APPENDIX

Delivery plan for recovering urgent and emergency care services

Leicester, Leicestershire & Rutland Integrated Care System

Final v4.0 / 31 July 2023

Contents

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

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

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

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

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

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

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

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

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

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

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

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

Executive summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Meeting this challenge will require sustained focus on five areas:

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

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

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

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

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

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

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

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

Why we need a UEC Recovery Plan

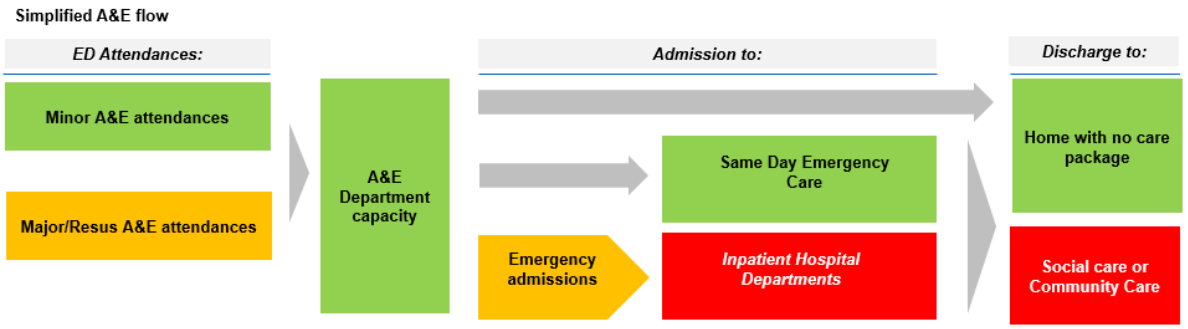
A. Why are we seeing pressures on Urgent and Emergency Care?

Current pressures

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

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

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



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

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

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

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

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

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

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

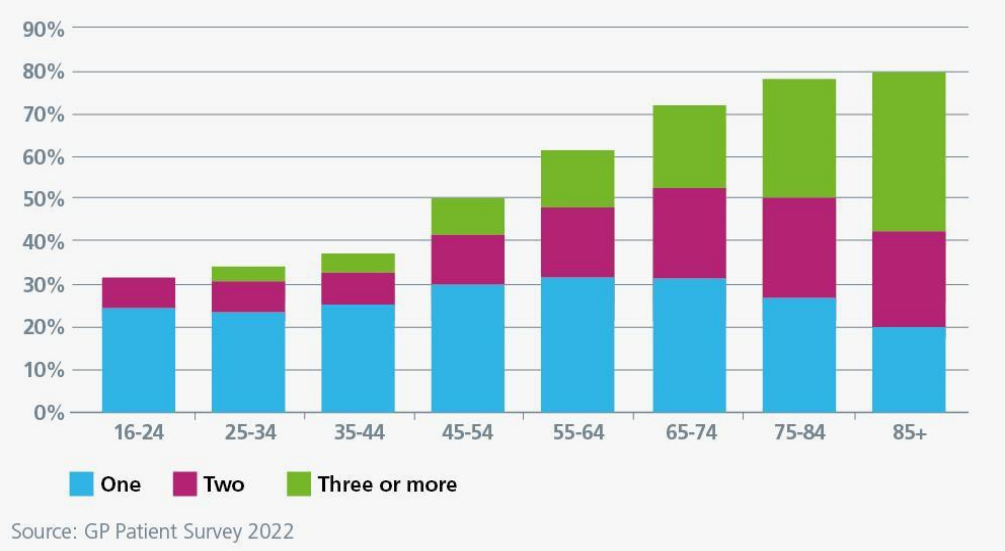
- Attendances at our Emergency Department have stabilized since the introduction of patient streaming with an average of 26 patients streamed into booked community slots instead
- Our community based Acute Respiratory Hubs have seen 8,971 patients in the period December 2022 to March 2023.
- Our General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

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

Longer term trends

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

Proportion of age cohorts living with long-term conditions



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

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

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

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

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

B. What we will deliver for patients and the public

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

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

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

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

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

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

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

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

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

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

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

1. Increasing urgent and emergency care capacity

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

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

A. Additional hospital bed capacity

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

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

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

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

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

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

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

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

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

B. Increasing ambulance capacity

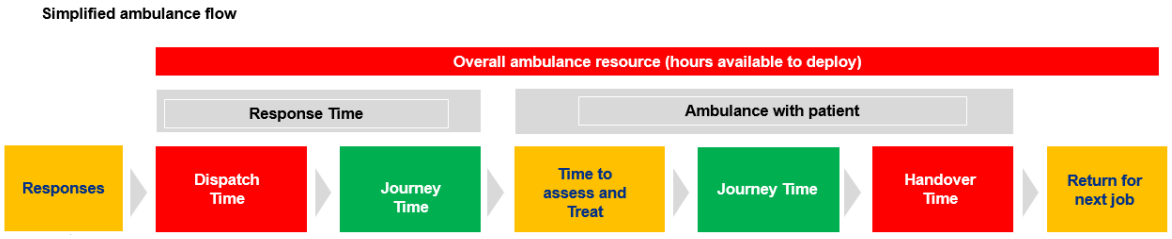
Ambition:

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

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

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

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



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

How we will deliver:

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

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

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

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

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

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

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

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

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

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

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

C. Improving processes and standardising care

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Increase workforce size and flexibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Example: LLR Virtual wards

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

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

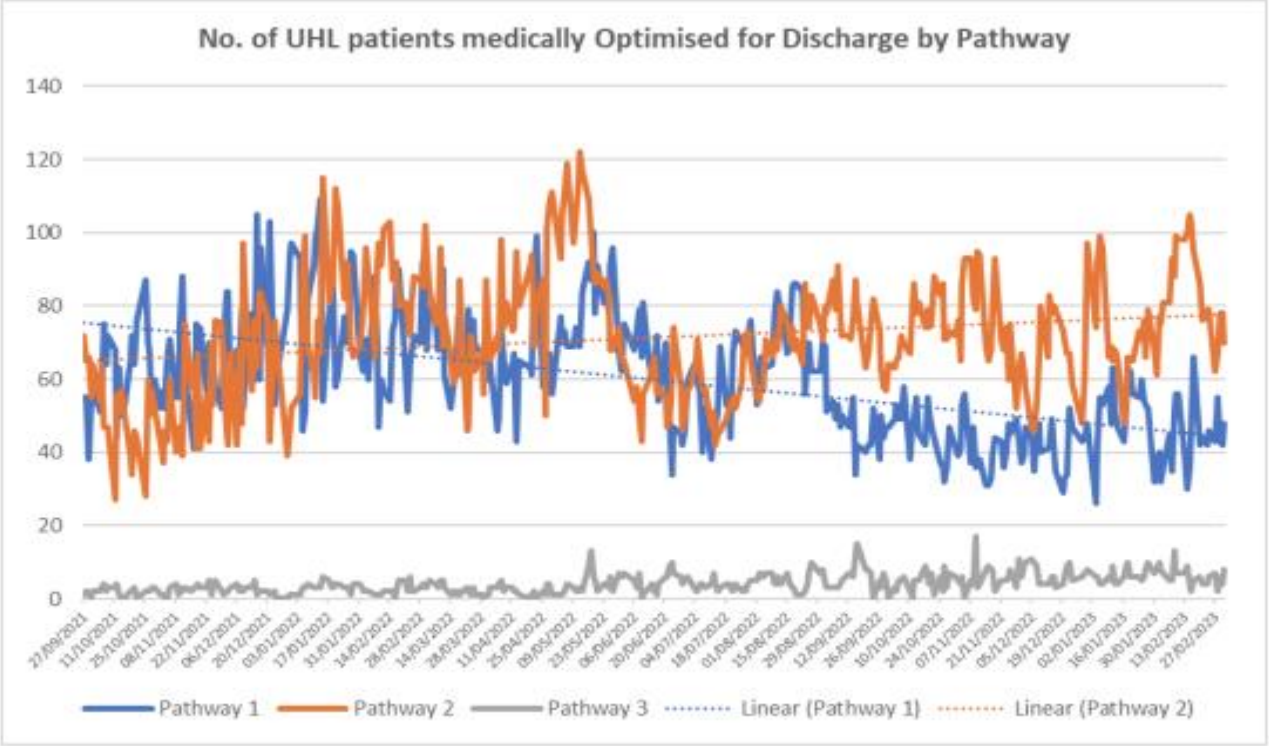
3. Improving discharge

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

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

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

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



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

Current Discharge Status

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

(Data taken from S1 Sitrep 26.04.2023)

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

We will therefore improve discharge by:

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

A. Improving joint discharge processes

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

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

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

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

How we will deliver:

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

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

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

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

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

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

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

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

Plan

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

B. Scaling up intermediate care

Ambition:

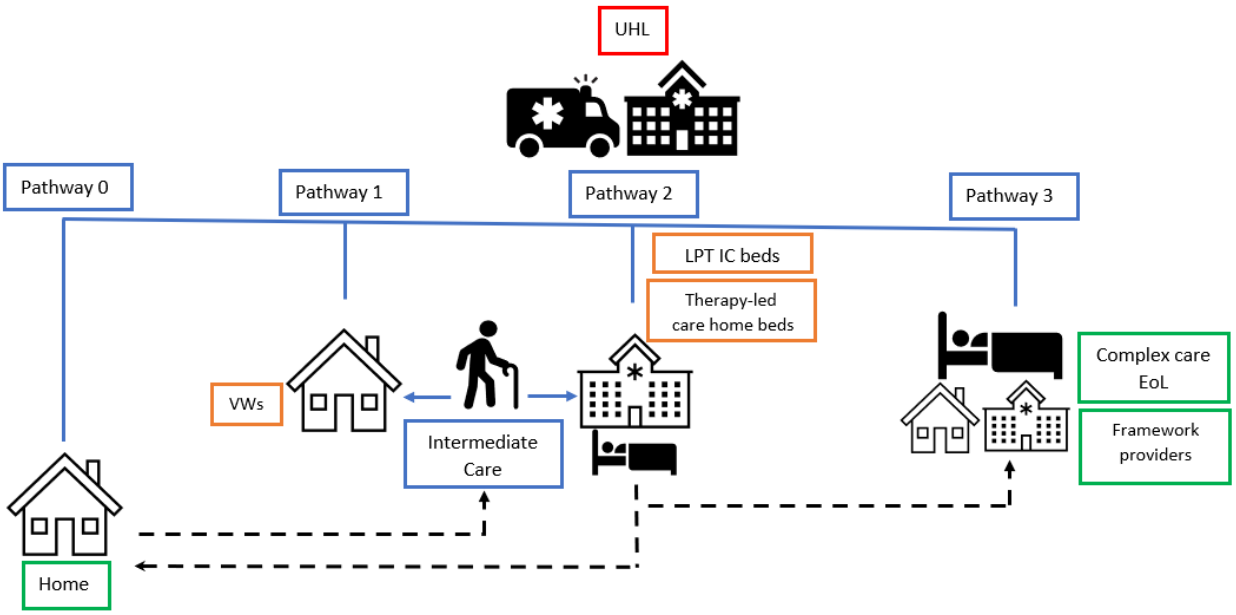
NHS England has begun a programme of work to develop and pilot a new approach to intermediate care, working with local authorities and voluntary and community partners. This expansion of 'step-down' care is designed to help people move from hospital into more appropriate settings for their needs, with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

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

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

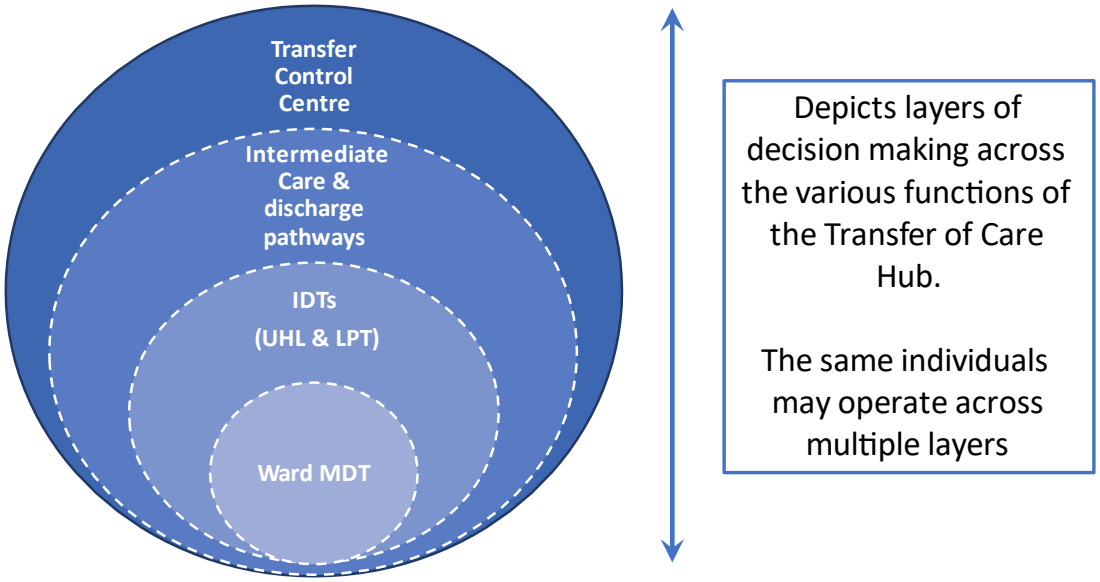
How we will deliver:

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



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

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



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

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

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

C. Scaling up social care services

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

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

Locally, the funding includes:

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

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

4. Expanding care outside hospital

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

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

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

Ambition:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Expand virtual wards

Ambition:

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

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

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

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

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

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

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

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

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

This would include:

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

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

5. Making it easier to access the right care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Delivering this plan

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

A. Accountability at all levels

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

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

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

Local delivery

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

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

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

Appendix A contains the UEC Partnership Terms of Reference.

Appendix B contains the activity planning and budgets schedule.

B. Transparency

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

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

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

C. Tiered intervention

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

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

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

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

D. Reducing unwarranted variation

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

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

E. Supporting innovation

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

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

Vaccinations and Immunisations

Autumn / winter 2023/24 vaccination campaign: Eligible cohorts

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

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

Campaign timing

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

Flu

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

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

COVID-19 & flu

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

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

Vaccination campaign

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

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

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

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

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

Tackling health inequality

To tackle health inequality, we will implement:

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

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

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

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

We are working to improve MMR uptake by:

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