerator team with regards to this.

See separate project tracker worksheet :

(a) Helps to track progress

(b) Helps to develop better plans, showing where the gaps are, and what extra resource/support may be required

The sheets aim to bring together the strands of

- Monitoring and Control
- Benefits Management
- Risk Management

This will help create a coherent and effective action plan.
NHSEI to provide this at a later date which we will utilise to report back to NHSEI

5. UEC Plan 2019/20

The 2019/20 LLR UEC Transformation Plan outlines how we aim to deliver all of the national, regional and local transformation priorities for urgent and emergency care. In addition, system agreement on local priorities for improvements has also been achieved. A high level diagram of the UEC Transformation plan broken down by key priority areas including national and local priorities is attached as Appendix B. As outlined in section 2 our plan is developed to support the system to achieve the following key objectives:

- Deliver improvements in performance in our 4 hour standard
- Eliminate ambulance handover delays
- Improve responsiveness of services
- Reduce the demand on our acute ED service
- Maintain the delivery of DTOC and achieve the standards for reducing long stay patients

Our objectives are then subsequently delivered through the following Priority Programme Areas:

Transformation Priority 1: Integrated Urgent Care

Our plan for delivering Integrated Urgent Care focuses on reducing demand on our acute ED service. In order to this we will need to:

- develop in and out of hospital same day emergency care (SDEC) pathways,
- improving access to extended primary care,
- use of digital technology that supports reducing demand on secondary care services,
- improving post discharge support to reduce readmissions
- working with PCN development to deliver full extended primary care cover during 2019/20
- Improve access to out of hospital Mental Health Crisis – delivering the Core 24 and extending access to MH crisis services through our CNH service.
- Enhance the clinical assessment of low acuity ambulance (CAT 3&4) activity in order to divert from originating in 999 calls so that over 50% of NHS 111 calls are receiving a clinical assessment
- Reduce 'A&E by default' to less than 1%
- Focus on reducing demand on A&E attends in the younger population group (18-25)
- Implement MiDOS in LLR in order to improve access to alternatives to ED
- Review professional advice and guidance for GPs – improving the offer and linking this to the development of PCNs.
- Increase the use of step-up referrals to community services through the redesign of our community services

- Use of PCNs and ILTs to deliver evidence based care for LTC/multi morbid patients in primary care

- Integrating the out of hours face to face service into the UTC offer in LLR

- NHS 111*6 – The process across LLR was driven by the Care Homes Sub-Group (CHSG) and the various quality teams. Care homes have been advised to follow a process for emergency and urgent care situations. If it is an emergency then they call 999. If it is urgent, then they call the resident's GP Practice. If the urgent situation is outside the opening hours of the practice or the practice suggests they are unable to link the clinicians with the care home, then they call the Health Care Professional number that links them directly to the Clinical Navigation Hub. If this number is engaged or unavailable, they then call 111 *6. Our local solution of direct access into our Clinical Assessment Service (LLRCNH) is much more effective and enables direct access to a clinician 24/7.

NHS Mail

A recent NHS Digital Demonstrator project has funded work to engage with up to 28 care homes and work with them on a number of elements that enhance their digital capability. Each of the care homes was supported to work through the accreditation for the Data Security and Protection Toolkit and achieves the "entry level" accreditation that permits them to apply for access to use the NHS Mail service. The process of administration to set-up NHS Mail has taken place with 26 care homes and 22 now have access to NHS Mail. Of the 26 care homes that are accredited to entry level, 21 progressed towards "standards met". This standards met level demonstrates a commitment to compliance that enables these care homes to have access to the care home module for SystmOne. Information Sharing Agreements need to be signed by all parties before SystmOne can be set-up for the care home. To date we have 10 care homes that have now gone live with the SystmOne module.

The table below outlines how we plan to deliver the above improvements and for some of these areas we are working through what the impact will be for LLR in reducing the demand on our acute services. (Full plan available in Appendix C)

	Priorities	Impact Area	Actions	Timeline
Integrated Urgent Care	LOCAL: Increased clinical assessment of low acuity of 999 activity	Redirection of CAT 3&4 Calls to CNH – testing in Aug-Sept will inform the quantifiable impact	Pilot implementation to test model agreed ahead of implementation in Q4. Testing to start on 19/08/19 – 02/0919. Following actions to be undertaken: Staffing the admin position – all agreed to look at potential staffing Confirmation of retesting Consider the electronic route back into EMAS Review process map	August – September 19 January 2020
	LOCAL: Clear specification & offer across the LLR IUEC tiers of care Model	Increase use and offer of Extended primary care in line with the PCN ambitions – Increase uptake of extended access to over 80% across LLR (MADD event findings – Circa 10% of walk ins advised by their GP to go to A&E) -	Updated primary care offer Senior clinical review which provides link to consult connect and bed bureau	September 2019

	Priorities	Impact Area	Actions	Timeline
Integrated Urgent		Specifications: Emergency Front door Community based Access	Specification agreed Agree UTC offer CCG	July March 2020
	LOCAL: Better targeting of patients straight to SDEC	Direct access to Clinics (MAAD event findings – Circa 15% ambulance conveyances potentially unnecessary) LOS on the SDEC Pathway in line with national ambition	Develop Service Spec for SDEC UCC conveyance mandated (EMAS/LLR) Review of 10 cases per week (over 3 months) on non-admitted ambulance conveyance to understand cases and learning for clinical feedback ID Pathways & KPI's for each unit UHL planning commenced 25th July 2019	September 19
		SDEC acute and out of hospital offer to be developed to increase community based access for diagnostics (Currently in PDSA phase)	Develop Model for diagnostic offer across out of hospital sites - LuCC Re-launch of 10 ambulatory care pathways to LUCC and mandated EMAS conveyance to LUCC goes live 5th Aug 2019	September 19
	LOCAL: clinical advice & Guidance	Direct access to Clinics	Review current clinical Advice and guidance offer	February 2020

Integrated Urgent	**Priorities**	**Impact Area**	**Actions**	**Timeline**
		Increase use of SDEC Pathways	Develop new model for clinical advice and guidance that fits with the development of PCNS across LLR UHL planning commenced 25th July 2019	
		(MAAD event finding's – Circa 20% of walk ins did not consider alternatives to A&E)	Injuries – ambulatory pathways to focus on 18/25 age group – targeted communications (fresher's week)	December 2019
	LOCAL: Reduce length of Stay SDEC Pathway	Increase in 0 LOS Reduction in NEL Admissions	Implement actions as identified by through the National Acceleration Programme provided by NHS Elect - Next visit on 24th October2019 UHL planning commenced 25th July 2019	September 19
	Local: Primary Care	Ensure that all extended access capacity is utilised to reduce demand on ED Accessing City Hubs Targeted demand management with GP Practices – LLR approach Demand Management	West – implement agreed operational delivery changes to ensure optimised appointment availability and provision – work with referring practices to ensure optimised and strategic use of available capacity Agree a population health based demand mgt approach – June completed Discuss the approach with localities – June completed	October 19

	Priorities	Impact Area	Actions	Timeline
Integrated Urgent		group set up with clinical representative	Test approach with one outlier practice and develop action plan – June/July completed Feedback progress to F&P and West GB July 19 Completed Present and discuss approach at West ACD meeting – 6 Aug – in progress Visit remaining outlier practices Aug-Mid Oct 19 In progress	
	Local: Reduce A&E attends 18-25 group	Reduce A&E attends 18-25 group. High volume of patients leaves before treatment/ do not need treatment. Injuries – ambulatory pathways use for this age group – role of	To reduce: 20% by 2019/20 50% by 2020/21	December 2019 December 2020

	Priorities	Impact Area	Actions	Timeline
Integrated Urgent		SDEC and the redirection to LUCC		
	Local: Mental Health support	Currently 111 dispositions into ED is 34% Reduction 1429 DX92 dispositions from 111 into ED Increase referral flow into CNH Reduce EMAS conveyance for low level into ED	To provide MH support to CNH. – MH Practitioner into CNH – test phase to commence in Late September Options appraisal during mobilisation Implement additional support Improve Access into crisis team for CNH, EMAS and GP without GP face to face review dispositions (34% June 18-May 19) Frequent attenders work to develop shared care plans for known cohort impacting on attendances for VB11Z and VB09Z Implementation of the CORE 24 standards	Sept 2019 testing to commence April 2020 – although would be able to implement this earlier if the MH crisis funding is available in Q3 2019/20 April 2020 onwards – the funding to support this is released in April 2020
	Local: Reducing Care Home Admissions	Reducing 1000 patients on a 7 day stay	Accelerate the enhanced health in care homes plan by CH Subgroup to achieve a further reduction in care home admissions based on the success in 18/19	December 2019

Integrated Urgent	Priorities	Impact Area	Actions	Timeline
			Implementation of the digital solutions – extending the current work further Delivery of telemedicine and scoping further ways in which this can be used to better manage patients living in care homes	October 19 March 20
	Local: LLR Falls Programme	A reduction in FEMUR fracture acute interventions and a reduction in consultant led first out-patient appointments where patients are triaged assessed and managed within a community setting	Postural Stability Exercise Programme – embedded in County and Rutland. City – went live 1st April 2019 with non-recurrent funding for 12 months Electronic Falls Risk Assessment – phased implementation commences in Aug. Non Blue Light Service Response – Coalville PDSA commenced 10th July 2019 Therapy Triage Service – embedded in County and Rutland Training & Equipment in Care Homes	Completion June 2020 Aug 2019 Aug 2019 July 19

	Priorities	Impact Area	Actions	Timeline
Integrated Urgent			– PDSA to commence Autumn 2019	Sep 19
	NATIONAL: Maintain a 50%+ proportion of NHS 111 calls receiving clinical assessment.	Increase in proportion of 111 calls receiving clinical assessment Increase activity in CNH	Enhance the clinical assessment of low acuity ambulance activity Review DoS to identify further opportunities for clinical assessment rather than A&E by default	October 2019
	NATIONAL: Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than 40% by 31st March 2020. By 31st March 2020, reduce 'A&E by default' selections on the Directory of Services (DoS) to less than 1% by the commissioning of appropriate services that are accurately recorded on DoS	Increase in percentage of patients booked into face to face consultation to over 40% from 37%	review our model of booked appointments vs walk in access across LLR implementing 1 GP appointment available to NHS111 for every 3000 patients across LLR Implementation of MiDoS	December 2019

In addition to the above we have developed our plan to manage demand in our system more effectively and have identified key actions that we will accelerate in 19/20 to reduce A&E attends and non-elective admissions focussing on the following 6 key areas:

- Primary Care
- Reduce A&E attends 18-25 group
- Mental Health
- Reducing readmissions
- Redirection of ambulance conveyance into alternative pathways
- Reducing care home admissions

Growing demand for care in all settings is continuing to increase; a demand management group has been set up with clinical representative to focus on the following areas:

- Federation QIPP
- Referral Support Service
- Planned Care - pathology
- Same Day Emergency Care – managing more care as 0LOS, shifting demand from LRI to Loughborough UCC
- Meds management
- Respiratory rapid response service, virtual clinics
- CHC savings
- Community Hospital repatriation

In addition to the above actions and plans in place further work is being carried out by the demand management group to focus on:

Maximising delivery of existing QIPP and 19/20 plans

- Working with outlying practices to address variation in levels of access to secondary care services
- Commissioning response - identifying pathways that could manage demand in different settings or at lower cost
- Additional NEL demand management savings identified
- Asking UHL to manage Elective activity within Plan

The following deliverables are in place or have been completed:

- Agree a population health based demand management approach – June completed
- Discuss the approach with localities – June completed
- Test approach with one outlier practice and develop action plan – June/July completed
- Feedback progress to F&P and West GB – July completed
- Present and discuss approach at West ACD meeting – 6 Aug – in progress
- Visit remaining outlier practices – Aug to Mid Oct – in progress

Transformation Priority 2: Urgent Treatment Centres

In 2019/20 we will review the LLR Urgent Treatment Centre offer as part of our tiers of care review. We will reach LLR wide agreement on future plans for our three designated UTCs by December 2019 including any changes to services necessary to fully implement the UTC model. The table below outlines our plan including our timeline.

	Priorities	Impact Area	Actions	Timeline
Urgent Treatment Centres	NATIONAL: Designate the majority of urgent treatment centres (UTC) by December 2019, with any exceptions to be agreed with the Regional Director.	Designation of UTCs in LLRs	Review the current designated sites and determine whether these remain as the designated UTCS for LLR and they can continue to fit into the LLR IUEC Model	December 2019

Currently in LLR we have the following 3 sites that are designated as UTC sites:

- Loughborough Urgent Care Centre (LUCC) – West Leicestershire
- Merlyn Vaz Hub – Leicester City
- Oadby Urgent Care – East Leicestershire & Rutland

LUCC is the only site in LLR that fully meets the national UTC specification and is LLR's 24/7 walk-in service that offers booked appointments. Merlyn Vaz is predominantly a booked appointment hub service and therefore partially meets the national UTC Specification. Oadby is a walk-in and booked appointment service and again partially meets the UTC specification.

UHL provide a front door primary care streaming offer and currently this is not designated within the UTC Spec offer as all activity that goes through this service is recorded as Level 1 A&E attends.

Currently LLR CCGs have agreed that LUCC will remain as a designated UTC. In relation to Oadby there are ongoing discussions taking place with a view to agree the position by early September.

In relation to the City Merlyn Vaz UTC, there is further analysis required of the activity that goes through the hub and what goes through UHL's front door primary care streaming to then inform what type of UTC offer is required in the City and how and where that is best placed. All potential changes that are being considered will go through an engagement and consultation with City residents. We will work to the December 2019 deadline of designation.

Transformation Priority 3: Ambulance

Over 40% of LLR 999 calls are not conveyed to ED with positive use of alternatives to ED. Regionally EMAS performs well for LLR on non-conveyance. We want to add to this success and increase our opportunity to deliver a safe reduction in ambulance conveyance, building on our low acuity ambulance clinical assessment pilot and development of alternative pathways for specific cohort of patients such as chest pain and injuries and to redirect conveyances straight to CDU as part of the RightCare opportunities.

The LLR planning function has actively utilised RightCare benchmarking and the NHSE released data packs to drive the 2019/20 LLR Commissioning Intentions, Operational Plan and system efficiency programme. The RightCare opportunity analysis highlights that there is a notable patient improvement & cost reduction opportunity for the LLR system from the improved management of patients with multi-morbidity (five or more long term conditions). It is anticipated that better case finding and subsequent prevention/crisis management for the following conditions would reduce urgent care and Non-Elective activity & spend:-

DISEASE AREA	**NON-ELECTIVE**
Gastrointestinal	£3,497,000
MSK	£00
Problems Of Circulation	£4,052,000
Trauma & Injuries	£1,878,000
Neurology	£1,878,000
Respiratory	£7,804,000
Cancer & Tumours	£340,000
Endocrine, Nutritional And Metabolic Disorders	£421,000
Genitourinary	£1,783,000
2019/20 TOTAL LLR OPPORTUNITY	**£21,653,000**

In-line with the release of the NHS England Long Term Plan, LLR have submitted plans to re-design service provision and release the opportunities within Gastrointestinal, Respiratory as well as Problems of circulation. The RightCare process, principles and analysis have guided the development of the LLR Urgent Care Transformation plan and will support the delivery of the identified opportunity.

Commissioners, UHL and EMAS will work together effectively to identify the causes of local ambulance handover delays and to resolve issues. We will ensure that 100% of ambulance handovers occur within 30 minutes.

Building on work begun in 2018/19, we will increase the digital maturity of EMAS so that clinicians on scene and working in the CAT team have access to patient information (SCR, PDS and EPR) and electronic prescribing. We will review options for providing access to service information at scene including MiDoS and Pathways Service Finder and will implement an effective solution for EMAS, taking into consideration our regional partners.

In regards to ambulance services to meet as a minimum a baseline level of digital maturity, discussions between EMAS and NHSEI took place to agree and to consider a local variation to National CQUIN 10 as long as the outcomes were still achieved. A variation proposal was sent to NHSEI by EMAS.
The coordinating commissioner view is that the national CQUIN is quite clear in terms of what is expected and although the rationales for the proposed exclusions are understood, the target for Q3 and Q4 is only 5%.
NHSEI have advised target of 5% should be a cumulative position over Q3 and Q4 and agree that this should be achievable without any delay in timeline or exclusions.

Further information and trajectories to be provided once confirmed.

(Refer to Appendix D to view proposal)

	Priorities	Impact Area	Actions	Timeline
Ambulance	LOCAL: Redirection of ambulance conveyance into alternative pathways	MADD event findings - paramedics decision-making not always consistent or protocols not consistent in and out of hours Improve consistency of protocols Increase non-conveyance by 1% in Q3 and 1.5% in Q4	Same day access to chest pain clinic – 24 hour pathway – learning from Notts and Northants Implement mandated conveyance to LUCC by EMAS – commences 2nd August Implement pathways to redirect conveyance straight to CDU Access to Health Care professional line (HCP) Implementation of MiDoS Training EMAS staff around mental health crisis/emotional distress	October 2019 August 2019 August 2019 In Place – monitoring use through failed pathways data TBC once agreed by partners October 2019
	NATIONAL: All ambulance services to meet, as a minimum, a baseline level of digital maturity including access to and usage of patient information at scene (e.g. Summary Care Record, Patient Demographic Service, Electronic Patient Record),	Improved clinical decision making Improved patient outcome Decreased EMAS on scene	Improve use of system one Potential of MiDOS EMAS ePRF already widely used	December 2019 December 2019 completed

	Priorities	Impact Area	Actions	Timeline
	access to service information at scene (e.g. DoS) and establishing Electronic Prescribing.	time Conveyance avoidance due to improved overall clinical picture		
	NATIONAL: Ensure 100% of ambulance handovers occur within 30 minutes	4 hr standard Ambulance handover turnaround performance Improved Quality of care MADD event findings - Handover delays occur when there are 4-5 ambulances arrive within 15 minutes	Improve Fit to sit Direct to clinic Transport Improved collaborative escalation procedure Mapped LLR Against NHSE/I Guidance and tailored to suit the locality Fit to sit Send EMAS straight to clinic Escalation procedure – improve communication between operational levels Nurse co-ordinator Operational group now meets every 2 weeks to enable continuous	Fit to sit – **Complete** Direct access to clinic – **Complete** however looking into further opportunity Learning visits **complete** Action Plan to developed post learning visit by 9th August 2019

	Priorities	Impact Area	Actions	Timeline
		More available resources to serve unseen patients in the community - (Matthews story)	oversight and improvement Visits arranged to Newcastle and Leeds to investigate learning opportunity Shared EMAS/UHL conveyance modelling to enable awareness of potential peak activity AHD group work – tracker in department role. UHL and EMAS will evaluate the requirement of a HALO and a nurse co-ordinator in ambulance assessment role	Conveyance modelling by the end of July
		MADD event findings – Ambulance assessment inconsistent and variation between process and workforce	Fit to sit Send EMAS straight to clinic Escalation procedure – improve communication between operational levels Nurse co-ordinator	

Transformation Priority 4: Hospitals

Improving Flow and delivering the 4 hour standard is a key objective in 2019/20. In order to do this successfully we will deliver SDEC services within UHL that operate at least 12 hours a day, 7 days a week by September and enhance our frailty service so that it operates effectively and for a minimum of 70 hours a week by December.

We will deliver 30% of non-elective admissions via SDEC by March 2020. We know that our hospital Bed Bureau service has worked very hard to keep pace with the many changes to the UEC system over the past years – in 2019/20 we will review this function and ensure that it meets the current needs of patients and staff and effectively supports maintaining system flow and direction of patients to the most appropriate services within UHL through better clinical decision making.

Our hospitals will share information more effectively with partners and agencies and we will carry out 'perfect ward' MADE (multi-agency discharge) events. We will reduce the number of aborted non-emergency patient transport journeys by improving discharge processes, and we will achieve >50% discharge across the whole of Medicine before 12pm. A Transport Improvement Group has been established. The primary purpose of the group is to focus on improving discharge flow overall, to enable TASL to respond appropriately to UHL's and LPT's needs in a timely manner in line with contract KPI's. This work has been given a priority status from the Integrated Urgent and Emergency Group which reports to the LLR A&E Delivery Board.

We will also be reviewing our overall medical and assessment bed capacity to ensure that we have sufficient capacity to meet demand and that the interventions to reduce demand are effective in managing the flow through our hospitals. We will be undertaking this review ahead of winter so that we are able to ensure we have sufficient capacity to manage increased demand over periods of surge in activity during that time.

	Priorities	Impact Area	Actions	Timeline (END Date)
Hospitals	LOCAL: Bed Bureau	Improve sign posting and utilisation of alternative ambulatory pathways Management of GP referrals for patient transport MAAD event findings – Bed Bureau relay function and acceptance is GP referral led as opposed to access criteria led	Task and Finish Group established Revised Model developed and agreed by partners Test of revised model Project group and lead to be set up working with consult connect and aligning with transport improvement group	Aug 2019 Sept 2019 Dec 2019
	LOCAL: Review of Bed Capacity – in particular Medicine and Assessment	Improve flow through Majors into medicine Improved usage of available bed capacity Early identification of gaps and plans developed to mitigate these Review of assessment beds	Task and Finish Group set up to undertake the review Undertake Bed Audit to understand bed usage Options appraisal for use of ward 7 as extension of AMU (direct admitting bed capacity)	August 2019

Hospitals	Priorities	Impact Area	Actions	Timeline (END Date)
	LOCAL: Transport (Non-emergency) – Reduce the number of aborts for transport , Up to 2 patients identified each day across 5 wards in medicine who will have criteria led discharge by the nurse	Increase flow of discharge earlier in the day – Increase number of discharges that occur before 12pm – currently approximately 30% discharges occur before 12 – to increase to more than 50% discharges across all of Medicine to occur before 12pm Reduce the number of aborts for transport	LLR Transport Improvement Group will lead on developing the plan for Priority 1.(what is referred to as priority 1) UHL, LPT and TASL to ensure that the transfer of patients from UHL to community Hospital are planned the previous day so that those patients are transferred by 10 am	September 2019
	LOCAL: Discharge before midday – "Go Green" - more than 50% discharges across all of Medicine to occur before 12pm	Up to 2 patients identified each day across 5 wards in medicine who will have criteria led discharge by the nurse	Tiger Team to be set up by Lead Nurse for Medicine to identify the 5 wards. Develop PDSA and evaluate the impact	June 2019 First PDSA August 2019
		Summary TTOs ready for each patient day in advance of discharge date	Tiger Team to be set up by Lead Nurse for Medicine to identify the 5 wards. Develop PDSA and evaluate the impact	September 2019
	LOCAL: Information	Transfer of clinical information electronically without	UHL Team to liaise with LLR IM&T	August 2019

	Priorities	Impact Area	Actions	Timeline (END Date)
Hospitals	sharing with partners and agencies	need for discharge summary.	team to ensure that this is part of the Digital Strategy.	
		Digital solution implementation: increase use of SCR and SystmOne which is already available	Implementation of Remote access for community clinicians to Nerve Centre	TBC
	LOCAL: Perfect ward – focused MADE. (Multi Agency Discharge Event)	Minimise number of medicine outliers Aim for no outlying after 9pm Implementation and embedding consistent and safe practice of SAFER and R2G	2 wards in Medicine - focussed MADE to create flow and embedding culture, practice, behaviour that supports good and safe practices - planned discharges	September 2019
	LOCAL: Reducing readmissions	Reducing readmissions from frequent flyers Reduction in readmission – further analysis of the data planned to set trajectory 6th August	Frequent flyers – to focus on individual patients. Top 10 between UHL, Community and EMAS Implement post discharge support best practice as per the Aston University research – adopt into LLR https://www2.aston.ac.uk/news/?simple-aftercare-slashes-nhs-hospital-readmissions	December 2019 October 2019
	NATIONAL: Ensure	Deliver the standard for SDEC	Participate in the National	September 2019

Hospitals	Priorities	Impact Area	Actions	Timeline (END Date)
	100% of trusts are providing Same Day Emergency Care (12 hours day / 7 days week) by September 2019	Increase usage of GPAU and CDU	Acceleration Programme for SDEC with NHS Elect Expand the scope of GPAU and review CDU	
	NATIONAL: Delivering 30% of non-elective admissions via SDEC by March 2020	30% reduction in non-elective admissions Increase in 0 LOS	UHL currently deliver same day emergency care via GPAU, TIA, and DVT. SDEC Pathway for GP referred patients in place on the Emergency floor (GPAU) monitor LOS on this unit to ensure the pathway is efficient as possible	March 2020
	NATIONAL: Providing a frailty service (70 hours a week) by December 2019.	Increase in Frailty provision by 70% Increase in activity through AFU and EFU	The Frailty Emergency Squad (FES) operates in the Emergency Department and in the Emergency Frailty Unit 08:00-18:00 7/7. This MDT team include a consultant geriatrician, Advanced Nurse Practitioner, pharmacist, discharge unit, OT and physio	December 2019

Transformation Priority 5: Reduce Length of Stay

LLR has made significant improvements is reducing delayed transfers of care and reducing the number of long stay patients in inpatient settings. We want to build on that success and continue to maintain the positive progress we have made by ensuring that we maintain our level of performance and deliver a 40% reduction in long stay patients and long stay beds by March 2020. LLR has made excellent progress in reducing DTOC over the past two years and in 2019/20 we will continue to perform well against our local targets.

We will continue to deliver our local targets by our continued roll out and use of the care home bed state tracker. Our local priorities for reducing length of stay include early discharge planning, supported by multidisciplinary/multi-agency discharge teams and Trusted Assessors. We will help patients to get home quicker and stay at home for longer through our Home First and Discharge to Assess (D2A) offer and we will help people who live in care homes to stay healthier at home through our enhancing health in care homes work. This includes increasing the number of care homes with access to nhs.net email and ensuring that care home staff use our dedicated 24/7 HCP telephone line service to access advice and help patients avoid unnecessary admissions to hospital.

In addition we aim to reduce our readmissions in order to reduce our non-elective demand further by implementing evidence based practice as recommended in the link below.

https://www2.aston.ac.uk/news/?simple-aftercare-slashes-nhs-hospital-readmissions

	Priorities	Impact Area	Actions	Timeline (END Date)
Reduce Length of Stay	LOCAL: Early Discharge Planning	Improve Discharge Co-ordination within Adult and older people MH services	Develop model for discharge co-ordination based on the IDT principles Adapt the IDT principles from UHL to implement into AMH and MHSOP	October 2019
		Improve Self-Funder – Support to patients, their families and staff	Appoint joint post across LLR for Self-Funder Project Lead Develop an LLR Self Funder Information advice and guidance strategy and process	April 2019 June 2019
		Improve Discharge planning in electives – particular focus on orthopaedics	Implementation of LLR process across all acute and non-acute sites in LLR	October 2019
	LOCAL: Systems to Monitor Patient Flow	Implementation and roll out of Integrated Needs Assessment Tool	Roll out of INAT tool across all discharge pathways and into community hospitals	July 2019
		Increase the Utilisation of care home bed tracker from 60% to 80%	Care home bed tracker currently 67% Engagement of care homes to utilise the tracker to update their bed state Engagement of IDT and discharge teams across acute and non-acute	Ongoing Ongoing

	Priorities	Impact Area	Actions	Timeline (END Date)
			including ASC to utilise the tracker to find suitable homes	
		Roll out of red bag scheme across all care homes in LLR	Roll out to all care homes to utilise red bag. LLR 28% complete (City 50% complete, 100% by end of Aug 19. West 50% by the end of Aug 19. East 25% complete)	August 2019
		Development of Local Decisions Unit (LDU) to support information flow from hospital to community services	Development of the service offer blueprint for Leicester, Leicestershire and Rutland Finalisation of service offer and model	June 2019 August 2019
	LOCAL: Multidisciplinary/multi-agency discharge teams	IDT – embedding culture and behaviour	Review and redefine case management across the pathways for LLR Expansion of Housing Enablement Team	August 2019 August 2019
	LOCAL: Home First/D2A	Increase the use of Discharge to Assess Home Pathway across City and County	Review access to D2A Home pathways in line with the community service redesign work Implementation of the Pull Model as part of CSR Review and develop therapy model that better supports D2A home	August 2019 Sept – Oct 2019 Sept 2019

	Priorities	Impact Area	Actions	Timeline (END Date)
			Implementation of NWB action Plan	Dec 2019
	LOCAL: Trusted Assessors	Increase utilisation of trusted assessment and assessors to support transfer and discharge of patients across acute and non-acute	Implementation of Trusted Assessment Model for Care Homes Evaluation of the impact of the model in reducing delays and LOS Embedding TA principles and competencies to support IDT	May 2019 September 2019 August 2019
	LOCAL: Enhancing Health in Care Homes	Reduce the number and length of delay relating to awaiting care homes to assess and accept patients for long-term placements	Rollout of INAT with Care Homes – using the TA to support this	August 2019
		Improve the sharing of information between care homes and hospitals to facilitate and support more timely and safe discharges.	Implementation of digital solutions with care homes to support better exchange of information – NHS.net email account and implementation of EPR- NHS Digital funding supporting the implementation and roll out of this across a number of care homes in LLR	December 2019
	NATIONAL: Nationally, deliver a 40% reduction in long stay patients (and long stay beds) from the March 2018 baseline by March 2020.	40% reduction in long stay patients by March 2020 – trajectory to be developed	Utilisation of regular MADE to embed changes in practice and consistency of Red to Green Embed long stay Wednesdays and system escalation calls to support safe	March 2020

	Priorities	Impact Area	Actions	Timeline (END Date)
			and timely discharge of patients	
	NATIONAL: Continue to make progress on reducing delayed transfers of care (DTOC) to achieve and maintain a national average DTOC position of 4,000 or fewer daily delays, with local targets to be set for 2019/20 through Better Care Fund (BCF) plans. Further detail on these expectations as well as wider requirements for BCF plans will be published later in 2019	Delivery of BCF Standards	See above local actions under the delivery of high impact actions	TBC – guidance just published awaiting technical guidance
	NATIONAL: Ongoing implementation of the Care Home Bed State Tracker, including embedding into Acute Trusts	Increase participation to 70% Increase usage 50%	See LOCAL Enhancing Health in Care Homes that outlines the actions to deliver this standard	March 2020

Transformation Priority 6: Digital

Our digital priorities will help us to deliver many of our other five priorities. In 2019/20 we will complete work begun in 2017 to ensure that our IUC system is fully interoperable, with electronic appointment booking available for all face to face consultations in urgent care settings. In 2019/20 we will go further and ensure that our ED is fully resourced and able to implement direct electronic appointment into extended primary care appointments. This is now a key KPI in the GMS contract for GP practices.

Record sharing is also a key priority. We want to build on past success by increasing the number of patients who consent to share additional information through e-SCR. In addition we plan to make the records accessible to UHL and EMAS of any patient with a frailty score of 7 and above.

The LRI ED and every e-prescribing pharmacy in LLR will have access to extended patient data via the SCR. Our UTCs and LRI ED will also have access to primary care records, mental health crisis records and end of life plans.

Finally, we will ensure that the Emergency Care Data Set is implemented in all our T1 and T3 departments. We have commenced working with our UTC and extended access provider to implement technical solutions that will support this. However it is important to note that currently not all of the technical solutions are readily available especially with SystmOne TPP community module. TPP is currently working on a technical solution.

	Priorities	Impact Area	Actions	Timeline (END Date)
Digital	NATIONAL: Implementation of ECDS into T1 / T3 departments (where not already implemented)	UTC's	Rectify issues around data extraction of ECDS from Adastra	Oct 2019
	NATIONAL: UTC and IUC/CAS that have appointment booking capability	Improved booking capability across all practices in LLR	Configure remaining 50% of practices across LLR	Oct 2019
	NATIONAL: Increase the number of patients who have consented to share their additional information through the extended summary care record (e-SCR)	LLR Patients A&E UTC / CNH /Social Care / Community Pharmacy	Clinical System Searches for EOL and Frailty cohorts with no consent preference IM&T Comms drive to public to consent to share eSCR Protocols for Practice Staff on to support consent uptake on patient contact Workstreams to support drive for Consent – Long Term Conditions and Community Service Redesign	Ongoing
	NATIONAL: Every A&E, and ePrescribing pharmacy will have access to extended patient data either through the Summary Care Record or local care record sharing	Community Pharmacy	UHL Adults and Children's ED has access to TPP EPR Core (for S1 patients and SCR for EMIS patients) and can access Integrated Care Plan which	March 2021

	Priorities	Impact Area	Actions	Timeline (END Date)
Digital	services		includes EOL,LTC, Cancer and frailty data – actions around appropriate access for clinicians and clinical facilitation Liaison with local Pharmacy system suppliers/LPC and NHS Digital to establish issues with enhanced data items not being visible Currently 98% of Community Pharmacy has access to SCR. Engagement with remaining 3%	 Oct 2019 June 2020
	NATIONAL: Access to primary care records, mental health crisis and end of life plan information available in 40% of A&Es and Urgent Treatment Centres	A & E / UTC's	UHL Adults and Children's ED has access to TPP EPR Core (for S1 patients and SCR for EMIS patients) and can access Integrated Care Plan which includes EOL,LTC, Cancer and frailty data – actions around appropriate access for clinicians and clinical facilitation 3 X LLR UTC's use S1 TPP and SCR	Ongoing

Digital	**Priorities**	**Impact Area**	**Actions**	**Timeline (END Date)**
		A & E / UTC's	for (EMIS patients) and can access Integrated Care Plan which includes EOL,LTC, Cancer and frailty data Gap with MH see below.	Complete
		A & E / UTC's UTC's	MH Crisis information available in S1 record when MH services migrate to S1 (Current Gap all above) Implementation of Standards based structured info (FHIR HL7) for MH Crisis (EMIS patients) into S1 record	June 2020 June 2020
	NATIONAL: NHS 111 will be able to book people into urgent face to face appointments where this is needed.	UTC's	Resolve EMIS and BlackPear interoperability issues (Remaining circa 15% practices)	August 2019
	LOCAL : Record Sharing between Health and Social Care Proof of Concept	Integrated Discharge Team (Social Care) DTOC	Structured transfer specification for INAT data items to Local Authority Case Management systems (Liquid Logic) eSCR in Local Authorities	March 2020 July 2020

	Priorities	Impact Area	Actions	Timeline (END Date)
Digi tal	LOCAL : Digitisation Care Homes (Inc. NHS Mail, DSPT compliance and EPR implementation)	Social Care Primary Care Networks	DSPT compliance, NHS Mail and EPR capability x 10 Care Homes Establish Project development and governance Further 119 Care Homes DSPT and NHS Mail 40% of LLR care homes have EPR capability Further homes DSPT and NHS Mail	June 2020 Oct 2019 March 2021 March 2021 Ongoing
	LOCAL: EMAS Record Sharing	Paramedics Patients CAT Team	Rollout Mobile Record Viewing Capability Implement OOH SystmOne Unit in CAT team	March 2021 Dec 2019
	LOCAL: ED deflection	UTC Patients	Supplier engagement and options appraisal development for decision on approach	Oct 2019
	LOCAL: EMAS Transfers of Care to ED	ED Patients	Develop specification for EMAS structured assessment data into Nerve Centre ED	March 2020

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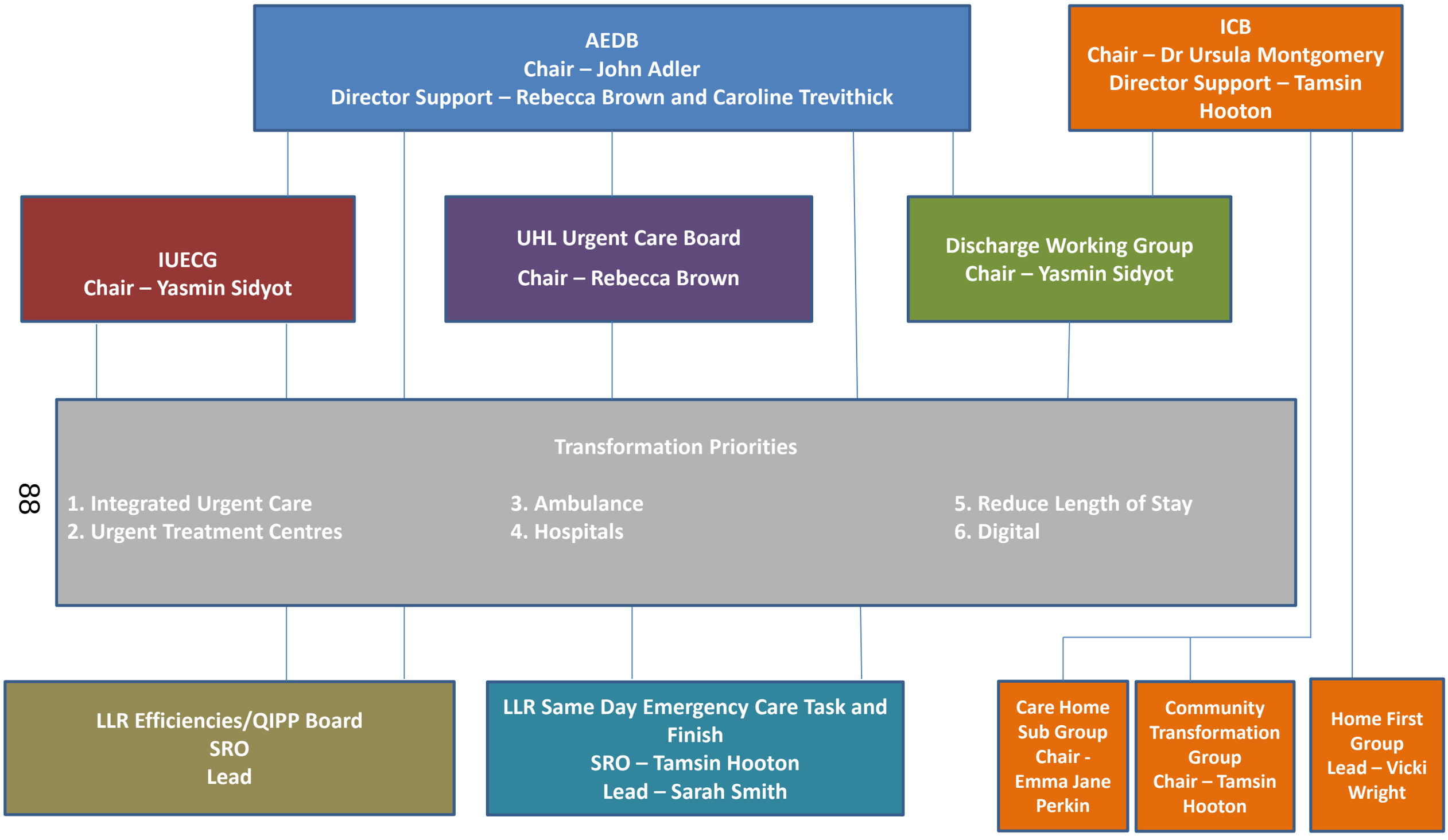
Appendix A



Final - Governance Structure UEC

Appendix B

Transformation Plan – National and Local priorities 19/20

Integrated Urgent Care

National priorities

- Maintain a 50%+ proportion of NHS 111 calls receiving clinical assessment.
- Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than 40% by 31st March 2020.
- By 31st March 2020, reduce 'A&E by default' selections on the Directory of Services (DoS) to less than 1% by the commissioning of appropriate services that are accurately recorded on DoS

Local priorities

- Increase clinical assessment of low acuity of 999 activity (CAT 3 and 4)
- Clear specification & offer of different tiers of care
- Better targeting of patients straight to SDEC
- Reduce length of stay on SDEC pathway
- Clinical advice and Guidance

Ambulance

National Priorities

- Deliver a safe reduction in ambulance conveyance to EDs with trajectories to be agreed between services and their lead commissioners.
- All ambulance services to meet, as a minimum, a baseline level of digital maturity including access to and usage of patient information at scene (e.g. Summary Care Record, Patient Demographic Service, Electronic Patient Record), access to service information at scene (e.g. DoS) and establishing Electronic Prescribing.
- Ensure 100% of ambulance handovers occur within 30 minutes.

Hospitals

National Priorities

- Ensure 100% of trusts are providing Same Day Emergency Care (12 hours day / 7 days week) by September 2019
- Delivering 30% of non-elective admissions via SDEC by March 2020
- Providing a frailty service (70 hours a week) by December 2019.

Local Priorities

- Bed Bureau
- Transport (Non-emergency) – Reduce the number of aborts for transport , Up to 2 patients identified each day across 5 wards in medicine who will have criteria led discharge by the nurse
- Discharge before midday – "Go Green" - more than 50% discharges across all of Medicine to occur before 12pm
- Information sharing with partners and agencies
- Perfect ward – focused MADE. (Multi Agency Discharge Event)

Urgent Treatment Centres

National priorities

- Designate the majority of urgent treatment centres (UTC) by December 2019, with any exceptions to be agreed with the Regional Director.

Reduce Length of Stay

National Priorities

- Nationally, deliver a 40% reduction in long stay patients (and long stay beds) from the March 2018 baseline by March 2020.
- Continue to make progress on reducing delayed transfers of care (DTOC) to achieve and maintain a national average DTOC position of 4,000 or fewer daily delays, with local targets to be set for 2019/20 through Better Care Fund (BCF) plans. Further detail on these expectations as well as wider requirements for BCF plans will be published later in 2019.
- Ongoing implementation of the Care Home Bed State Tracker, including embedding into Acute Trusts

Local Priorities

- Early Discharge Planning
- System to monitor patient flow
- Multidisciplinary/multi-agency discharge teams
- Home First/D2A
- Trusted Assessors
- Enhancing health in care homes

Digital

National Priorities

- Implementation of ECDS into T1 / T3 departments (where not already implemented) Implementation of any digital elements not delivered in 2018/19 such as:
- UTC and IUC/CAS that have appointment booking capability
- Increase the number of patients who have consented to share their additional information through the extended summary care record (e-SCR)
- Every A&E, and ePrescribing pharmacy will have access to extended patient data either through the Summary Care Record or local care record sharing services
- Access to primary care records, mental health crisis and end of life plan information available in 40% of A&Es and Urgent Treatment Centres
- NHS 111 will be able to book people into urgent face to face appointments where this is needed.

Local Priorities

- Record Sharing between Health and Social Care
- Digitisation Care Homes
- EMAS Record Sharing
- ED deflection EMAS
- Transfers of Care to ED

UEC Detailed National and Local Priorities

Appendix C

	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
Integrated Urgent Care	LOCAL: Increased clinical assessment of low acuity of 999 activity	Redirection of CAT 3&4 Calls to CNH - testing in Aug-Sept will inform the quantifiable impact	Elizabeth Amias	Pilot implementation to test model agreed ahead of implementation in Q4 Testing to start on 19/08/19 – 02/0919. Following actions to be undertaken: Staffing the admin position – all agreed to look at potential staffing Confirmation of retesting Consider the electronic route back into EMAS Review process map	August – September 19 January 2020	EOL Home First IM&T Discharge Programme IM&T HVS EMAS (Regional) Primary Care WLCCG UCCs/EPC ELRCCG UCCs/EPC LCCG Primary Care Hubs UEC DoS
	LOCAL: Clear specification & offer across the LLR IUEC tiers of care Model	Increase use and offer of Extended primary care in line with the PCN ambitions - Increase	LLR CCG Primary Care Leads	Updated primary care offer	September 2019	EOL Home First IM&T

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
		uptake of extended access to over 80% across LLR				
		Specifications: Emergency Front door Community based Access	Vicki Enright Lead TBC	Specification agreed Agree UTC offer CCG	July March 2020	Home First Paediatrics IM&T
		(MADD event findings – Circa 10% of walk ins advised by their GP to go to A&E) -		Senior clinical review which provides link to consult connect and bed bureau		
	LOCAL: Better targeting of patients straight to SDEC	Direct access to Clinics LOS on the SDEC Pathway in line with national ambition	Sarah Smith SDEC group	Develop Service Spec for SDEC ID Pathways & KPI's for each unit UHL planning commenced 25th July 2019	September 19	SDEC Programme 111 (regional) CNH
		SDEC acute and out of hospital offer	SDEC Group	Develop Model for diagnostic offer across out of hospital sites - LuCC	September 19	SDEC Programme 111 (regional)

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
		to be developed to increase community based access for diagnostics (Currently in PDSA phase)		Re-launch of 10 ambulatory care pathways to LUCC and mandated EMAS conveyance to LUCC goes live 5th Aug 2019		
		(MAAD event findings – Circa 15% ambulance conveyances potentially unnecessary) LOS on the SDEC Pathway in line with national ambition SDEC acute and out of hospital offer to be developed to increase community based access for diagnostics (in PDSA phase)		UCC conveyance mandated (EMAS/LLR) Review of 10 cases per week (over 3 months) on non-admitted ambulance conveyance to understand cases and learning for clinical feedback ID Pathways & KPI's for each Unit UHL Planning commenced 25th July 2019 Develop Model for diagnostic offer across out of hospital sites - LuCC Re-launch of 10 ambulatory care pathways to LUCC and mandated EMAS conveyance to LUCC goes live 5th Aug 2019	Sept 19	

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
	LOCAL: clinical advice & Guidance	Direct access to Clinics Increase use of SDEC Pathways	TBC	Review current clinical Advice and guidance offer Develop new model for clinical advice and guidance that fits with the development of PCNS across LLR UHL planning commenced 25th July 2019	February 2020	SDEC Programme Primary Care Networks Community Service Redesign
		(MAAD event finding's – Circa 20% of walk ins did not consider alternatives to A&E)		Injuries – ambulatory pathways to focus on 18/25 age group – targeted communications (fresher's week)	December 2019	
	LOCAL: Reduce length of Stay SDEC Pathway	Increase in 0 LOS Reduction in NEL Admissions	SDEC Group	Implement actions as identified by through the National Acceleration Programme provided by NHS Elect . – next visit on 24th October 2019 UHL planning commenced 25th July 2019	September 19	SDEC Programme UHL Flow

d Urgent Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
	Local: Primary Care	Ensure that all extended access capacity is utilised to reduce demand on ED Targeted demand management with GP Practices – LLR approach Accessing City hubs	David Muir – West Paula Vaughan – ELR Arlene Neville – West City and East - TBC	West – implement agreed operational delivery changes to ensure optimised appointment availability and provision – work with referring practices to ensure optimised and strategic use of available capacity Agree a population health based demand mgt approach – June completed Discuss the approach with localities – June completed Test approach with one outlier practice and develop action plan – June/July completed Feedback progress to F&P and West GB – July completed Present and discuss approach at West ACD meeting – 6 Aug – in progress Visit remaining outlier	October 19	

d Urgent Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
				practices – Aug to Mid Oct – in progress		
	Local: Reduce A&E attends 18-25 group	Reduce A&E attends 18-25 group. High volume of patients leave before treatment/ do not need treatment. Injuries – ambulatory pathways use for this age group - Role of SDEC and the redirection to LUCC	Vicki Enright Sarah Smith	To reduce: 20% by 2019/20 50% by 2020/21	December 19 December 2020	

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
	Local: Mental Health support	Currently 111 dispositions into ED is 34% Reduction 1429 DX92 dispositions from 111 into ED Increase referral flow into CNH Reduce EMAS conveyance for low level into ED	Elizabeth Amias /DHU &LPT Sarah Warmington (MH Commissioning Team) Matt Pickard & Alyson Taylor	To provide MH support to CNH.- MH Practitioner into CNH – test phase to commence in Late September Options appraisal during mobilisation Implement additional support Improve Access into crisis team for CNH, EMAS and GP without GP face to face review dispositions (34% June 18-May 19) Frequent attenders work to develop shared care plans for known cohort impacting on attendances for VB11Z and VB09Z Reduction of 1429 DX92 dispositions Implementation of the CORE 24 standards	October 19 April 2020 Sept 2019 testing to commence April 2020 – although would be able to implement this earlier if the MH crisis funding is available in Q3 2019/20 April 2020 onwards – the funding to support this is released in April 2020	

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
	Local: Reducing Care Home Admissions	Reducing 1000 patients on a 7 day stay	Vicki Enright & Emma Jane Perkins	Accelerate the enhanced health in care homes plan by CH Subgroup to achieve a further reduction in care home admissions based on the success in 18/19 Implementation of the digital solutions – extending the current work further Delivery of telemedicine and scoping further ways in which this can be used to better manage patients living in care homes	December 19 October 19 March 20	
	Local: LLR Falls Programme	A reduction in FEMUR fracture acute interventions and a reduction in consultant led first out-patient appointments where patients are triaged assessed and managed within a community setting	Sarah Smith	Postural Stability Exercise Programme – embedded in County and Rutland. City – went live 1st April 2019 with non-recurrent funding for 12 months Electronic Falls Risk Assessment – phased implementation commences in Aug. Non Blue Light Service Response – Coalville PDSA	Completion June 2020 Aug 2019 Aug 2019 July 19	

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
				commenced 10th July 2019 Therapy Triage Service – embedded in County and Rutland Training & Equipment in Care Homes – PDSA to commence Autumn 2019	Sep 19	
	NATIONAL: Maintain a 50%+ proportion of NHS 111 calls receiving clinical assessment.	Increase in proportion of 111 calls receiving clinical assessment Increase activity in CNH	IUEC Group Elizabeth Amias	Enhance the clinical assessment of low acuity ambulance activity Review DoS to identify further opportunities for clinical assessment rather than A&E by default	October 2019	IUEC Programme CNH Development Regional 111 Programme
	NATIONAL: Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than 40% by 31st March 2020. By 31st March 2020, reduce 'A&E by default' selections on the Directory of Services (DoS) to less than 1% by the commissioning of appropriate services that are accurately recorded on DoS	Increase in percentage of patients booked into face to face consultation to over 40% from 37%	IUEC Group Elizabeth Amias	review our model of booked appointments vs walk in access across LLR implementing 1 GP appointment available to NHS111 for every 3000 patients across LLR Implementation of MiDoS	December 2019	IUEC Programme Primary Care Networks

	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
Urgent Treatment Centres	NATIONAL: Designate the majority of urgent treatment centres (UTC) by December 2019, with any exceptions to be agreed with the Regional Director.	Designation of UTCs in LLRs	IUEC Group Yasmin Sidyot	Review the current designated sites and determine whether these remain as the designated UTCS for LLR and they can continue to fit into the LLR IUEC Model	December 2019	SDEC Programme IM&T/LHIS LLR Primary Care Strategy Extended Primary Care Access

	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
Ambulance	LOCAL: Redirection of ambulance conveyance into alternative pathways	MADD event findings - paramedics decision-making not always consistent or protocols not consistent in and out of hours Improve consistency of protocols Increase non-conveyance by 1% in Q3 and 1.5% in Q4	Jade Atkin Sarah Smith and Dan Webster Dan Webster, Julie Dixon and Russ Smalley	Same day access to chest pain clinic – 24 hour pathway – learning from Notts and Northants Implement mandated conveyance to LUCC by EMAS – commences 2nd August Implement pathways to redirect conveyance straight to CDU Access to Health Care professional line (HCP) Implementation of MiDoS Training EMAS staff around mental health crisis/emotional distress	October 2019 August 2019 August 2019 In Place – monitoring use through failed pathways data TBC once agreed by partners October 2019	

ɔ — ɐ	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
	NATIONAL: All ambulance services to meet, as a minimum, a baseline level of digital maturity including access to and usage of patient information at scene (e.g. Summary Care Record, Patient Demographic Service, Electronic Patient Record), access to service information at scene (e.g. DoS) and establishing Electronic Prescribing.	Improved clinical decision making Improved patient outcome Decreased EMAS on scene time Conveyance avoidance due to improved overall clinical picture	EMAS SLT Lead & regional commissioning	Improve use of system one Potential of My DOS EMAS ePRF already widely used	December 2019 December 2019 completed	System one Nerve centre EMAS ePRF
	NATIONAL: Ensure 100% of ambulance handovers occur within 30 minutes	4 hr standard Ambulance handover turnaround performance Improved quality of care More available resources to serve unseen patients in the community -(Matthews story) MADD event findings – Ambulance assessment inconsistent and variation between process and workforce	AEDB LLR CCG UEC EMAS GM/SDM UHL COO	Improve Fit to sit Direct to clinic Transport Improved collaborative escalation procedure Mapped LLR Against NHSE/I Guidance and tailored to suit the locality Operational group now meets every 2 weeks to enable continuous oversight and improvement Visits arranged to Newcastle and Leeds to investigate learning opportunity Shared EMAS/UHL conveyance modelling to enable awareness of potential peak activity AHD group work – tracker in department role. UHL and EMAS will evaluate the	Fit to sit – **Complete** Direct access to clinic – **Complete** however looking into further opportunity Learning visits complete Action Plan to developed post learning visit by 9th August 2019	UHL EMAS

	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
		MADD event findings - Handover delays occur when there are 4-5 ambulances arrive within 15 minutes		requirement of a HALO and a nurse co-ordinator in ambulance assessment role Fit to sit Send EMAS straight to clinic Escalation procedure – improve communication between operational levels Nurse co-ordinator	Conveyance modelling by the end of July	

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
Hospitals	LOCAL: Bed Bureau	Improve sign posting and utilisation of alternative ambulatory pathways Management of GP referrals for patient transport MAAD event findings – Bed Bureau relay function and acceptance is GP referral led as opposed to access criteria led	Sarah Smith Elizabeth Amias Dan Webster Julie Dixon Joanna Clinton DHU	Task and Finish Group established Revised Model developed and agreed by partners Test of revised model Project group and lead to be set up working with consult connect and aligning with transport improvement group	August 2019 September 2019 December 2019	Primary Care IUC IM&T

Hospitals	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
	LOCAL: Transport (Non-emergency) – Reduce the number of aborts for transport , Up to 2 patients identified each day across 5 wards in medicine who will have criteria led discharge by the nurse	Increase flow of discharge earlier in the day – Increase number of discharges that occur before 12pm – currently approximately 30% discharges occur before 12 – to increase to more than 50% discharges across all of Medicine to occur before 12pm Reduce the number of aborts for transport	Joanna Clinton	LLR Transport Improvement Group will lead on developing the plan for Priority 1. UHL, LPT and TASL to ensure that the transfer of patients from UHL to community Hospital are planned the previous day so that those patients are transferred by 10 am	September 2019	
	LOCAL: Discharge before midday – "Go Green" - more than 50% discharges across all of Medicine to occur before 12pm	Up to 2 patients identified each day across 5 wards in medicine who will have criteria led discharge by the nurse	Sharon Harding Rachel Marsh – Clinical Leadership	Tiger Team to be set up by Lead Nurse for Medicine to identify the 5 wards. Develop PDSA and evaluate the impact	June 2019 First PDSA August 2019	
		Summary TTOs ready for each patient day in advance of discharge date	Sharon Harding Rachel Marsh – Clinical Leadership	Tiger Team to be set up by Lead Nurse for Medicine to identify the 5 wards. Develop PDSA and evaluate the impact	September2019	
	LOCAL: Information sharing with partners and agencies	Transfer of clinical information electronically without need for discharge summary.	LLR IM&T UHL medicines CMG reps	UHL Team to liaise with LLR IM&T team to ensure that this is part of the Digital Strategy.	September 2019	

Hospitals	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
		Digital solution implementation: increase use of SCR and SystmOne which is already available	LLR IM&T UHL medicines CMG reps	Implementation of Remote access for community clinicians to Nerve Centre	TBC	
	LOCAL: Perfect ward – focused MADE. (Multi Agency Discharge Event)	Minimise number of medicine outliers Aim for no outlying after 9pm Implementation and embedding consistent and safe practice of SAFER and R2G	UHL to lead Requires strong clinical leadership, Jackie Wright, Ashraf Osman, Rachel Marsh (to identify the who), Sue Burton (nursing perspective), Sharon Harding Chrissie David King (pharmacy)	2 wards in Medicine - focussed MADE to create flow and embedding culture, practice, behaviour that supports good and safe practices - planned discharges	August 2019	
	LOCAL: Reducing readmissions	Reducing readmissions from frequent flyers Reduction in readmission – further analysis of the data planned to set trajectory 6th August	Mark Pierce & Alyson Taylor UHL LPT CCG – DWG	Frequent flyers – to focus on individual patients. Top 10 between UHL, Community and EMAS Implement post discharge support best practice as per the Aston University research – adopt into LLR	December 2019 October 19	

Hospitals	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
				https://www2.aston.ac.uk/news/?simple-aftercare-slashes-nhs-hospital-readmissions		
	NATIONAL: Ensure 100% of trusts are providing Same Day Emergency Care (12 hours day / 7 days week) by September 2019	Deliver the standard for SDEC Increase usage of GPAU and CDU	LLR SDEC Group UHL – Rebecca Brown	Participate in the National Acceleration Programme for SDEC with NHS Elect Expand the scope of GPAU and review CDU	September 2019	
	NATIONAL: Delivering 30% of non-elective admissions via SDEC by March 2020	30% reduction in non-elective admissions Increase in 0 LOS	LLR SDEC Group Sarah Smith	UHL currently deliver same day emergency care via GPAU, TIA, and DVT. SDEC Pathway for GP referred patients in place on the Emergency floor (GPAU) monitor LOS on this unit to ensure the pathway is efficient as possible	March 2020	
	NATIONAL: Providing a frailty service (70 hours a week) by December 2019.	Increase in Frailty provision by 70% Increase in activity through AFU and EFU	LLR SDEC Group Julie Dixon	The Frailty Emergency Squad (FES) operate in the Emergency Department and in the Emergency Frailty Unit 08:00-18:00 7/7. This MDT team include a consultant geriatrician, Advanced Nurse Pracititioner, pharmacist, discharge unit, OT and physio	December 2019	

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
Reduce Length of Stay	LOCAL: Early Discharge Planning	Improve Discharge Co-ordination within Adult and older people MH services	LPT – AMH and MHSOP	Develop model for discharge co-ordination based on the IDT principles Adapt the IDT principles from UHL to implement into AMH and MHSOP	October 2019	DWG IDT UHL LPT AMH
		Improve Self-Funder – Support to patients, their families and staff	Leicester City Council	Appoint joint post across LLR for Self-Funder Project Lead Develop an LLR Self Funder Information advice and guidance strategy and process	April 2019 June 2019	IDT DWG
		Improve Discharge planning in electives – particular focus on orthopaedics		Implementation of LLR process across all acute and non-acute sites in LLR	October 2019	Planned Care NWB DWG IDT
	LOCAL: Systems to Monitor Patient Flow	Implementation and roll out of Integrated Needs Assessment Tool	LLR Tiger Team for IDT	Roll out of INAT tool across all discharge pathways and into community hospitals	July 2019	IM&T Home First DWG
		Increase the Utilisation of care home bed tracker from 60% to 80%	LLR Project support hosted by Rutland County Council	Care home bed tracker currently 67% utilised Engagement of care homes to	Ongoing	Flow IDT Home First Care Home Sub

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
				utilise the tracker to update their bed state Engagement of IDT and discharge teams across acute and non-acute including ASC to utilise the tracker to find suitable homes	Ongoing	Group ICB ASC
		Roll out of red bag scheme across all care homes in LLR	LLR	Roll out to all care homes to utilise red bag. LLR 28% complete (City 50% complete, 100% by end of Aug 19. West 50% by the end of Aug 19. East 25% complete)	August 2019	Flow IDT Home First ASC
		Development of Local Decisions Unit (LDU) to support information flow from hospital to community services	Community Services Redesign LPT & LA's	Development of the service offer blueprint for Leicester, Leicestershire and Rutland Finalisation of service offer and model	June 2019 August 2019	Home First CSR DWG IDT ASC
	LOCAL: Multidisciplinary/multi-agency discharge teams	IDT – embedding culture and behaviour	LLR Discharge Working Group (DWG)	Review and redefine case management across the pathways for LLR Expansion of Housing Enablement Team	August 2019 August 2019	
	LOCAL: Home First/D2A	Increase the use of	LLR DWG and	Review access to D2A Home	August	Community

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
		Discharge to Assess Home Pathway across City and County	Community Transformation Group	pathways in line with the community service redesign work Implementation of the Pull Model as part of CSR Review and develop therapy model that better supports D2A home Implementation of NWB action Plan	2019 Sept – Oct 2019 Sept 2019 Dec 2019	Service Review ICB Care Home Sub Group IDT ASC LPT
	LOCAL: Trusted Assessors	Increase utilisation of trusted assessment and assessors to support transfer and discharge of patients across acute and non-acute	Leicestershire County Council UHL&LPT	Implementation of Trusted Assessment Model for Care Homes Evaluation of the impact of the model in reducing delays and LOS Embedding TA principles and competencies to support IDT	May 2019 September 2019 August 2019	Community Service Review ICB Care Home Sub Group IDT
	LOCAL: Enhancing Health in Care Homes	Reduce the number and length of delay relating to awaiting care homes to assess and accept patients for long-term placements		Rollout of INAT with Care Homes – using the TA to support this	August 2019	Trusted Assessment Home First CSR
		Improve the sharing of information between care homes and hospitals to facilitate and support	LLR & IM&T	Implementation of digital solutions with care homes to support better exchange of information – NHS.net email account and implementation	December 2019	

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
		more timely and safe discharges.		of EPR- NHS Digital funding supporting the implementation and roll out of this across a number of care homes in LLR		
	NATIONAL: Nationally, deliver a 40% reduction in long stay patients (and long stay beds) from the March 2018 baseline by March 2020.	40% reduction in long stay patients by March 2020 – trajectory to be developed	LLR DWG	Utilisation of regular MADE to embed changes in practice and consistency of Red to Green Embed long stay Wednesdays and system escalation calls to support safe and timely discharge of patients	March 2020	
	NATIONAL: Continue to make progress on reducing delayed transfers of care (DTOC) to achieve and maintain a national average DTOC position of 4,000 or fewer daily delays, with local targets to be set for 2019/20 through Better Care Fund (BCF) plans. Further detail on these expectations as well as wider requirements for BCF plans will be published later in 2019	Delivery of BCF Standards	LLR DWG	See above local actions under the delivery of high impact actions	TBC - guidance just published awaiting technical guidance	
	NATIONAL: Ongoing implementation of the Care Home Bed State Tracker,	Increase participation to 70% Increase usage 50%	LLR Care Homes Sub Group	See LOCAL Enhancing Health in Care Homes that outlines the actions to deliver this standard	March 2020	

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
	including embedding into Acute Trusts					

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
Digital	NATIONAL: Implementation of ECDS into T1 / T3 departments (where not already implemented)	UTC's	DHU	Rectify issues around data extraction of ECDS from Adastra	Oct 2019	Supplier technical data extraction capability
	NATIONAL: UTC and IUC/CAS that have appointment booking capability	Improved booking capability across all practices in LLR	DHU	Configure remaining 50% of practices across LLR	Oct 2019	Supplier Technical
	NATIONAL: Increase the number of patients who have consented to share their additional information through the extended summary care record (e-SCR)	LLR Patients A&E UTC / CNH /Social Care / Community Pharmacy	CCG's	Clinical System Searches for EOL and Frailty cohorts with no consent preference IM&T Comms drive to public to consent to share eSCR Protocols for Practice Staff on to support consent uptake on patient contact Workstreams to support	Ongoing	Patients wanting to Consent Community Services Redesign and all other SCR workstreams Target to achieve - all people with LTC to have access to eSCR: LTC Baseline With access : 86,000 (LLR) LTC Target by Dec 2020:

Digital	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
				drive for Consent – Long Term Conditions and Community Service Redesign		296,888 (LLR) LTC Additional 210,888 to consent
	NATIONAL: Every A&E, and ePrescribing pharmacy will have access to extended patient data either through the Summary Care Record or local care record sharing services	Community Pharmacy	UHL	UHL Adults and Children's ED has access to TPP EPR Core (for S1 patients and SCR for EMIS patients) and can access Integrated Care Plan which includes EOL,LTC, Cancer and frailty data – actions around appropriate access for clinicians and clinical facilitation	March 2021	Future reliance on GP connect to support contextual view within NC
			Local Pharmaceutical Committee (LPC)	Liaison with local Pharmacy system suppliers/LPC and NHS Digital to establish issues with enhanced data items not being visible	Oct 2019	Pharmacy System Supplier capability
				Currently 98% of Community Pharmacy has access to SCR. Engagement with remaining 3%	June 2020	Prioritisation due to release of new pharmacy contract

Digital	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
	NATIONAL: Access to primary care records, mental health crisis and end of life plan information available in 40% of A&Es and Urgent Treatment Centres	A & E / UTC's	UHL	UHL Adults and Children's ED has access to TPP EPR Core (for S1 patients and SCR for EMIS patients) and can access Integrated Care Plan which includes EOL,LTC, Cancer and frailty data – actions around appropriate access for clinicians and clinical facilitation	Ongoing	UHL RA services HSLI Funding
		A & E / UTC's	DHU	3 X LLR UTC's use S1 TPP and SCR for (EMIS patients) and can access Integrated Care Plan which includes EOL,LTC, Cancer and frailty data Gap with MH see below.	Complete	LPT Strategic Direction to consolidate to a single EPR (S1) Current MH EPR migration to S1 June 2020
		A & E / UTC's	UHL	MH Crisis information available in S1 record when MH services migrate to S1 (Current Gap all above)	June 2020	Supplier led Interoperability Programme – FHIR standards signed off
		UTC's	DHU	Implementation of Standards based structured info (FHIR HL7)	June 2020	Gap area MH – all others ok

Digital	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
				for MH Crisis (EMIS patients) into S1 record		
	NATIONAL: NHS 111 will be able to book people into urgent face to face appointments where this is needed.	UTC's	DHU	Resolve EMIS and BlackPear interoperability issues (Remaining circa 15% practices)	August 2019	DHU resources

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
Digital	LOCAL : Record Sharing between Health and Social Care Proof of Concept	Integrated Discharge Team (Social Care) DTOC	Leicestershire County Council	Structured transfer specification for INAT data items to Local Authority Case Management systems (Liquid Logic) eSCR in Local Authorities	March 2020 July 2019	HSLI System Funding Supplier capability – LL and NC Nottingham LA team
	LOCAL : Digitisation Care Homes (Inc. NHS Mail, DSPT compliance and EPR implementation)	Social Care Primary Care Networks	Leicestershire County Council	DSPT compliance, NHS Mail and EPR capability x 10 Care Homes Establish Project development and governance Further 119 Care Homes DSPT and NHS Mail 40% of LLR care homes have EPR capability Further homes DSPT and NHS Mail	June 2019 Oct 2019 March 2021 March 2021 Ongoing	HSLI Funding Digital Social Care Pathfinders Funding Care Homes Infrastructure
	LOCAL: EMAS Record Sharing	Paramedics Patients	EMAS	Rollout Mobile Record Viewing Capability	March 2021	National SCR programme NHSD Identify Management Service

Digital	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
		CAT Team		Implement OOH SystmOne Unit in CAT team	Dec 2019	Future of RBACS smartcards
	LOCAL: ED deflection	UTC Patients	UHL	Supplier engagement and options appraisal development for decision on approach	Oct 2019	NC GP Connect Assurance for Direct Appointment booking as consumer HSLI Funding
	LOCAL: EMAS Transfers of Care to ED	ED Patients	EMAS	Develop specification for EMAS structured assessment data into Nerve Centre ED	March 2020	Medusa approval to release data extracts National Ambulance Spec for TOC GP and Care Connect Programme HSLI Funding

Appendix D

EMAS variation Proposal to NHSEI

10a Assurance

The national CQUIN specifies four nationally approved systems. The proposal from EMAS is to access the patient record via the ***GP Connect System***, which is not one of the four systems.

Crews will use their GETEC devices (the handheld devices that electronically record and submit patient record forms (ePRF)) to enter the web based system which is compatible with other systems to allow their crews to view the patient record.

This will allow EMAS to view the record only, they will not be able to edit any patient record. The crews will be able to see patients medications, allergies etc, their current health and wellbeing, any current or outstanding issues, details of any referrals, observations or immunisations, and also view the last three contacts with healthcare professionals.

The system will allow EMAS to store a copy of the record so it will be possible to identify if the crews access the records or not, and through the ePRF record, the GP will also be able to see what information the crews accessed.

The coordinating commissioning team view is that this proposal will allow EMAS to demonstrate that they can access the patient record, and therefore achieve the outcomes specified within the national documentation, and therefore recommend that this proposal is agreed as a local variation.

10b Demonstration

The second half of the CQUIN is for EMAS to then demonstrate that they have accessed the patient records. The national CQUIN milestone states 5% during Q3 and Q4. This CQUIN is not applicable for Q1 and Q2.

EMAS have confirmed that there is no technical reason why this system cannot be implemented for 1st October however they will need GPs to grant access for crews. EMAS have confirmed that they have begun to link in with local PCNs, however may need commissioner support in this area.

EMAS have proposed two variations to this part of the CQUIN;

1. EMAS have proposed that Q3 should commence once the system is fully implemented. For example, if the system isn't fully implemented until 10th November, then Q3 demonstration would only count for the period 10th November – 31st December.

2. EMAS have also proposed that there are some exclusions to the count (contrary to the national CQUIN which clearly defines the count). The four proposed exclusions are;
    a. C1 calls
    b. HCP calls

c. VAS/PAS crews - EMAS have stated that VAS/PS crews wouldn't be able to access the patient record as they do not have the GETEC devices – VAS/PAS PRFs are completed on paper.
d. Where no NHS number is identified.

The coordinating commissioner view is that the national CQUIN is quite clear in terms of what is expected and although the rational for the proposed exclusions are understood, the target for Q3 and Q4 is only 5%.
We have sought advice from NHSE, and they too have stated that the target of 5% should be a cumulative position over Q3 and Q4 and agree that this should be achievable without any delay in timeline or exclusions.

Appendix C

Report to Scrutiny Commission

Health and Wellbeing Scrutiny Commission

Date of Commission meeting: 10 October 2019

Health and Wellbeing Related Manifesto Commitments

Report of the Director of Public Health

Leicester City Council

Useful information

- Ward(s) affected: All
- Report author: Ivan Browne
- Author contact details: 0116 454 2024 ivan.browne@leicester.gov.uk
- Report version number: 1.0

1. Purpose of Report

1.1 To provide the Health and Wellbeing Scrutiny Commission with an overview of the manifesto pledges which fall under the theme of Health and Wellbeing for discussion.

2. Summary

2.1 The *Labour in Leicester Manifesto 2019 – 2023* sets out a number of ambitions that seek to improve health and wellbeing amongst the Leicester population.

2.2 There are nine health and wellbeing related commitments that have been assigned under the theme health and wellbeing/ public health.

2.3 This report sets these out the nine health and wellbeing commitments alongside the key actions departments are taking or propose to take to fulfil them.

3. Recommendations

3.1 The Health and Wellbeing Scrutiny Commission are recommended to:

a) note the nine health and wellbeing commitment areas

b) note the current focus of the work that is being undertaken to deliver the health and wellbeing commitments

c) provide comment/feedback on the current interpretation and actions adopted for the delivery of health and wellbeing commitments.

4. Main Report

4.1 A spreadsheet summarising each of the nine health and wellbeing manifesto commitments and associated divisional delivery undertakings is included for discussion in this this report.

Ref	Theme	Commitment	Key Actions Required	Portfolio Area/ Executive Lead Member	Department
HC10	Health & Wellbeing/ Public Health	***Protect our leisure services and keep them publicly-owned***	To continue to transform the performance and improvement of leisure facilities and develop a medium to long term leisure facilities investment and viability plan.	Piara Singh Clair	Public Health
HC11	Health & Wellbeing/ Public Health	***Building on the Cities Changing Diabetes pledge, each of our professional sports clubs and the council – Team Leicester – will establish a partnership promoting healthy lifestyles***	Continue to co-ordinate meetings between the professional clubs, council depts and Leicester Diabetes Centre. Agree a programme of work with the profesional clubs to promote e.g. healthy weight, physical activity, NHS checks, diabetes screening and good mental health.	Vi Dempster	Public Health
HC12	Health & Wellbeing/ Public Health	***Map all heart defibrillators in the city and support CPR training in employment areas to make a Leicester a HeartSafe city***	work with city centre businesses and EMAS to map AED locations and ensure they are registered with EMAS. (N.B unable to publish online following discussion with EMAS as distracts from the key message to call 999, who can then provide AED location information). Ensure LCC commissioned First Aid training includes AED use/CPR in specs. Work with businesses to ensure AED/CPR training is available.	Vi Dempster	Public Health
HC14	Health & Wellbeing/ Public Health	***Publish an alcohol strategy and look to set up a Community Alcohol Partnership***	Progress the development of the alcohol strategy and partnership by: 1. Delivery of an alcohol conversation event in 2019. 2. Reinstatment of the alcohol harm reduction working group. 3. Work with Strategic Partners to develop and publish the alcohol strategy for the city. 4. Investigate the appetite and potential configeration locally for a community alcohol partnership.	Vi Dempster	Public Health
HC16	Health & Wellbeing/ Public Health	***Promote the Daily Mile in schools and map one-mile-long community running and walking routes***	To have at least 60 primary schools and 5 secondary schools participating by July 2021.	Vi Dempster & Elly Cutkelvin	Public Health
HC17	Health & Wellbeing/ Public Health	***Help get 20,000 people more active by expanding our Learn to Swim programme and bolstering our public leisure offer by investing at least £2m in our leisure centres***	To expand the Learn to Swim programme and workforce to meet future growth and demand. Complete the Leisure Capital Programme to extend the health and fitness facilities within key leisure facilities.	Piara Singh Clair	Public Health
HC18	Health & Wellbeing/ Public Health	***Provide free sanitary products in city council public buildings.***	Identify, and rectify, any gaps in the provision of free sanitary products in City Council buildings to help address period poverty.	Vi Dempster, Sarah Russell	Public Health
LL6	Lifelong Learning	***Ensure our holiday hunger programme continues for as long as it's needed***	Deliver holiday hunger programme in 2019 using available non-recurrent budget. Develop a plan and secure resources to ensure that the programme becomes sustainable in subsequent years.	Sarah Russell	Public Health
SL4	Sustainable Leicester	***Provide free drinking water in public spaces across the city to reduce single use plastic usage***	Comms launch as official partner of Refill Encourage local businesses to sign up Map business/availability Consider LCC/public premises to provide freely available water Embed within the Food Plan's action plan. Allocate Programme Officer to lead on implementation of the action.	Adam Clarke	Public Health

Health and Wellbeing Scrutiny Commission

Work Programme 2019 – 2020

Meeting Date	Topic	Actions arising	Progress
4th Jul 19	1. Merlyn Vaz Health and Social Care Centre 2. Primary Care Networks 3. NHS Long Term Plan 4. Public Health Overview		
29th Aug 19	1. Primary Care Strategy 2. Community Health Services Redesign 3. Leicestershire Partnership NHS Trust		
10th Oct 19	1. LCC Update on Manifesto Commitments 2. UHL new developments following funding announcement 3. CCG report on LLR Urgent & Emergency Care Transformation Plan 2019/20		
5th Dec 19	1. Strategic Outline Case for the Rebuild of the Bradgate Unit 2. All-age Mental Health Transformation Programme 3. 0-19 Children's Offer 4. Public Health Contribution to Minimum Space Standards 5. CCG Merger Plans – Feedback from Stakeholders		
30th Jan 20	1. Council's Budget 2. UHL Priorities 2020/21 3. Maternity Services		
2nd Apr 20			

Forward Plan Items

Topic	Detail	Proposed Date
Young People's Council's Mental Heath Report	Discussions to be had with the YPC about the best way to bring this to scrutiny.	
Childhood Obesity	To be included on the work programme once Public Health Data has been released.	
To explore position on parking permits for district nurses / health professionals	Arrange Task & finish group to look into this issue	
Public health & council's food plan	Commission to receive a report – possibly Dec 2019 tbc	
NHS local plan for Leicester - proposals	To arrange members briefing tbc	
Council's Local Plan	Commission to be updated on progress re: key areas relating to health scrutiny	
JOINT SCRUTINY WORK	10th September 2019 – Joint Scrutiny of 'Better Care Fund (BCF) Annual Report' including work with NHS and Over 85s. Health scrutiny members invited to attend Adult Social Care Scrutiny Commission meeting.	

Briefing Note for Leicester City Health Oversight Scrutiny Committee (HOSC) - 10 October 2019

Two requests for update were received from the chair of City HOSC:

Hospital Close residences

Hospital Close is a residential Close adjoining the Leicester General Hospital. Built mainly in the 1970's and originally providing 175 lettable staff residential units including 33 semi-detached houses and a variety of self-contained and shared flats.

In addition to the residential units, The Trust's Administrative Cancer Team and a National Charity for Brain Injuries are also located in Hospital Close.

Whilst NHS Trusts have no legal responsibility to provide staff accommodation, either directly on-site or via third party tenancy agreements, a greater percentage (74%) of Acute hospitals (113 of 152 reporting in 2017/18) provide some form of staff accommodation either internally, via third parties or on a mixed basis. This figure reduces slightly to 66% (21 of 32 reporting in 2017/18) for Large Acute Teaching Hospitals, like UHL Trust. More often than not relatively large numbers of units of staff accommodation are provided by third party organisations with Trusts having either exclusivity or nominations arrangements in place. Until recently, UHL Trust provided accommodation for some (less than 3.5%) of our staff via our own buildings at the General and Glenfield Hospitals and via a third party at the Royal Infirmary.

Unfortunately the residential accommodation at the Leicester General Hospital, like many parts of our hospital estate is below what we would consider an acceptable standard and crucially, that applies to clinical space as well. As such the Trust constantly has to balance the need to carry out maintenance and improvements to essential clinical space, like wards and operating theatres, versus the important but not clinically essential parts of our estate.

This balance between clinical and non-clinical need is always made against the background of scarce capital resource and inevitably clinical need will be prioritised. In the case of the residential accommodation at Hospital Close, the properties have deteriorated over the years and sufficient investment has not been possible to ensure that they remain fully compliant with the increased requirements for Health and Safety and in particular fire safety standards. For many years this has been managed with interim, short term remedies, but this reached a stage where this was no longer possible and a more comprehensive scheme was required to bring them up to acceptable and safety compliant standards. Surveys of the properties indicated that in order to address all of these issues a comprehensive plan would require investment of circa £5m. This figure is simply unaffordable when assessed against the many requirements within clinical areas for expenditure to rectify backlog problems. In January 2019, of the 175 units of accommodation available for let, only 86 units were occupied.

The decision to implement a phased closure programme relating to Hospital Close was not taken lightly. In February 2019, following comprehensive discussions and debate within the Trust and at the Trust Board, it was agreed that a phased closure programme of Hospital Close would be implemented with a view to completely vacating all occupied properties before the end of 2019.

As part of this phased closure, UHL have offered as much support as possible to assist affected staff in identifying alternative accommodation, including offering priority relocation to any available

properties on our Glenfield site, liaison with Sovereign Housing who operate the premises adjacent to the LRI, together with face to face briefing sessions and road shows at which Local Authority Housing representatives and Local Letting Agents were in attendance.

As of the 25/09/2019, we have 9 occupied properties left all of which, in line with the processes of the phased closure programme, have been issued with Section 21 Notices advising the occupants of the Trust's intention to end their tenancy and take possession of the property. Of these 9 properties, the occupants of 4 of them have already informed us of their intention to leave their accommodation ahead of their Section 21 Notice expiry date and we expect the remaining residents to follow suit with the continued support of the Trust in finding suitable alternative accommodation.

The future of the residences once all tenants have moved out has been discussed at our Annual Public Meeting and it has been subsequently determined that we would constitute any future disposal as part of Phase 1 of the Development Control Plan for the Leicester General Hospital Site.

The land has been declared surplus as part of our required annual return to the Department of Health and has also been identified with Leicester City Council as part of their 'call for sites' in accordance with Leicester's Strategic Housing and Economic Land Availability Assessment (SHELAA).

The release of the land is aligned with the Government's Spending Review originally issued in 2015 and updated in November 2017, which committed the NHS to finding £3.3bn from NHS land sales by 2020-21 and releasing land for 26,000 houses. As part of any disposal of NHS land, typically 25% of the development would comprise Affordable Housing in accordance with S106 requirements. A commitment is given that NHS key worker staff have 'first refusal' on this affordable accommodation.

The timing for offering the site for disposal has not yet been finalised, however the Trust hopes to be in a position to commence marketing early in 2020.

Jarrom Street – proposed development.

When fully staffed, UHL employ 6,500 nurses across the three acute sites. Vacancies are consistently running at about 10% so there are approximately 650 vacancies at any particular time.

Recruitment of Nurses has been challenging with a heavy reliance on recruitment of overseas Nurses, who need accommodation relatively close to each of the acute sites to attract them to UHL.

The LRI has the most significant recruitment issues and since 01/04/2000 the Trust has had in place a nominations agreement with Sovereign Housing Group (SHG) which is agreed annually for the provision of residential accommodation for its staff members, patient relatives and other visitors to the Trust situated at the Walnut Street residencies.

Over the last 19 years a mixture of staff expectations in relation to their accommodation needs and the need to minimise risk in relation to void rent loss costs to the Trust, has seen the minimum occupancy guarantee reduce to 112 units of the available 592 units of accommodation. The space offered is shared whilst demand is now clearly for studio type accommodation. This level of occupancy guarantee does not take into account International Nurse cohorts- usually 40 nurses per cohort and currently a minimum of 5 cohorts per annum.

As a consequence of this requirement and having become aware of a proposed private development aimed at providing 'key worker' accommodation, in close proximity to the LRI in Jarrom Street, the Trust have been working with a developer for 18 months or so to agree a form of design that it believes would provide accommodation that would attract key NHS workers, including Nurses and Junior Doctors to the LRI.

Initial designs caused some concern to our local Councillor over the small size of the rooms, which were typically 25m² per unit. Having met the Councillor to understand his concerns, UHL staff made representations to the developer to increase the size of 50% of the units. This was accommodated by the developer so that of the 159 units now within the scheme, 71 of the units are 38m² and 8 are 31m². The figure of 50% was derived from the UHL experience that typically 50% of the key workers generally move on to their own accommodation after approximately the first 3 months.

In addition, with the development of the East Midlands Congenital Heart Centre facility at the adjacent Kensington Building, there will also be a requirement for patient relatives to be offered overnight stays and for which the smaller studios would be suitable.

The Trust have been involved in the evolution of the scheme design and have now reached a position where it feels that the balance of studio sizes will both meet the requirement of the Trust and take into account the previously expressed concerns of our local Councillor.

Next steps for the Trust will be to take a fully developed business case to the Trust Board which will include options for the occupancy arrangement,s including securing a lease for the whole development and for full management of the accommodation.