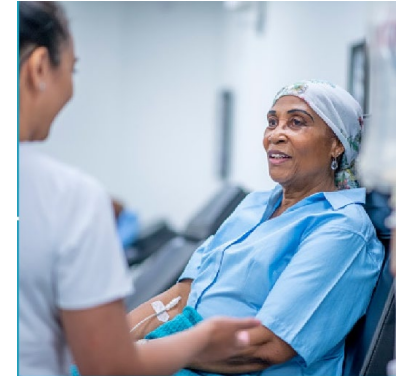


Leicester, Leicestershire, Rutland & Northamptonshire ICB Cluster – Winter Plan 2026/27 -FINAL



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Exec Summary

System intent

To maintain safe, timely and effective care through winter by reducing avoidable demand, strengthening alternatives to hospital, improving flow and discharge, protecting quality and dignity, supporting the workforce, and maintaining system grip through clear governance and escalation

- A whole-system approach focused on prevention, neighbourhood care, urgent community response, frailty, same day emergency care, mental health crisis alternatives, discharge, infection prevention, vaccination, communications and escalation.
- UHL and UHN modelling identifies a material acute capacity gap, with mitigations focused on additional winter capacity, decision-maker capacity, SDEC optimisation, length of stay reduction, virtual wards, discharge lounge capacity, transport, pharmacy and imaging support.
- LPT & NHFT plans focus on children and young people, vulnerable adults, community health services and mental health, including UCR, virtual frailty ward, direct admissions, improved inpatient discharge, crisis alternatives and co-streaming at the ED front door.
- Local Authority Plans provides a place-based plan for prevention, Home First, reablement, adult social care market resilience, vaccination, urban and rural severe weather resilience, mental health escalation routes and local winter reporting.
- System oversight will be through the System Coordination Centre, SHREWD, daily System Flow Calls, established UEC governance, provider governance and clear escalation to executive forums.

• Northants

• Overall Assurance Position: Amber

- The Northamptonshire submission demonstrates a clear strategic direction supported by established governance arrangements, strong system leadership and mature operational oversight through the System Coordination Centre. The submission describes a broad range of initiatives focused on admission avoidance, neighbourhood delivery, discharge improvement, mental health support and winter resilience, with evidence of collaborative working across acute, community, mental health, primary care and ambulance partners.
- Strengths are evident within the Quality, Neighbourhoods, Discharge and CYP sections, with good evidence of proactive schemes supporting frailty, admission avoidance, community-based care and patient safety. The system also demonstrates strong operational grip through established escalation processes, daily coordination arrangements and clear governance structures.
- Whilst the submission provides a reasonable level of assurance, several areas would benefit from further detail regarding workforce resilience, delivery timescales, measurable outcomes, winter-specific enhancements and how existing schemes will be adapted to manage sustained winter pressures. Additional assurance is also required in relation to IPC arrangements, mental health flow and crisis enhancements, and how operational intelligence is translated into coordinated system action

• LLR

• Overall Assurance Position: Green/Amber

- The Leicester, Leicestershire and Rutland submission presents a well-developed and mature approach to winter planning, demonstrating strong system leadership, established governance arrangements and evidence of collaborative working across health and care partners. The plan highlights a broad range of initiatives focused on admission avoidance, discharge improvement, neighbourhood delivery, mental health support and CYP services, underpinned by established operational oversight through the System Coordination Centre and system escalation processes.
- The submission provides confidence that appropriate governance, escalation and partnership arrangements are in place to manage winter pressures. There is clear evidence of integrated working across acute, community, primary care, mental health, local authority and ambulance partners, alongside a strong focus on prevention and supporting people closer to home. Mental Health, CYP, Primary Care and Community Care arrangements are particularly well developed.
- Whilst the overall submission provides a good level of assurance, further confidence could be gained through greater quantification of planned benefits, clearer workforce resilience arrangements during sustained periods of pressure, and further evidence demonstrating how key schemes will be monitored, evaluated and adapted throughout winter. Additional assurance is also required in relation to IPC arrangements and the ongoing management of corridor care and system capacity pressures.

Planning Principles

- Evidence-based and realistic, with quantified capacity, workforce and financial assumptions where available.
- System first, with shared risk, mutual aid, clear escalation, and a single view of demand, capacity and risk.
- Home First and prevention-first, with proactive care for high-risk cohorts and escalation into appropriate community alternatives.
- Quality and dignity, with a focus on mitigating harm associated with long waits, ambulance handover delays and non-standard environments.
- Clear accountability, with named organisational and system governance routes for delivery, adaptation and escalation.

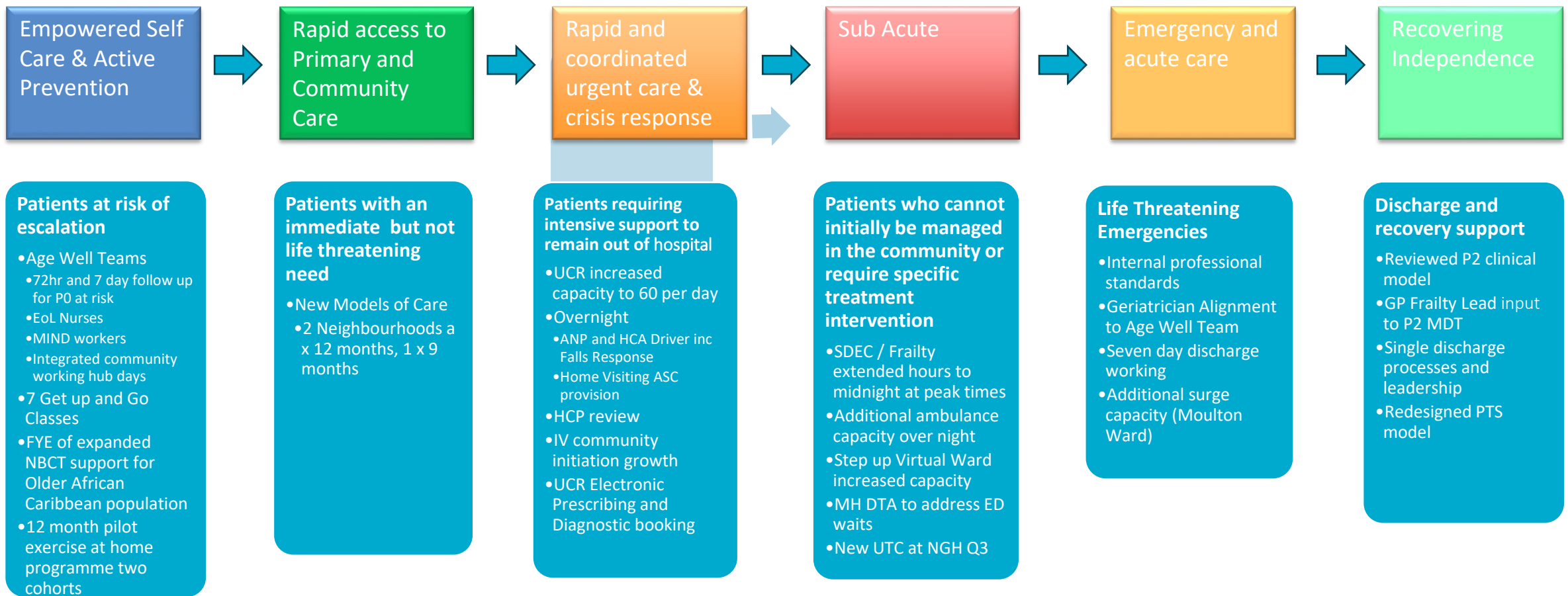
Learning from Winter 25/26 LLR and Northants

What should be retained	What should be strengthened
Clear escalation plans, system coordination, teamwork and shared awareness.	Earlier contingency triggers and clearer activation thresholds across acute, community and social care.
Admission avoidance through PTCDA, UCR, SDEC, Ageing Well and neighbourhood support.	More consistent discharge pathways, weekend responsiveness and social care alignment.
Discharge coordination, MDT working and homecare capacity management.	Workforce resilience, communication, and reducing staff burnout and sickness.
Adverse weather preparedness and operational resilience.	Earlier surge capacity decisions, particularly where mobilisation affects patient experience and staff pressure.
Use of direct access SDEC pathways, CDU pull from ED, escalation spaces and extended pharmacy access.	Capacity planning for cardiology demand, infection prevention constraints, pharmacy delays, transport and patient moves across sites.
	Implement the actions and take the learning to improve long ambulance waits at NGH

Northants UEC New 26/27 Elements

Right Care, Right Time, Right Place

An Integrated Multi Partner Approach to Mitigating and Responding to Urgent and Emergency Care Demand



System Mitigations to Reduce Acute Demand and Improve Flow 26/27 - Northants



Scheme	Timeline	Impact on Attends
Age Well Teams Expansion – Full year effect of new starters in March for NBCT, End of Life Nurses from September, MIND workers from October and additional local group programmes	Phased with completion in Q3	Medium
Primary Care New Models of Care – Provision of additional same day capacity in two of the nine neighbourhoods using hub and spoke approach, ensuring same day access for complex patients can be delivered in own practice and releasing GP capacity to better support LTC patient care planning	First site Q1 launch, Q3 phased impact, Second site Q2 launch, Q4 phased impact	High
Urgent Community Response – Additional core hour provision 4 patients per day with further overnight capacity for 6 persons per day including night falls response. Additional night response vehicle and crew for winter	25% in Q1, 60% by Q3 and 100% in Q4	Medium
Reduce Admissions – Continued expansion of SDEC including Frailty SDEC with access to overnight sitting services, greater use of virtual ward capacity as step up and use of neighbourhood P2 capacity for step up as alternative to hospital admission. These are alongside the go-live for NGH UTC	Q3	Low
Pathway 2 Transformation – Improved outcomes from revised skill mix and staffing models for confusional bed pathways and increased specialist therapy for stroke, spinal, FND etc. Increased through put supporting decreased lost acute days and timely flow but also to decrease entries to permanent 24 hour care settings	Q3	Low
Reduced Readmission Rates – Improved discharge arrangements with new integrated discharge hub. Alignment of Hospital Geriatricians with Neighbourhood Teams for pathway zero concern follow up and future joint working, actions to tackle deconditioning during hospital stays to increase persons returning to home successfully. Redesign of patient transport model to better meet requirements of safe and effective UEC system	By the end of Q2	Medium

Our UEC Strategic Priorities

10-Year Plan

Focusing on preventing sickness, not just treating it

Moving more care from hospitals to communities

Better use of technology in health and care

Priority A:

Prevention and proactive, personalised care (including LTC management); People are supported and empowered to avoid the need for emergency services wherever possible

Priority B:

When people need **same day or urgent care**, they can easily and rapidly access the **right care at the right place at the right time**

Priority C:

Effective and efficient urgent and emergency care pathways for:
children & young people;
frailty;
mental health crisis;
learning disability & autism;
palliative & end of life care

Priority D:

Partners work together to ensure joined up and **coordinated care, including improved flow and early supported and safe step-down from services**

Priority E:

Be **data & intelligence led**; understand and predict our population needs in order to support those at greatest risk, tackle **health inequalities** and deliver tailored population-based approaches

Health Inequalities and Neighbourhood Health

All Priorities have an all-age approach

System Mitigations to Reduce Acute Demand and Improve Flow 26/27 - LLR



Scheme	Timeline	Impact on Attends
Merlyn Vaz Streaming Model – Optimise and expand walk-in capacity through UTC front-door triage and revised appointment lengths, improving access to same-day care and reducing avoidable ED attendances	By the end of Q2	High
Proactive Care Planning for People with Complex Needs – Support delivery of personalised care plans to improve anticipatory care, reduce crisis presentations and support patients to remain well at home.	Commenced in April 2026- 70% completed by Q3, 30% by the end of Q4	Medium
CRM Model – Transition from LUCID and Enhanced Diabetes Management programmes to a targeted CRM approach, focusing proactive interventions on high-risk patient cohorts within Primary Care.	July 2026	Low
Population Cluster Approach – Expand the City INT outreach model to targeted population cohorts, improving health literacy, promoting self-management and shifting activity from ED and urgent care settings into Primary Care and Community Pharmacy	By the end of Q2	Medium
Neighbourhood Frailty Management – Introduce community frailty management through Integrated Neighbourhood Teams, with three neighbourhood footprints , supporting earlier intervention and admission avoidance.	4 neighbourhoods by October 2026, remaining 7 neighbourhoods by the end of Q4	Medium
Integrated Single Point of Access – Deliver a single access route into community urgent care services, improving navigation, reducing duplication and enabling timely access to the most appropriate community response.	October 2026	Medium
Single Integrated Frailty Service (Hospital at Home) – Develop a coordinated frailty service that strengthens admission avoidance, supports earlier discharge and provides acute-level care within community settings.	September 2026	Medium
48-Hour Post-Discharge Follow-Up – Provide proactive follow-up for high-risk patients following discharge to reduce avoidable readmissions and improve recovery outcomes	August 2026	Medium

System Winter Priorities 2026/27



1. Prevention and admission avoidance

Proactive care, neighbourhood working, primary care, community pharmacy, social prescribing, voluntary sector support, PTCDA, UCR, frailty and falls pathways.

2. Alternatives to ED and ambulance conveyance

SPoA, clinical navigation, UTC optimisation, SDEC with direct access, virtual wards, Hospital at Home principles, mental health crisis alternatives and co-streaming.

3. Flow through hospital and community services

Acute capacity schemes, SDEC expansion, direct admissions, community hospital flow, transfer improvements, AMU/CDU/ward processes and operational grip. Co-streaming by MH clinicians in ED to identify MH service users earlier for alternative place to assess.

4. Discharge, Home First and reablement

Integrated discharge hubs, discharge to assess, P0 to P3 pathway targets, Rutland Home First, reablement, MADE events, discharge lounges and transport optimisation.

5. Infection prevention, vaccination and health protection

IPC advice, cohorting, isolation, respiratory virus screening, care home outbreak management, staff and patient vaccination, targeted outreach and communications.

6. Mental health and crisis pathway resilience

Assessment Hub, Central Access Point, CAP 111 Mental Health Line, Crisis Cafes, CRHT prioritisation, inpatient discharge planning from day one and partnership working.

7. CYP resilience

Paediatric SDEC, under-5s advice, school-aged flu programme, CAMHS day hospital pilot, CAMHS Crisis Plus, vaccination outreach and Paediatric virtual ward/OPAT optimisation.

8. Workforce wellbeing and resilience

Workforce risk identification, safe staffing review, agency oversight, staff vaccination access, wellbeing support and clear operational communications.

9. Communications and public confidence

Right care, right place, winter wellness, targeted public and colleague communications, local clinician-led content and community channels.

10. System grip, governance and escalation

SCC, SHREWD, System Flow Calls, OPEL, surge and escalation plans, provider governance, UEC Collaborative and executive escalation.

Demand, Capacity and Bed Modelling

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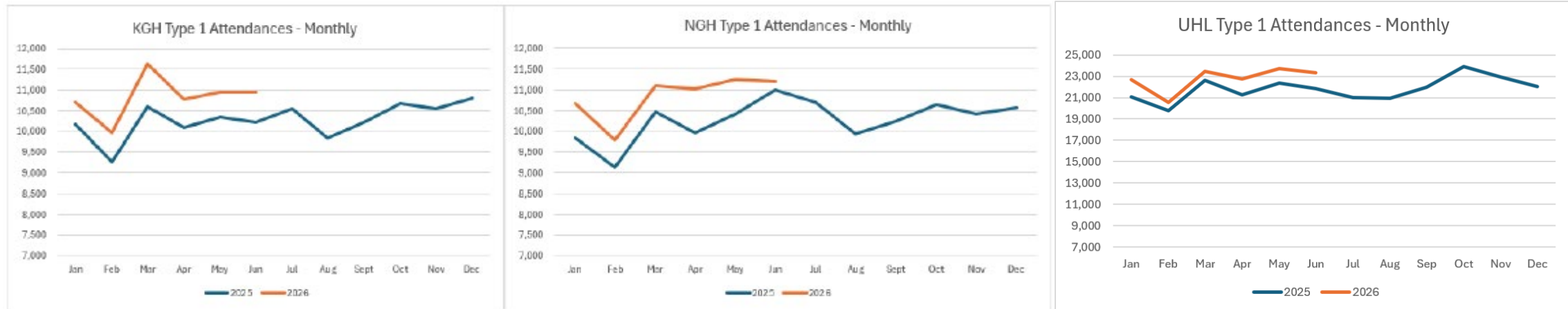
Operational plan summary

The operational plan was set to take into account Winter pressures and the impact of the mitigation schemes:

- The planned number of **primary care appointments** is 8m for LLR and 5m for Northamptonshire
- The **ambulance handover time** for UHL is planned to come down to 30 minutes by March 2027 from a planned high of 37 minutes in both October and January. For both KGH and NGH this is planned to be 25 minutes by March 2027 from a planned high of 32 minutes for KGH and 40 minutes for NGH in April 2026
- The planned number of **Type 1 attendances** is based on 25/26 outturn with 0 growth plan across the three providers. This breaks down as 265k for UHL, 124k for KGH and 113k for NGH
- The **Non-Elective** admissions UHL has 120k planned with KGH 43k and NGH 36k. The percentage planned to be 0 length of stay is 46% in UHL, 48% in KGH and 21% in NGH
- The total number of discharges for **non-elective admissions** is planned to be 65k for UHL, 22k for KGH and 29k for NGH
- The **overnight general and acute bed occupancy** ranges from 86% in May for UHL to 94% in January and March. For KGH it remains at 97%+ for the year apart from August. For NGH it is 95% for most of the year with a peak of 98% in December
- Activity plans submitted in the operational plan are included at the end of the pack.

ED Type 1 Attends & Emergency

The system's operational plans for 26/27 was based on 25/26 outturn with no growth in Emergency Department (ED) attendances, factoring in work as part of Neighbourhoods, primary care access and alternatives to ED (At-ED). YTD position as of M3 demonstrates a 6% increase in Type 1 ED attendances for KGH and NGH as well as for UHL



The reasons from the growth are multi-factorial. There is a combination effect of long-standing growth (which has been running at 5-7% and likely represents inability to address chronic issues such as inequality, preventative interventions and altering public expectations) but also includes primary care contract changes and altering seasonal presentation patterns. To address this there has already been a meeting of the Health Partners Executive to create a bespoke action plan. Whilst ED attends have increased this is **not** translating into additional admissions in several key cohorts

Bed Modelling - UHL

The Trust has used the PWC bed model to assess the expected capacity required, whilst the model does not give detailed monthly analysis assuming the maximum requirement in the model is representative of Winter this is demonstrating a gap of -123 beds the majority of which are in ESM and RRCV.

The assumptions in the PWC model are:

- 92% occupancy – raising the occupancy to 95% would reduce the beds needed to 1841 and therefore reducing the gap by 62 beds. This would create challenges with flow and would therefore create a risk to the achievement of ambulance handovers, 24 hr in ED or 12 hr performance metrics.
- The activity plan submitted as part of planning – in Q1 we have admitted 2282 (5%) more patients and using the current activity level this would increase the gap by 18 beds.
- The projected gap is like that forecast last year (181 v's 178) which is representative of the progress being made as the plan is set higher in 26/27 (outturn of 25/26) and the gap was based on plan for 25/26.
- When added Bad Beds (waits in ED, Corridor Care, CDU) are included this gives a gap of 215 beds.

26/27 Bed Requirements based on PWC bed model

Max - Winter

CMG	Need	Got	Gap	Bad Beds	Gap
ESM	759	674	-85	-50	-135
CHUGGS	354	327	-27	-5	-32
MSS	143	162	19	-2	17
RRCV	509	465	-44	-35	-79
W&C	138	152	14	0	14
Total	1903	1780	-123	-92	-215

Bed Modelling - UHL

To mitigate the gap, we have developed various schemes that are detailed below. These schemes include additional capacity and efficiency schemes such as optimisation of SDEC and reduced LOS.

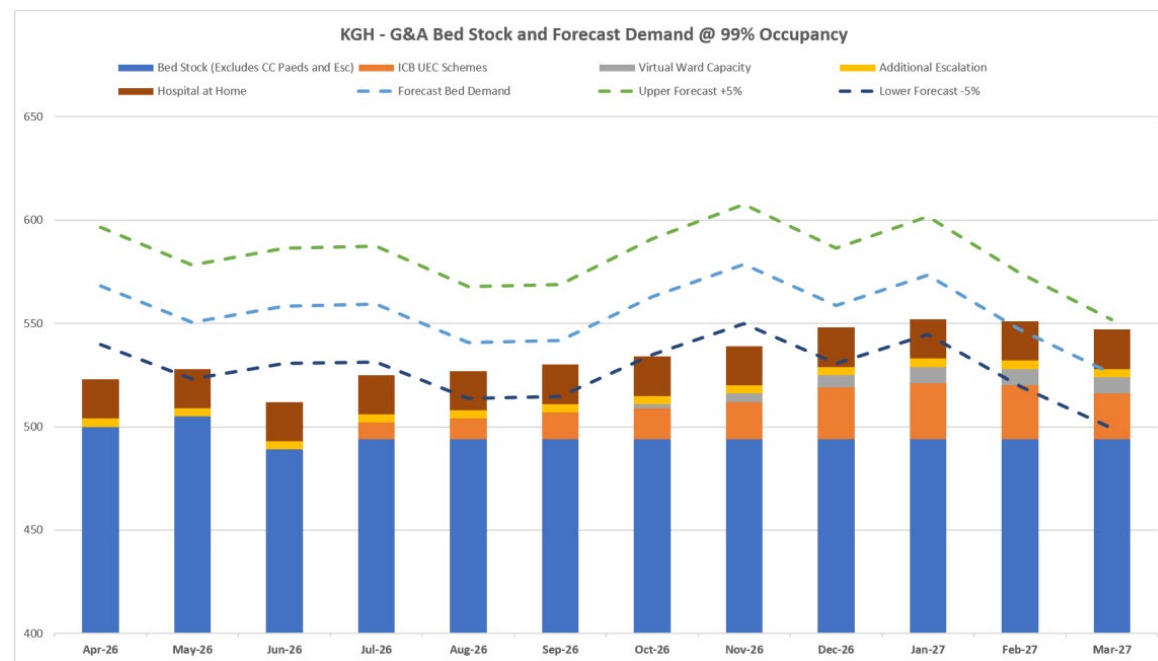
These mitigations if fully delivered reduce the bed gap from -215 to -109, however with our current mitigations we do not have sufficient plans to reduce this risk any further. We continue to review all options. In planning the mitigations, we have reviewed the gap at a CMG level as detailed below, therefore our plan is weighted to ESM and RRCV.

Mitigations	Total	CMG IMPACT				
Gap pre mitigations	215	ESM	RRCV	MSS	CHUGGS	W&C
Ward 19 LGH	20	20				
Ward 11 LGH	13	13				
Ward 16 GH	5		5			
Ward 17 GH	5		5			
Ward 23 Annex	5		5			
Reduced LoS	25	10	6	2	5	2
Paediatric SDEC	5					5
Acute VW	12	12				
Adults SDEC's	11	5	3		3	
MeMed	5		5			
Total	106	60	29	2	8	7
Remaining Gap	-109					

	Gap	Mitigation	Gap
ESM	-135	60	-75
CHUGGS	-32	8	-24
MSS	17	2	19
RRCV	-79	29	-50
W&C	14	7	21
Total	-215	106	-109

Bed Modelling - KGH

Metric	Assumptions	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Forecast Beds required (99% bed occupancy)	99%	537	519	526	528	509	509	530	546	526	541	515	493
Forecast Beds required (95% bed occupancy)	95%	559	541	548	550	530	531	553	569	548	564	537	514
Additional Escalation		4	4	4	4	4	4	4	4	4	4	4	4
Bed Stock (Excludes Paeds & CC)		500	505	489	494	494	494	494	494	494	494	494	494
DTA Backlog within the ED (demand impacting beds required)		40	40	40	40	40	40	40	40	40	40	40	40
Cardiology Virtual Ward								2	4	6	8	8	8
Impact of ICB UEC Schemes					8	10	13	15	18	25	27	26	22
Hospital at Home		19	19	19	19	19	19	19	19	19	19	19	19
UHN LoS bed reduction as per IBP (1.5% reduction)		8	8	8	8	8	7	8	8	8	8	8	7
Surplus / Deficit at 99% Occupancy		-62	-39	-62	-51	-30	-27	-44	-55	-26	-37	-12	7
Surplus / Deficit at 95% Occupancy		-85	-61	-85	-73	-51	-49	-67	-79	-49	-60	-34	-14



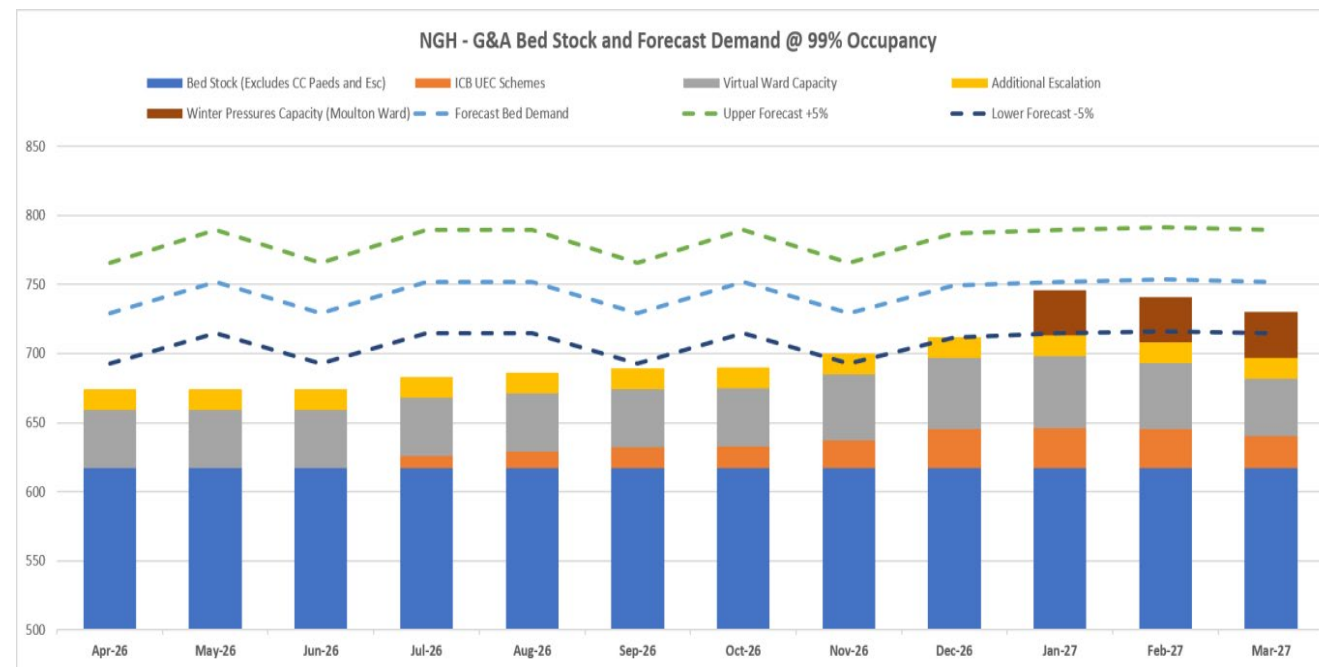
KGH Bed Model Forecast

- There is a mitigated bed deficit of -62 beds in April as the worst month which improves to 7 in March, based on actual and forecast beds at 99% bed occupancy. This includes
- There is a 9 bed reduction in KGH core bed stock comparing 25/26 to 26/27 through expansion of planned care unit and short stay unit with associated a LOS reduction (4.4 to 2.2 days) with this new model of care.
- Delivery of system schemes being delivered up to capacity of 27 beds, as per Appendix Two.
- Delivery of KGH reduction in non-elective length of stay as per plan.
- Hospital at home capacity is planned throughout the year to be maintained at existing levels with 19 bed capacity for patients who otherwise would meet criteria to reside.
- Planned expansion of cardiology virtual ward

Bed Modelling - NGH

NGH Bed Model Forecast

- There is a mitigated bed deficit of -78 beds in May as the worst month which improves to -6 in January, based on actual and forecast beds at 99% bed occupancy. This includes
- Delivery of system schemes being delivered up to capacity of 29 beds, as per Appendix Two.
- Escalation bed capacity including discharge lounge (6), day rooms (6) and on average 3 escalation beds in New Heart Centre without impacting elective TCIs.
- Operational go live of Moulton Ward is planned to open late December (21st) providing a full 3 month escalation capacity of 33 beds during Q4, mitigating the bed deficit to -6 beds in January 2027.
- Delivery of NGH reduction in non-elective length of stay as per plan.
- A UHN Virtual Ward steering group supports oversight and governance in utilising virtual ward capacity for patients who otherwise would meet criteria to reside and therefore, freeing up physical capacity within the acute bed base, a key mitigation of the bed deficit during Q3/4. Bed capacity plan for 26/27 is detailed below with maximum capacity of 52 beds across acute medicine, stroke and respiratory. Additional capacity for cardiology heart failure virtual ward is now in place at NGH with up to 8 beds, expanding to KGH from October 2026.



Metric	Assumptions	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Forecast Beds required (99% bed occupancy)	99%	689	712	689	712	712	689	712	689	709	712	714	712
Forecast Beds required (95% bed occupancy)	95%	718	742	718	742	742	718	742	718	739	742	744	742
Additional Escalation		15	15	15	15	15	15	15	15	15	15	15	15
Bed Stock (Excludes CC Paeds and Esc)		617	617	617	617	617	617	617	617	617	617	617	617
DTA Backlog within the ED (demand impacting beds required)		40	40	40	40	40	40	40	40	40	40	40	40
Virtual Ward Capacity		42	42	42	42	42	42	42	48	52	52	48	42
Impact of ICB UEC Schemes					9	12	15	16	20	28	29	28	23
Winter Pressure Capacity (Moulton Ward)											33	33	33
UHN LoS bed reduction as per IBP (1.5% reduction)		10	11	10	11	11	10	11	10	11	11	11	11
Surplus / Deficit at 99% Occupancy		-55	-78	-55	-69	-66	-40	-62	-29	-37	-6	-13	-22
Surplus / Deficit at 95% Occupancy		-84	-108	-84	-99	-96	-69	-92	-58	-67	-36	-43	-52

Prevention and Vulnerable Cohorts

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Vaccinations - 2026/27 Ambitions

Vaccine	Cohort	ICB	2025/26 Outturn	2026/27 Plan	Notes
Flu	Pregnant Women	LLR	42.9%	44.0%	Uplift of 1.1%
		Northants	49.3%	53.8%	Uplift of 4.5%
	Children 2-3 Years	LLR	44.6%	46.4%	Uplift of 1.8%
		Northants	41.5%	44.3%	Uplift of 2.8%
	Children -Primary School	LLR	52.3%	56.5%	Uplift of 4.2%
		Northants	46.0%	52.3%	Uplift of 6.3%
	Children - Secondary School	LLR	46.2%	49.1%	Uplift of 2.9%
		Northants	40.2%	45.1%	Uplift of 4.9%
	Adults 18-64 at risk	LLR	40.3%	41.5%	Uplift of 1.2%
		Northants	39.7%	42.2%	Uplift of 2.5%
	Adults 65+	LLR	74.9%	75.0%	Uplift of 0.1%
		Northants	75.1%	75.0%	Maintain
	Adults 16+ who are homeless	LLR			New cohort
		Northants			

Vaccine	Cohort	ICB	2025/26 Outturn	2026/27 Plan	Notes
COVID	All cohorts	LLR	56.3%	56.3%	Maintain
		Northants	58.8%	58.8%	Maintain
RSV	Care homes	LLR	71.0%	71.0%	Maintain
		Northants	65.2%	65.2%	Maintain
	Catch up cohort	LLR	68.6%	70.0%	Uplift of 1.4%
		Northants	69.9%	70.0%	Uplift of 0.1%
	Routine cohort	LLR	46.3%	60.0%	Uplift of 13.7%
		Northants	42.5%	60.0%	Uplift of 17.5%
	Pregnant women	LLR	40.5%	50.0%	Uplift of 9.5%
		Northants		50.0%	No baseline
	65-74 years	LLR			New cohort
	75-79 years	LLR			New cohort
	80+ years	LLR			New cohort
		Northants			

- Additional plans to be set around pneumococcal vaccines when NHSE regional team share baselines
- Frontline staff are local targets and will be updated if NHSE set these centrally
- As part of the additional actions for Winter a LNR RSV vaccination campaign through General Practice to deliver the 50%

Improving Uptake in Underserved Communities

LNR commissioning approach:

Commission resources at an LNR level and manage their distribution using population health data to target key communities and co-design interventions; this involves:

- Taking a proportionate universalism approach
- Gaining insights and understanding by listening to communities and working with VCSE organisations
- Taking a system-wide approach in collaboration with public health teams and providers
- Monitoring and evaluating uptake and impact of interventions

Family Hubs

Piloting vaccination clinics inside Family Hubs, to be delivered alongside antenatal classes and other family services.

Super Vaccinators

Team of healthcare professionals can offer all vaccines
Flexible resource, targeted at low uptake practices
Provides workforce resilience

Communications and Engagement Resources

Vaccine Hub website, materials tailored to local communities, geo-location mapping

Central Booking Team

Inbound patient phone-line
GP Lists - call and text priority groups
Immunosuppressed, Care home and housebound patients



Supervaccinator, Alex, working on the RHU with its driver, Justin

Roving Healthcare Unit

Target: low uptake, high deprivation, diverse communities
Vaccination offer: COVID-19, flu, MMR, pertussis and RSV
Plus: Blood pressure checks and MECC
Collaboration with other services i.e. AAA, fibro scanning, cancer

Training and Development

Culture & Faith in LLR training
Meetings with local cultural and faith leaders
Visits to community settings and faith centres

Working with Voluntary and Community Sector Enterprises

To gain insights and understand barriers
Collaborative projects commissioned through VCSE to improve uptake i.e.
Local Immunisation Street Team
Health & wellbeing fairs and events



Priority Cohorts: Vulnerable and Underserved Groups



Housebound Patients

For patients of opted-out GP practices, a dedicated team will offer COVID vaccinations in patient's own homes, ensuring individuals are not disadvantaged where their registered practice is not participating in the vaccination programme. Acute and community providers will vaccinate pre-discharge (inc RSV in LLR) and those who are long-stay in hospital.

Care home Residents

Dedicated team in place for patients of opted-out GPs, who will work with care home providers to proactively plan a dedicated vaccination delivery. Acute and community providers will vaccinate pre-discharge (inc RSV in LLR) and those who are long-stay in hospital.

IS Patients

Targeted identification, proactive call/recall, trusted clinical communications, accessible vaccination routes, collaboration with VCSEs who support IS patients, & continuous performance monitoring.

Access Clinics

Offering a range of accessible vaccination settings, eg specialist clinics, CP, GP practices, RHUs. Working with carers, VCSEs & providers to deliver targeted comms, outreach & support to reduce barriers, improve convenience & ensure equitable access.

Pregnant Women

Strong collaboration with maternity services, proactive promotion at every antenatal contact, convenient vaccination opportunities across multiple settings, & targeted comms delivered by trusted healthcare professionals.

VCSE

Collaborating with VCSE to maximise trusted community networks with targeted engagement & locally tailored comms. Combining community insight with accessible vaccination opportunities will improve awareness, reduce inequalities & increase uptake amongst groups at greatest risk of being underserved.

Homeless

Working with homelessness services, LAs & VCSE partners to deliver targeted outreach through the RHU & community settings, & providing flexible, accessible vaccination opportunities, to reduce barriers & address inequalities.

Proactive Contact

Central Booking Team proactively identifies, invites & reminds eligible individuals of their vaccination status via multiple comms channels & signposting them accordingly.

Promotional Events

Vaccinations promoted through a programme of targeted community engagement events, working with LAs, VCSE partners, healthcare providers & trusted community networks.

Comms Campaigns

Combining national with local messaging to deliver a coordinated, multi-channel comms campaign to raise awareness of the vaccination offers, improving vaccine confidence & encourage uptake.

Winter Vaccination Programme Assurance

- Robust governance in place through the LNR Vaccination & Immunisation Board, with CMO oversight as SRO.
- Delivery plans developed following winter 2025 review, with provider trajectories, performance monitoring and regular reporting established.
- System plans aligned to national requirements for Flu, COVID-19, RSV and Pneumococcal vaccination programmes.
- Risk-stratified approach targeting older adults, care home residents, pregnant women, children, frontline staff and clinically vulnerable groups.
- Targeted programme in place to improve uptake and reduce unwarranted variation across LNR.
- Population health data used to identify and prioritise communities with lower uptake and higher risk.
- Outreach delivery through roving healthcare units, community pharmacies, Family Hubs and community settings.
- Strengthened communications, call/recall and VCSE partnerships to support underserved and vulnerable populations, including housebound patients, care home residents and people experiencing homelessness.



Risk Stratification and pro-active care planning - complex LTC



Risk stratification is used at both practice and Place level to identify high need patients and patient cohorts with contractual incentives in place to support practice to work with their highest need patients. Additionally the ICB has a number of specific workstreams to respond to the highest areas of need identified in our recent Integrated Needs Assessment (INA.)

Cardiovascular Kidney Metabolic (CVKM) disorders. CKM represents the largest cause of avoidable morbidity and health inequalities for the ICB. We are developing a twin track approach to identify undiagnosed patients and maximise best practice care practice and neighbourhood level and to establish MDT care models targeted at our higher need patients. These models used proven care models and emerging treatments which have been shown to have in year impact. Our initial focus is in two areas of CKM

- *Chronic Kidney Disease (CKD)* – The LUCID model covers most of LLR PCNs and is being progressively rolled out. A virtual MDT supports patients to access treatments such as Finerenone which has been shown to reduce risk of emergency admissions and delay progression to dialysis and other high cost treatments.
- *Heart Failure (HF)* – Developing the proven LUCID focus on HF will be the use of SGLT2i treatments which are shown to reduce exacerbations and admissions. This will initially be targeted to high risk patients and those with recent HF admissions.

Care Planning

Work in LLR ICB has demonstrated that patients with complex health needs who have a care plan in place are significantly less likely to be admitted as an emergency than those who don't. This is supported by a LES in LLR and this learning is being applied in Northamptonshire through the Neighbourhood based New Care Models programme.

Neighbourhood-led coordination Integrated Neighbourhood Teams support same-day care, rapid assessment and navigation — ensuring people are directed to the right service first time	• Agreement of core neighbourhood team membership for the high-risk cohorts • Agreement of extended neighbourhood team membership • Mapping of current position and timeline to achieve extended provision for each neighbourhood • Alignment of key hospitals medics to neighbourhoods • Completion of a maturity matrix, mapped against neighbourhood framework to determine gaps and opportunities • Design delivery model for proactive upstream approach (LLR) • Reduce progression into higher frailty and complexity cohorts • Neighbourhood in reach via ACP and Consultant to support EoL and palliative care. Increase completion of RESPECT planning, reduction in 'crisis episodes' and increase in patients dying in their preferred place of death. • Multi-agency drop-in sessions at community venues across LLR • Increase use of neighbourhood mental health cafes for same day support from primary care • Increased signposting / referrals to 'Getting Help in Neighbourhoods' projects to meet individual needs.
Neighbourhood Teams at the centre of delivery Integrated Neighbourhood Teams bring together primary care, community services, mental health, social care, hospices and VCSE partners to provide coordinated, wrap-around support for people with complex needs,	• Agreement of core neighbourhood team membership and extended neighbourhood team • Mapping of current position and timeline to achieve extended provision for each neighbourhood • Alignment of key hospitals medics to neighbourhoods • Completion of a maturity matrix, mapped against neighbourhood framework to determine gaps and opportunities • Design delivery model for proactive upstream approach (LLR) • Additional nonclinical content visible in-patient record • Released time for extended reviews for persons with complex LTC • Identification of digital opportunity to enable self-care and prevention • Accurate recording of baseline frailty index within primary care record • Additional End of Life Nurses as part of integrated neighbourhood MDTs to reduce frequent admissions in last year of life

Primary Care & Admission Avoidance

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PC PLANS FOR SURGE AND ESCALATION	• Maintain oversight of General Practice capacity and operational pressures through GPAD, GPES, General Practice OPEL and system intelligence, enabling early identification of risks and timely escalation through the System Control Centre. • Prioritise same-day urgent care through effective triage, care navigation, online consultations and Pharmacy First, supporting delivery of Right Care, Right Place, First Time. • Proactively manage vulnerable patients through population health management, personalised care planning and Enhanced Health in Care Homes, helping reduce avoidable admissions and support care closer to home. • Continue to expand digital access by increasing: • NHS App logins increasing by 44%, • online consultations by 154% • Northamptonshire continues to be one of the top users of online consultations in the country. • 100% of LLR practices are enabled for GP Connect with 97% in Northants, improving patient access and supporting integrated care. • Strengthen multidisciplinary primary care capacity through the Additional Roles Reimbursement Scheme (ARRS), with workforce increasing by 20% during 2025/26 and a further 3% in Q1 2026/27, supporting improved access and winter resilience.
URGENT DENTAL CARE	• Deliver the national requirement for 8.2% of NHS dental contractual activity to be allocated to urgent dental care appointments across the LNR Cluster. • Monitor provider compliance, service utilisation and Directory of Services availability to maintain timely access and reduce pressure on General Practice, NHS 111 and Emergency Departments.

Primary Care Access and Recovery

SAME DAY ACCESS (SDA) AND ENHANCED ACCESS	• Deliver additional winter capacity through a coordinated seven-day Same Day Access model across the LNR Cluster, including 64,901 commissioned urgent appointments annually across LLR and approximately 1,450 additional same-day urgent appointments each week through the Northamptonshire SDA pilot. • Delivery of Acute Respiratory Infection hubs for 120 persons per day including direct booking for acute, 111, EMAS • Support delivery of the ambition for 90% of clinically urgent requests to be managed on the same day, reducing demand on Emergency Departments, NHS 111 and other urgent care services. • Maintain Enhanced Access services to protect core General Practice capacity, with LLR consistently delivering between 8% and 24% above commissioned capacity while Northamptonshire has delivered between 15% and 30% above commissioned hours over the last three years, demonstrating provider flexibility and resilience during periods of peak demand.
CONTRACTUAL COMPLIANCE	• Maintain oversight of 2026/27 GP Contract delivery through GPAD, the General Practice Dashboard and local intelligence, providing targeted improvement support where required. • Ensure practices maintain compliant access arrangements, including core opening hours, online consultation availability and patient communications, supported by 100% GP Connect enablement across LLR practices. • Continue to promote digital access and quality improvement to enhance patient experience and reduce unwarranted variation.

Urgent Care

- Across LNR there are four Urgent Treatment Centres open 7 days a week (inc BH);
 - Loughborough – 24 hours
 - Oadby – 8am – 9pm
 - Merlyn Vaz (Leicester City) - 8am – 8pm
 - Corby – 8am – 8pm
- These services will run as planned and winter comms plan will continue to encourage our population to contact NHS111/NHS111 online to be directed/booked to the most appropriate service for their needs.
- Northampton General Hospital will open their onsite UTC at the end of August and extend the hours to overnight late September. This will improve patient experience and outcomes and decompression on main ED to allow higher risk patients to be better managed.
- Corby UTC will also expand their bookable appointment slots to Primary Care to reduce redirection to ED for urgent on the day needs.

Urgent Care

Merlyn Vaz UTC

- To support winter (and longer term) the ICB are proposing to make changes to the Merlyn Vaz service to maximise the UTCs contribution to the Urgent and Emergency Care pathway. This includes:
 - Increase UTC appointments from 15 minutes to 20 minutes.
 - Introduce Point of Care Testing and Healthcare Assistant support to improve clinical decision-making and reduce onward referrals to ED.
 - Enable acceptance of ED dispositions via the DoS to reduce avoidable Emergency Department attendances and improve patient flow.
 - Introduce a clinical triage function with a new Advanced Practitioner role to support early pathway intervention, redirection to alternative services, and to maximise ED avoidance for Walk-in patients.
- The proposed change will take effect from September 2026 – March 2027, with the plan to fund recurrently following review of change and evaluation.
- The service change is expected to avoid 50 ED attends a day, with further improvements anticipated as the model becomes established.

Community Pharmacy

- The system will continue to maximise Community Pharmacy's contribution to winter resilience through Pharmacy First, Hypertension Case Finding, the Pharmacy Contraception Service and the Discharge Medicines Service, supporting delivery of **approximately 70,000 Pharmacy First** and **26,400 contraception consultations** during 2026/27 for LLR and around **110,000** Pharmacy First referrals in Northamptonshire (including contraception consultations).
- Demand and utilisation of Community Pharmacy has doubled through 25/26- 26/27, where we are seeing record numbers in LLR for referrals.
- Pharmacy First activity has more than doubled since 2025/26, with LLR achieving one of the highest growth rates nationally per 100,000 population supported by continued referral optimisation from General Practice, NHS111 and UTCs.
- Explore the opportunity to use independent prescribing in community pharmacy to widen the scope of patients that can be seen in Pharmacy First via an additional winter pressures service.
- Community Pharmacy capacity remains sufficient to meet demand, providing confidence that referrals can continue to divert activity safely from General Practice and Emergency Departments throughout winter. This will be monitored to ensure mitigations are in place in case this does become a challenge.
- We will work to maximise participation in the expanded Pharmacy First Service by increasing the number of pharmacies signed up to deliver additional prescribing-only clinical pathways and prescription management services.

Community Services



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Rapid response and alternatives to admission

Urgent Community Response & Admission Avoidance

- **Increase Urgent Community Response (UCR) capacity**, including extended core hours and overnight provision, delivering a **25% increase in NHS 111 and EMAS transfers** across Northamptonshire
- **Increase LLR UCR activity by 10%**, supporting an additional **2,050 people** to receive urgent care in the community.
- **Introduce seven-day IV therapy pathways within Urgent Community Response**, supported by point of care testing.
- **Expand overnight sitting services**, supported by ambulatory follow-up, reducing short-stay admissions and enabling more people to remain at home.
- **Develop step-up capacity within Community Hospitals**, initially providing **five step-up beds across LLR** to support admission avoidance

Frailty, Virtual Wards & Remote Monitoring

- **Implement a single integrated frailty service**, operating **7 days a week (08:00–20:00 minimum)**, supporting an additional **546 people**.
- **Increase access to specialist community support across the cluster**, including greater use of step-up Virtual Wards to safely manage people at home.
- **Increase the number of people supported through remote health monitoring**, enabling earlier identification of deterioration and proactive intervention.
- **Expand the Falls Response service**, including point of care testing, increasing the proportion of people remaining at home from **80% to 90%**.

Urgent Access, Diagnostics & Clinical Decision Making

- **Expand community diagnostics and point of care testing**, enabling earlier clinical decision-making and reducing unnecessary hospital attendance.
- **Increase alternatives to Emergency Department attendance** through new Urgent Treatment Centres, same-day community hubs and direct access pathways.
- **Increase use of direct access to SDEC** and expand Frailty SDEC capacity and operating hours in line with GIRFT recommendations.
- **Mobilise the LLR Single Point of Access (October 2026)**, providing health and care professionals with a single route into urgent community services and avoiding an estimated **2,400 ED attendances**.

Specialist Community Support

- **Expand the PTCDA service**, supporting an additional **500 people** and avoiding **400 Emergency Department attendances** (2025/26 baseline: **4,102 people supported and 2,560 admissions avoided**).
- **Expand rapid specialist palliative and end of life care assessment and intervention**, including consultant and ACP in-reach, supporting an additional **115 people** and reducing Emergency Department attendances and hospital admissions.

Faster recovery and reduced length of stay

Stronger post-hospital support, reablement and neighbourhood-based follow-up help people regain independence sooner and avoid readmission

Discharge Flow & Reducing Length of Stay

- **Strengthen seven-day working** across partner organisations and enabling services (including diagnostics) to reduce delays and minimise patients with no reason to reside.
- **Further transform Pathway 2 services**, reducing demand for Pathway 3 and improving the timeliness of discharge.
- **Implement an Acute Medicine Hospital at Home pilot**, supporting selected patients with acute medical conditions to receive hospital-level care at home, with capacity for 20 virtual ward beds, supporting approximately 180 patients during the pilot period

Recovery, Rehabilitation & Reablement

- **Optimise reablement, rehabilitation and recovery services**, maximising short-term support to help people regain independence following illness or crisis.
- **Strengthen frailty and falls prevention**, through proactive identification, rapid therapy input, strength and balance programmes, home safety interventions, care home falls reviews, intermediate care and targeted prevention.

Post-Discharge Support & Preventing Readmission

- **Strengthen Pathway 0 (simple discharge) pathways**, including joint community MDT follow-up to support people recovering at home.
- **Implement an enhanced 48-hour post-discharge offer**, supporting recovery closer to home and targeting a reduction in readmissions from the current **22% baseline to 20%**

Surge and Super Surge conditions and actions

Surge and Super surge actions linked into OPEL Triggers linked to following key risks:

- Workforce resilience and availability (increased sickness/industrial action) across health and care sector incl. Vol Sector
- Surges in service demand linked to peaks in illness (respiratory) with same day urgent referrals peaking
- Extreme weather events (flooding, snow, freezing temperatures)
- IT/digital infrastructure impacts

Key system Actions to support during surge and super surge in Community:

- Twice weekly staffing reviews to support forward planning
- Delivery of staff vaccination plan
- Additional recruitment to staff bank
- Triage and prioritisation of visits based on urgency and capacity v demand
- Redeployment of staff to support key areas
- Robust business continuity plan to support adverse weather and IT outage
- Use of 4x4 services
- Strengthen lone worker support
- Discharge Co-ordinators to work closely with Adult Social Teams regarding timely discharges.
- Clear escalation and system support for escalation

Flow, Occupancy & Discharge



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Managing Flow and Occupancy - LLR



The LLR System Discharge Operational Group supports overarching governance, system performance and escalations across discharge pathways and aims to reduce delays, with membership from: UHL, LPT, ASC, ICB, Care Home Sectors, EMAS and Non-Emergency Patient Transport. LLR health and social care partners have agreed to deliver the following:

- **Transfer of Care (Acute to Community Hospitals/Care homes)** Achieve 80% of transfers by 17:00 each day.
- **Timely Discharge of P0 patients** Achieve 66% of discharge by 17:00 each day.
- **7-day Discharge Model** Consistent discharge plans in place for 50 patients Monday-Friday, 30 patients Saturday-Sunday.
- **Early submission of RDS forms** To support early discharge planning.
- **Pathway 3** To secure discharge plans within 7 days.

UHL Surge Actions

- UHL are in the process of introducing the SHOP model that will enable early flow from wards.
- Use of MADE at UHL for ED and Front door wards.
- Reviewing alternative pathway to support patient discharge.
- Continue MDTs with partners to progress early discharge planning and unblock challenges with complex cases.

LPT Surge Actions

- Additional escalations calls with extra board rounds with ANP, use of boarding beds to increase capacity and matrons on board rounds to escalate challenges
- In-reach review by VIR Frailty ACPs, and silver meetings with senior colleagues during super-surge

LLR ASC Actions:

- ASC will continue to source packages of care and placements in-line with demand, supported by ICRS/CRS where necessary. However, challenges remain for patients requiring two carers, larger packages, and the availability of placements in the care home market.

Partners to utilise SCC as a point of escalation, particularly for external/OOA support.

Discharge Plan - LLR

- LLR Discharge Hub transferring to UHL to provide greater system working.
- New System Discharge Co-Ordinator for LLR Discharge Hub to be in post to support with discharge planning.
- UHL are progressing a series of MADE events during peak periods of pressure in UHL, focused on improving ED flow by reducing bed waits and enabling safe discharge for patients not requiring acute admission.
- Increase use of UHL's Intermediate Care beds for ED patients who do not require acute care but are also unable to return to usual residence due to housing, safeguarding, social breakdown.
- UHL target of <11% G&A beds occupied by patients no longer meeting the criteria to reside.
- Local Authority to support during times of pressure in-line with key metrics and BAU, surge and super-surge actions, acknowledging the limitations of the care home market.
- Community Hospitals are piloting a new model of enhanced staffing that will reduce deconditioning and support a reduction in LOS.
- All available High Dependency beds to be utilised, including accepting step-up referrals from ED.
- All available community hospital beds to be pre-allocated daily, with a focus on discharge before noon.
- Improved flow through LPT Community Hospital to support system, including flexing of beds, boarding SOP, LOS reduction, and system pathway transformation e.g., Stroke.
- Improve the timely discharge from community and MH beds into community setting facilitated with support from LA partners

Managing Flow and Occupancy - Northants

- Integrated Discharge Hub fully operational seven days in October
- EMAS PTS Transformation lead as part of Hub in September
- Partners use of OPTICA to improve pre discharge tracking and planning
- Revised delivery arrangements West Northants to reduce P1 delayed days to 3 days average from Q3 and 2 days Q4
- Increased flow through P2 capacity for additional 20 patients per month
- AQP Framework appointed provider for 'at home transition' for people moving through confusional beds pathway
- Decrease NRTR patients from 150 to 100 (system count)
- Improve intensive support for persons entering care homes to increase take and reduce readmission failure
- Internal transformation programmes within NGH and KGH to reduce deconditioning
- Refresh of training to ensure that 4AT are correctly completed on admission for all patients to generate early flags for engagement of Dementia & Delirium Team
- Clinical Senate set trigger point actions in escalation to ensure safe management of flow and balanced risk sharing across partners
- Moulton Ward escalation beds Dec – March to support step-down at UHN

Managing surge and escalation – LNR

Whole System response to deliver sufficient patient flow to meet demand at times of surge and super surge:

- Provider Winter Plans outline their respective actions to safely manage flow with specific actions:
 - Additional escalation bed capacity
 - Utilisation of all available escalation capacity across the hospitals including boarding
 - Review of cancelling non-cancer/non urgent elective inpatient surgery and outpatient clinical to free up medical and nursing staff and support capacity
 - Review of urgent electives (not cancer)
- Establishment of Clinical Senate at system level to:
 - Agree system triggers for critical incident
 - Dynamic risk assessment – clinical and patient safety in relation pressure, surge and critical incident
 - Agree short term system actions at organisation level beyond OPEL 4 measures that support de-escalation and enable patient flow as safely as is possible

Governance, Command and Escalation



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Leadership and Governance –Command & Escalation

Level	Mechanism	Purpose
System	System Coordination Centre, SHREWD, daily System Flow Calls, SCC SOPs and escalation action cards.	Maintain shared view of demand, capacity, flow and operational risk; coordinate mitigating actions and mutual aid.
Executive	COO meetings, UEC Delivery Board, UEC Collaborative, Transformation Boards, ICB Committees and Board.	Maintain senior accountability, assurance and escalation where delivery is off track or system risks materialise.
Clinical	Clinical Executive, Clinical Responsibility Group, System Quality Group and clinical escalation routes. Establishment of Clinical Senate	Ensure clinical leadership, oversight of risk and consistency of patient safety response.-
Provider	UHL/UHN UEC Transformation Group, Trust Leadership Team, tactical command, LPT/NHFT operational governance, LA local reporting.	Track organisational actions and escalate risks to system governance.
Regional	Daily SCC connectivity with Regional Operations Centre when operational pressure escalates.	Articulate system pressures, actions and support needs to regional teams.

Quality, Safety, Risk Management, IPC, Workforce Wellbeing and Assurance



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Quality, Safety, IPC and Workforce Wellbeing



Quality and dignity

- Mitigate harm from long waits, delayed handover and non-standard care through daily safety review, rapid flow, escalation huddles and clear clinical responsibility.
- Review patient experience, incidents, falls, pressure damage and other quality indicators through provider and system governance.
- Apply explicit quality safeguards to ASC super-surge derogations and monitor impact during and after their use.
- Monitor intended and unintended consequences of SPoA and home visiting pathway changes.

• Infection prevention and outbreak response

- Use symptom-based screening across telephone and face-to-face care, separating symptomatic patients promptly and applying appropriate PPE.
- Maintain enhanced cleaning, ventilation checks, PPE stock assurance and outbreak escalation arrangements.
- DHU plan specifies a minimum six-week PPE stock at sites, staff exclusion while symptomatic and rapid response to linked cases; local IPC leads should confirm alignment with current national and system guidance before final issue.
- Maintain UHL screening, cohorting, isolation, IPC advice and health protection support; protect ambulance handover areas from inappropriate cohorting.
- Formalise independent sector care provider contingency for respiratory and norovirus outbreaks, staffing shortages and weekend decision-making.

• Workforce Wellbeing

- Provide convenient staff vaccination routes, peer or local champions, outreach to care sector staff and regular uptake reporting.
- Target eligible residents, care home residents, vulnerable groups, unpaid carers, pregnant women and CYP, with action to reduce inequalities in uptake.

Integrated Risk Register



Risk	Impact	Mitigation	Escalation
Residual acute capacity gap	Long waits, occupancy and quality risk.	Deliver UHL/UHN mitigations; maximise SDEC, virtual ward, discharge and support services.	UHL/UHN governance, TLT, SCC and UEC governance.
SPoA mobilisation or demand mismatch LLR Only	Unintended demand shift to ambulance, ED or community services.	Readiness assurance, live demand/capacity monitoring, MDT governance, early warning and corrective action.	DHU, commissioners, SCC and UEC governance.
Home visiting pathway transition LLR Only	Reduced responsiveness or increased conveyance after 1 October change.	Pathway clarity, Primary Care readiness, workforce stability, monitoring and contingency.	DHU, Primary Care, ICB and SCC.
Primary care access pressure	Higher 111, UTC and ED demand.	OPEL oversight, same-day access, enhanced access, digital routes, ARRS and Pharmacy First.	Primary Care and ICB escalation to SCC.
ASC capacity or market instability	Delayed discharge, unmet need and carer breakdown.	Market monitoring, provider contingency, brokerage, reablement flow, seven-day capacity and mutual aid.	Local authority, ICB and SCC.
Super-surge quality risk	Poorer experience or outcomes and higher long-term care use.	Senior authorisation, individual risk review, time-limited derogation, monitoring and recovery plan.	ASC senior leadership and system quality governance.
Care home / service outbreaks	Closures, delayed discharge and staff shortage.	Vaccination, IPC, outbreak response, PPE, provider contingency and health protection support.	Public Health, UKHSA, provider IPC and SCC.
Workforce sickness and burnout	Reduced capacity and resilience.	Recruitment, backfill, rotas, redeployment, vaccination, wellbeing and mutual aid.	Provider and system workforce escalation.
Severe weather	Disrupted travel, visits, homecare and transport.	4x4 access, weather alerts, emergency planning, prioritisation and local resilience.	Local authority emergency planning, DHU and SCC.
Data or trajectory not validated	False assurance or misdirected capacity.	Confirm LLR-only baselines, owners, reporting frequency and data definitions before approval.	ICB programme governance and system executive.

Delivery Dashboard and Assurance



Domain	Core measures	Oversight
Demand and access	111 demand and response; GP OPEL; same-day access; UTC activity; ED attendances.	SCC, Primary Care, DHU, UHL, UHN, EMAS
Ambulance and front door	Conveyance, Category 3 deflection, handover, first assessment, 4/12/24-hour waits.	SCC, EMAS, UHL, UHN, DHU.
SPoA and community alternatives	SPoA activity, referral source/outcome, deflection, UCR, home visiting, falls, night nursing, virtual wards.	DHU, NHFT, LPT, ICB, UEC governance.
Acute capacity and flow	Open beds, occupancy, escalation spaces, SDEC, LOS, long stays, bed gap mitigations.	UHL/UHN tactical command and SCC.
Discharge and ASC	MOFD/CRFD, pathways 0-3, reablement dwell, brokerage, P2/P3 capacity, transport, readmission.	Discharge governance, local authorities, SCC.
Care market	Domiciliary capacity, care home vacancies, provider risk, outbreaks and staffing.	Local authorities, ICB and SCC.
Primary care and pharmacy	Capacity, access, urgent same-day handling, Pharmacy First referrals/activity, GP Connect and urgent dental access.	Primary Care and ICB governance.
Mental health and CYP	Crisis activity, ED co-streaming, inpatient LOS/CRFD, paediatric SDEC and CYP navigation.	NHFT, LPT, UHL, UHN, DHU and SCC.
Quality and IPC	Harm reviews, incidents, falls, pressure damage, outbreaks, side-room demand, PPE and vaccination.	System Quality Group and provider quality.
Workforce	Sickness, vacancies, agency, rota fill, additional capacity fill and wellbeing signals.	Provider and system workforce governance.
Communications	Reach, engagement, service navigation feedback, stakeholder issues and staff understanding.	System and partner communications leads.

Readiness Actions and Recommendations

No.	Action	Owner	Timing
1	Confirm accountable executive and operational leads for every priority, provider/place contribution and risk.	System / organisations	Before final approval
2	Validate all LLR and Northants Primary Care baselines, trajectories and activity commitments;	ICB Primary Care	Before final approval
3	Complete SPoA and home visiting transition readiness assurance for 1 October 2026, including demand, workforce, pathways, communications and fallback. LLR Only	DHU / ICB / Primary Care	Before 1 October 2026
4	Confirm NHS 111 winter plan after completion of the regional plan and incorporate material changes.	DHU / ICB	When regional plan available
5	Complete ASC desktop stress test across operational and social work teams.	LA ASC	September 2026
6	Test independent sector contingency and ASC surge/super-surge decision-making, including quality safeguards and recovery.	Local authorities / ICB	Before winter escalation
7	Confirm financial approvals, mobilisation dates, workforce and benefits for UHL/UHN/NHFT/LPT and system schemes.	UHL/UHN /NHFT/LPT ICB	Before winter escalation
8	Agree final dashboard, data definitions, trigger thresholds and reporting cadence across SCC and governance.	System UEC leadership	Before final approval
9	Validate escalation action cards across provider, Primary Care, local authority, place, SCC and regional routes.	All partners	Before winter escalation
10	Complete an integrated system readiness review and evidence closure of critical dependencies.	UEC governance / executives	Before winter escalation

Operational plan detail

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Primary Care, Ambulance handover and ED attendances

Operational Plan

Appointments in General Practice

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Leicester, Leicestershire and Rutland	599,811	657,550	644,947	638,127	644,952	695,141	778,858	721,258	620,450	718,437	664,326	704,655
Northamptonshire	404,819	404,819	354,216	455,421	354,216	404,819	506,203	455,421	404,819	455,421	404,819	455,421

Operational Plan

Average handover time (Total Handover time (ED and non ED) / No of handovers (ED and non-ED))

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	00:33:19	00:37:14	00:31:52	00:29:57	00:35:32	00:31:59	00:37:06	00:31:51	00:30:09	00:37:15	00:30:11	00:30:12
KGH	00:32:56	00:31:10	00:31:06	00:29:55	00:29:37	00:28:29	00:28:31	00:27:36	00:26:46	00:26:19	00:25:40	00:25:00
NGH	00:40:00	00:38:00	00:36:00	00:35:00	00:34:00	00:33:00	00:32:00	00:31:00	00:30:00	00:27:00	00:26:00	00:25:00

Operational Plan

Number of attendances at type 1 A&E departments

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	21,296	23,100	22,341	20,966	20,666	22,016	23,119	23,741	22,958	21,759	20,763	22,819
KGH	10,110	10,406	10,324	10,598	9,940	10,280	10,511	10,710	10,964	10,182	9,604	10,988
NGH	9,964	10,430	11,008	10,692	9,943	9,442	9,875	9,264	8,861	8,118	7,551	8,690

NEL admissions

Operational Plan

Number of specific acute non-elective spells in the period with a length of stay of zero days

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	4,445	4,525	4,505	4,487	4,428	4,496	4,674	4,633	4,757	4,845	4,570	4,829
KGH	1,339	1,503	1,521	1,786	1,624	1,749	1,727	1,669	1,774	2,013	2,055	2,248
NGH	969	844	684	498	500	611	726	569	662	601	554	638

Operational Plan

Number of specific acute non-elective spells in the period with a length of stay of one or more days

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	5,235	5,329	5,305	5,284	5,215	5,295	5,505	5,456	5,602	5,705	5,382	5,688
KGH	1,885	1,988	1,866	1,886	1,798	1,846	1,875	1,889	1,921	1,957	1,774	1,848
NGH	2,445	2,454	2,320	2,336	2,224	2,287	2,432	2,352	2,703	2,419	2,376	2,745

Operational Plan

Number of specific acute non-elective spells in the period

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	9,680	9,854	9,810	9,771	9,643	9,791	10,179	10,089	10,359	10,550	9,952	10,517
KGH	3,224	3,491	3,387	3,672	3,422	3,595	3,602	3,558	3,695	3,970	3,829	4,096
NGH	3,414	3,298	3,004	2,834	2,724	2,898	3,158	2,921	3,365	3,020	2,930	3,383

Discharge and Bed Occupancy

Operational Plan

Overnight total general and acute bed occupancy %

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	90%	86%	89%	91%	88%	89%	93%	90%	91%	94%	93%	94%
KGH	97%	97%	97%	97%	94%	97%	97%	97%	98%	98%	97%	97%
NGH	95%	95%	95%	95%	94%	95%	95%	95%	98%	95%	95%	94%

Operational Plan

Total number of discharges for non-elective admissions

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	5,235	5,329	5,305	5,284	5,215	5,295	5,505	5,456	5,602	5,705	5,382	5,688
KGH	1,885	1,988	1,866	1,886	1,798	1,846	1,875	1,889	1,921	1,957	1,774	1,848
NGH	2,445	2,454	2,320	2,336	2,224	2,287	2,432	2,352	2,703	2,419	2,376	2,745

Bed Modelling

UHL Acute Capacity Modelling

CMG	Need	Got	Initial gap	Bad beds	Gap including bad beds
ESM	759	674	-85	-50	-135
CHUGGS	354	327	-27	-5	-32
MSS	143	162	19	-2	17
RRCV	509	465	-44	-35	-79
W&C	138	152	14	0	14
Total	1903	1780	-123	-92	-215

UHL Mitigated Position

CMG	Gap	Mitigation	Residual gap
ESM	-135	60	-75
CHUGGS	-32	8	-24
MSS	17	2	19
RRCV	-79	29	-50
W&C	14	7	21
Total	-215	106	-109