2023-24 priorities and operational planning

Recovery Plan Narrative Submission

Version Number	Date	Details of change
V1.0	26 Jan 2023	Initial version
V2.0	3 Feb 2023	Updates highlighted to (i) reflect the final UEC recovery planning requirements, (ii) update the link provided in the first question in the cancer section
V3.0	6 Feb 2023	UEC recovery plan narrative section added. Additional question on health inequalities added to 'Overall approach to recovery planning' section (highlighted)

Introduction

1. Overview

This template focuses on the immediate priority set out in the 2023/24 priorities and operational planning guidance: **to recover our core services and productivity**. ICBs are asked to submit a system narrative plan for the recovery of performance for the 2023/24 financial year, setting out:

- the overall system approach to recovery planning for their system
- key actions system partners will take to recover their core services and productivity
- key assumptions that underpin their numerical plan returns.

Narrative submissions will be reviewed by national and regional colleagues as part of plan assurance and to identify cross-cutting themes and issues.

2. Interactions with other templates and guidance

This submission focuses on the overall approach to recovery of core services and productivity as well as specific plans for elective, cancer, and diagnostics services. This version now also incorporates the narrative element of the UEC recovery plan submission requirements following publication of the national Delivery plan for recovering urgent and emergency care services. Further Information on the full UEC recovery plan submission requirements are available on the NHS Planning FutureNHS collaboration platform via the "UEC Recovery Plan" button on the main dashboard.[1] Collectively these returns will inform the process for the allocation of additional capacity funding for hospital and ambulance services above those already included within issued allocations.

The General Practice Access Recovery Plan is expected to be published at the end of February and there will be a linked system recovery plan submission requirement. We are therefore not asking for a narrative submission covering primary care as part of the 23 February draft plan submission.

3. Submission process and contacts

Narrative plans should be submitted at ICB level, using this template, to the appropriate regional planning mailbox (see table below) for **draft submission by 12noon Thursday 23 February 2023** and for **final submission by 12noon Thursday 30 March 2023.**

Further information including a list of all activity and performance metrics can be found within the submission guidance and supporting documents available on the NHS Planning FutureNHS collaboration platform.

Any queries relating to this submission should be directed to regional planning leads:

[1] You will need a FutureNHS account to access the pages and can get this at: FutureNHS Collaboration Platform following the registration process outlined.

Location	Contact information
North East and Yorkshire	england.nhs-NEYplanning@nhs.net
North West	england.nhs-NWplanning@nhs.net
East of England	england.eoe-planning@nhs.net
Midlands	england.midlandsplanning@nhs.net
South East	england.planning-south@nhs.net
South West	england.southwestplanning@nhs.net
London	england.london-co-planning@nhs.net

4. Guidance on completing the narrative submission

Responses to the elective, cancer and diagnostics sections should succinctly and clearly:

- summarise the current and planned position / performance
- articulate the actions and assumptions that underpin the numerical submission, including:
    - plans to deliver the key evidence-based actions set out in the annex of 2023/24 priorities and operational planning guidance
    - key demand and capacity assumptions
    - activity, workforce, and financial plans and transformation goals that will support delivery of the objective
- set out key delivery risks and/or dependencies on other elements of the system recovery plan
- make links where relevant to other ICB partner plans (e.g. Cancer Alliances).

Please complete all sections. Further instructions to support completion are set out below and within each section of the template.

2023/24 operational plan narrative- performance

System name:	

Overall approach to recovery planning	
Please describe the approach your system has taken to recovery planning and how you have assured deliverability of the plan. Please set out any key assumptions, interdependencies, and risks.	
Please describe the approach your system has taken to recovery planning: - **How have you balanced delivery across the national recovery objectives for 2023/24, including delivery of balanced financial position?** - **How have you planned to maximise productive capacity (including workforce) across the system to support delivery of the national recovery objectives?** - **How have you planned to continue to narrow health inequalities in access,**	**<u>Balancing delivery of the 23/24 recovery objectives (including finances)</u>** **Delivery:** *System VWA achievement* The ICB VWA model indicates system achievement for 23/24 of 107.3% VWA without coding and counting and 113.2% including it. •For UHL, the ICB model gives 98.9% VWA without coding and counting and 106.3% including it. •UHL have evaluated their plan at achieving 103% including coding and counting. Analysis will be undertaken with UHL in the next few days to further understand our estimates of VWA and compare our methodology and that used by NHSE. Some possible reasons for differences between the UHL and ICB evaluation of VWA for UHL are: • ICB 19/20 baseline is adjusted for working days • Difference in pricing methodology and prices used

outcomes, and experience?	• ICB activity use the operational planning elective activity metrics i.e. are specific acute specialties excluding maternity, mental health and learning difficulties and outpatients are consultant-led only • ICB model uses the 19/20 baseline historic activity data supplied by NHSE within the 23/24 operational planning activity template For comparison, the NHSE Elective Recovery evaluation within the activity template itself indicates LLR achieving 103.6% VWA without coding and counting, 110.3% including it and 113.5% including cost-weighted activity for pathways avoided through specialist advice. The NHSE calculations use the lower 19/20 average price to cost 23/24 which gives the lower figures since, as mentioned above, these prices are on average 4% lower than the 22/23 average price used to cost 23/24 VWA in the ICB model. **Finance:** *Previous position as at 30th March 2023:* Our draft system finance plan is currently at c£49m deficit. This is made up of deficits of £32.5m for UHL, £5.4m for LPT and £11.3m for ICB. We understand the drivers of our financial deficit (largely investment to support system flow, safer staffing, prescribing) and continue work to minimise the scale of deficit. The national expectations are clear: • Legal and collective responsibility to balance the plan • Consequences of not achieving will be on ability to approve new spend and rights to operate • Current plans are not credible so will be treating March submission as a draft and will be expecting fortnightly updates Firm requirements: • Income flowing to providers is ‘flat cash’ • Growing of the workforce needs to stop and hold at current workforce levels to cover capacity • ICB pressures in areas such as prescribing and CHC must be tackled within existing resources and scope to reduce ‘over prescribing’

- CIP levels must be between 4-5%

The current level of deficit in our plans exists even though we are planning:

- Minimal increases in staffing, except for those related to emergency care capacity expansion or elective recovery initiatives.
- A larger cash releasing efficiency programme than national expectations (>4% collectively) and significantly larger than we have ever delivered.
- That inflation costs will be in line with national assumptions and funding levels (local analysis suggests this could be c£40m short).

The above assumptions also present the most significant risks to delivery of the existing plan. We continue to work to identify further saving opportunities to meet the challenges included within plans but also if possible, to reduce the deficit further to the required position (breakeven).

To ensure we can deliver this stretching plan, a number of task and finish groups are set up reporting into our System Executive and will be assured by key ICB Committees as follows:

Workstream		SRO	Assurance through	Reporting to
1. Improvement across emergency care pathway		ICB, UHL and LPT Chief Operating Officers	Finance Committee	System Executive
2. Management of planned care (PIFU and OP f/ups)		ICB, UHL and LPT Chief Operating Officers	Finance Committee	System Executive
3. Access to Care thresholds		ICB, LPT and UHL Medical Directors	Finance Committee	System Executive
4. Workforce growth constraints		ICB, UHL and LPT Chief People Officers	People Board	System Executive
5. ICB internal opportunities (including running costs)		TBC	EMT	System Executive

	It is acknowledged that recurrent financial sustainability will require a multi-year approach. We are currently developing our 5 Year Joint Forward Plan (JFP) for submission by the end of June 2023. Our JFP is based upon insights from our staff and our communities and tells us that we have to focus on in three key areas – making it easier to access care when it is needed, making it easier for our teams to be able to deliver this care in an effective and efficient manner and to ensure this care will deliver equitable outcomes for the people of LLR. The JFP sets out a number of key interventions across a range of health and care programmes in order to improve outcomes relating to performance, equity and finance. To support this, we are developing a 5 Year Allocative Strategy designed to: • Achieve a sustainable financial position • Ensure we invest in the areas where we can make a longer-term impact • Increase the percentage of allocation to non-acute services • Underpin our Five Year Forward View Plan A set of principles have been drafted to underpin the strategy and will be agreed as part of the overall approval of the JFP. These include: • Deliver a sustainable financial position by 2025/26 • Each organisation to deliver in year efficiency target of 3% (Year 1 and 2, review for years 3-5) • Deliver upper quartile performance in terms of efficiency and elimination of waste • Maintain the Mental Health Investment Standard • Ensure the percentage allocation for non-acute services increases and acute decreases over the next five years • Focus growth on: ▪ Prevention and Population Health Management ▪ Health Equity ▪ Children and Young People ▪ Community Based Services

	Latest Position: 1. Feedback from the financial plan submission at end of March was that the Midlands region deficit stood at £650m (2.9% of Midlands ICB allocations) which represented a £473m deterioration from 22/23 forecast outturn with efficiency plans totalling £1.3bn. National message still that systems are expected to break even- no workforce growth, push to improve productivity and CIP of at least 4%. 2. A deep dive was subsequently carried out by Adrian Roberts (national lead) across UHL, ICB and LPT to identify further opportunities and gain assurance over pressures as highlighted; he concluded that financial plans for 2023/24 are tightly drawn across the three partner organisations, demonstrating significant reining-in of costs and ambitious programmes for sustainable, recurrent cash releasing efficiencies and productivity improvements, underpinned by strengthening of workforce and other controls being embedded in operational practice. He recommended further changes to drive the deficit lower and suggested if these could be addressed the remaining defining issue- the scale of UEC capacity and flow funding challenges, now fully drives the £25.5m deficit (£25.5m UHL, £0m ICB and LPT £0m). 3. Following discussions with the NHSE national leadership team on 28/04/23 further revisions have been made to the planned deficit reflecting further ambition to drive down urgent care costs within UHL (£10m) and expected income from NHSE with respect to inflationary pressure (£5.5m), as such the planned deficit now stands at £10m. **ICB position** As per end of March submission, the ICB deficit was £11.3m. ICB have now identified a route to breakeven with specific schemes which have a nominated SRO and Operational Lead and will report progress up through EMT. The final list of schemes were reviewed by the Executive team as particularly challenging and include: o Running costs- push forward on schemes to make the remaining £2.8m to achieve the 30% (estates, discretionary spend, pay reductions)- £2.1m

	○ Service Development Funding slippage- against range of new funding including long covid, prevention, diabetes, cancer from over £40m funds- increasing this from £5m to £6m ○ CSU- reconsidering current level of service and assume 30% reduction in line with ICB target - £0.8m ○ Prescribing- 3.4% uplift on 22/23 plan by assuming some of the NCSO pressures are non-recurrent- further £0.5m ○ Personalisation- reduce further as budget has been uplifted by 11.7% on 22/23 plan- £1m ○ Technical adjustments around year end 22/23 c/fwd via provisions as improvements linked to national income rec'd- £2m ○ Slippage against utilisation of POD net underspend non recurrent opportunity-£5.1m Leaving a small contingency of £1.2m to cover off risks associated with achieving some of these more stretching schemes. The ICB now has a CIP target of £52.5m (prior to the impact of the national 1.1% efficiency ask across providers) which equates to 3.1% of the total allocation (and 5.9% of expenditure excluding UHL and LPT). A robust process has been put in place to deliver this programme with Executive Leads, which will be managed via the ICB Operational Delivery Group through weekly reporting. **LPT position** LPT reported a planned deficit of £5.4m for 2023/24 in its submission to NHSE at the end of March. They were committed to going further and reducing their position to break even and needed to assure themselves of the plans they will need to put in place to deliver this ask. They have now moved their position to reflect breakeven for 23/24 plan. LPT have 4.0% CIP to deliver to achieve this target which equates to £15.9m and £9m of costs relating to capacity they need to keep open to cover the emergency pressures – majority of cost is agency staff.

	Recovery plan approach has been undertaken to identify schemes to close the CIP planning gap with Exec SROs in place for identified themes. **UHL position** UHL reported a planned deficit of £32.5m for 2023/24 in its submission to NHSE at the end of March. Since then, it has undertaken a deep dive with the national team to focus on: what's driving pressures in the plan, workforce-safer staffing, CIPs, ERF and balance sheet flexibility. 4. The scale of UEC capacity and flow funding challenge, is the remaining defining issue, which now fully drives the £10m. Bid was submitted to Region as part of the 23/24 planning round of £54m to cover recurring costs of meeting key emergency care pathways targets; so far £14m has been approved. 5. UHL has set itself a stretch target to reduce costs by £24.5m across UEC (of which £7m was a new target following deep dive and a further £10m followed the discussion with the national team)- it has modelled the need to provide additional beds and capacity to sustainably deliver 92% bed occupancy and 76% ED 4 hr wait including: continuation of Discharge lounge, Ambulance hub / modular funding, Glenfield site, ward 8 and modular ward. 6. UHL has £63m of CIP (4.2%) which includes significant reductions in costs relating to the emergency care pathway as stated above. It is working through how it will deliver all of these in year and has a strong process in place with Exec leads to drive the achievement of this programme. **Risks:** Currently across LLR risks total £204m or 9.9% but this is worst case, and more work is required to rag rate and assess probability.

	The most significant risks are: • Workforce- ability to motivate staff to deliver given low morale as evidenced through industrial action, competing priorities linked to delivering performance and financial targets, increasing expectations to improve productivity whilst reducing reliance on agency (209wte) and reduction in some areas such as ICB (30% or £6.6m ask) • Scale of efficiency ask- ability to achieve transformational change required in short time frame; approximately twice what has historically been delivered (£126m) and not all of CIP has been identified (1%). Significant proportion of this year's schemes are blunt tools of holding vacancies, blocking non pay spend and telling services to stop spending money • Level of risk still in the system outside of plan £204m- such as the decision taken not to fund existing cost pressures, excess inflation (£35m) and improvements in elective recovery currently the plan assumes all ERF targets will be delivered and exceeded for IS (£12m) **Workforce** Both UHL and LPT are looking to increase their substantive numbers and reduce reliance on agency at minimal financial cost; LPT are at zero financial increase and UHL are at 1.4% which may reduce further once the impact of their CIPs linked to UEC transformation have been scoped up. The net increase for UHL is 398wte which includes 351wte substantive, 69wte bank and 23wte fewer agency staff. For LPT it's a net growth of 255wte, which comprises 385wte substantive increase and 56wte bank less 186wte agency. **Cost Improvement Programme**

	LLR is describing a programme to generate savings of £131.5m or 6.4% of resource allocation (prior to impact of 1.1% national efficiency ask across providers). Schemes have been identified across all three organisations and shared with CFOs. These have been considered as part of the deep dive undertaken by national team and discussed at the Finance Committee with particular focus on assurance that they would not have a detrimental impact on other organisations and clinical risks had been reviewed and were understood. Most schemes are aimed at cost avoidance and there are none associated with ceasing service provision although some, such as use of Service Development Funding, will involve delaying improvement schemes in year. The Finance Committee has requested robust monitoring is put in place to review progress against the schemes and that they be RAG rated to establish level of risk in deliverability for the next meeting in May. **Maximising Productive Capacity** For the Acute sector, productivity has been maximised to support delivery of 30% more elective activity by 2024/25. A Theatre Utilisation Programme is in place, which will employ GIRFT principles, with one of the objectives to drive theatre utilisation to 85%. A number of projects will support this programme, which include *Improve overall theatre utilisation to 85%, HVLC targets and Day surgery rates, On the Day Cancellations, Average Case Per List (ACPL), Pre-operative Assessment (POA).* As with theatre utilisation, GIRFT and the National Outpatient Recovery and Transformation (OPRT) team have established a set of principles to tackle escalating demand for outpatient appointments and best use of clinic capacity. The key projects established both within UHL and adopted across the system will focus on: • Demand and Capacity • Productive clinic templates • Remote consultation • Reducing DNAs • Communication with patients, identifying and working with under-represented communities

	In LPT, a plan is being developed for 23/24, building on existing work and bringing it within a structured framework. The plan will focus on: • Enhancing Value Group – forum to identify opportunities • Return on investment – increased activity where investment has been made • Unwarranted variation between and within teams • Reviewing face-to-face virtual contacts to maximise capacity and flow • Redesigned multi-disciplinary, multi-organisational neurodevelopmental service to reduce duplication / increase capacity • Continuous skill mix reviews to increase capacity, improve patient experience and address skill shortages. The current Workforce modelling is reflective of boosting productivity by tackling safer levels of staffing and growing the workforce to drive activity (theatre utilisation, outpatients). The current workforce growth projections will deliver benefits on both of these fronts, but it is also important to highlight that UHL's projections are for recruitment to vacancies, rather than a genuine growth in establishment. **Narrowing health inequalities in access, outcomes, and experience** *1) Strengthened Governance and leadership for Health Inequalities* Continued progress in narrowing health inequalities in LLR will be founded upon strengthened governance and leadership in this area. The Health Equity Committee is a sub-committee of the ICB and provides assurance to the Board on implementation of health equity work at system, place, and neighbourhood. We have commissioned a Health Inequalities Champions training programme to increase clinical and managerial leadership across all partners in the arena of health inequalities. There are thirty-five participants on the first course which runs March – July 2023. Individual Design Groups in Learning Disabilities, Maternity and Mental Health have set up health inequalities sub-groups to undertake needs analyses and develop improvement projects. The Director of Health Inequalities and Inclusion at UHL, and the GP Lead for Health Inequalities for the ICB are participating in the NHSE Health Inequalities Ambassadors Programme. We will be nominating additional clinicians for any future places on this programme. A Head of Women's Health has been appointed in January 2023 to lead delivery of the components of the Women's Health Strategy.

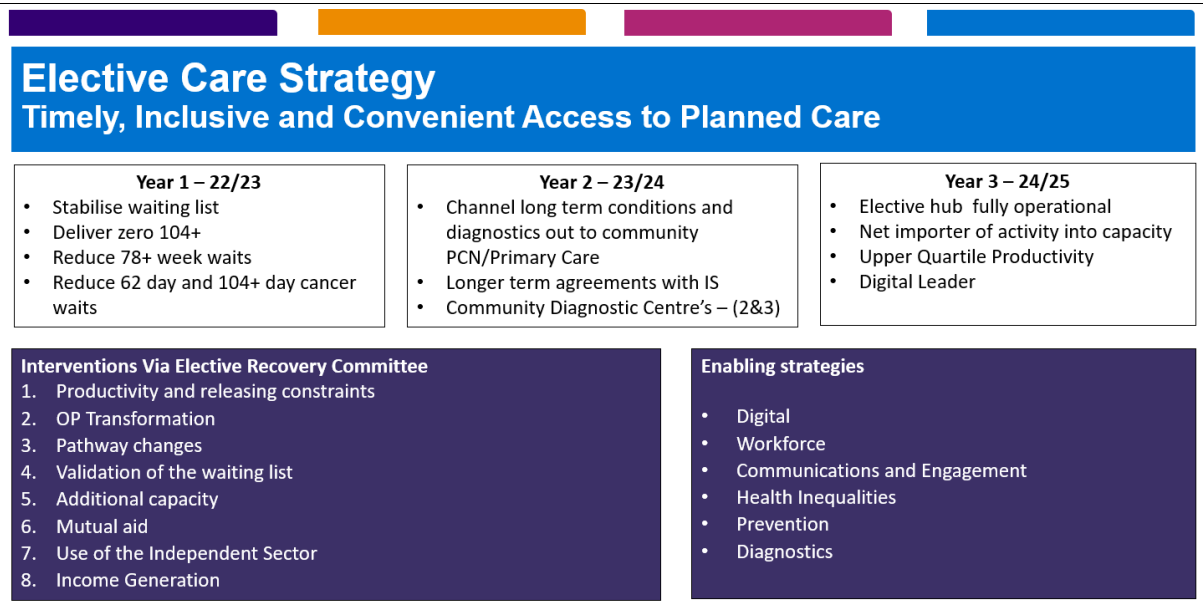
	UHL Health Equity group under the chair of Dr Ruw Abeyratne, Director of Health Inequalities and Inclusion brings together a range of UHL consultant physicians and NHS managers. It is overseeing seventeen separate Health inequalities projects (either in train or planned) across a range of clinical specialties. *2) Improving the timeliness and completeness of data to support Improvement programmes and research in health inequalities.* As per the commitment given in the LLR Health Inequalities Framework, LLR has created a Health Inequalities Support Unit (HISU) under the direction of a Steering Group drawn from ICB, Public Health, NHS Provider, CSU, and university research colleagues. A data analyst has been recruited. The unit will be operationally led by the ICB Head of Strategic Business Intelligence. The unit will support Design Groups and Collaboratives to undertake data analyses to improve understanding of inequities in access, experience and outcomes in their clinical pathways and services. The HISU will support evaluation of LLR improvement programmes, and research in health inequalities. We are working with East midlands colleagues to develop a full business case in 2023-24 for a Secure Data Environment (SDE) for research – including in health Inequalities. Service specifications for 2023-24 have been edited to include specific requirements on data collection related to ethnicity and protected characteristics. We will continue to work with NHSE East Midlands to develop a health inequalities dashboard, but in the interim are working with ML CSU to develop such a dashboard for local use. *3) Implementing the CORE20Plus5 approach for Adults and Children* A wide range of projects is underway at system, place and neighbourhood/PCN level to deliver on the CORE20Plus5 programme for adults. This includes projects to improve ED/OPD access and experience for people who are homeless, blood pressure ascertainment and case-finding of atrial fibrillation projects in deprived parts of LLR, vaccination programmes for those with LD and AIS improvement work within UHL and LPT. However, the two main health inequality projects for H1 of 2023-24 in LLR will be (a) improving cancer access, experience, and outcomes -especially in the CORE20 population, and (b) improving childhood immunisation rates in which there are wide disparities which appear to be linked to deprivation and ethnicity. A wider delivery plan for the CORE20Plus5 for children and young people will be developed in 2023-24.
How has the system leadership assured itself that the plan is deliverable and triangulated	The LLR System Executive agreed its approach to Operational Planning at its meeting on 28th October 2022. The core of this approach was to ensure that we develop a plan that is ambitious but at the same time both realistic and deliverable. This intent has then set the framework for the way the plan has been developed by Design Groups and

across activity, workforce, and finance?	Collaboratives and reviewed by cross system functional groups with regular updates provided to UHL / LPT and ICB executive meetings, the LLR System Executive and LLR ICB Board. The LLR plan across activity, workforce and finance has been constructed in a *Bottom-Up* manner, for example, from the Clinical Management Groups in the Acute Sector up to a System level. This ensures that it is clinically led, credible and deliverable. A key feature of our bottom-up planning process is to ensure that all components of the plan have been constructed and challenged within and across partner organisations, while simultaneously ensuring alignment with a top-down system approach. For example, our System Executive will be receiving progress updates in February and March on how our plans will address the drivers of our financial deficit (safer staffing, investment to support system flow, prescribing, delivering organisational CIPs etc) To date, we have consistently checked alignment between the activity we say we will deliver, the amount of workforce required to deliver it and the overall spend we expect to incur. However, we will continue to monitor alignment and provide evidence of this to assure the System Executive. We will use the ICS Triangulation Tool that was published on 10th February and review its outputs to inform corrective action if the triangulation metrics identify any alignment or data quality issues in the activity, workforce and finance plans.
What are the key assumptions that underpin your recovery plan?	Some of the key assumptions underpinning the LLR Recovery Plan include: • Emergency demand will remain stable and within projections, such that it will not negatively impact of Elective activity • Workforce: Staff sickness, agency use, and recruitment are as forecasted. No prolonged Industrial Action. • Delivery of efficiency targets
Please summarise the key interdependencies across your plan?	We know that the high demand within Urgent and Emergency Care is impacting our ability to deliver Elective Care and this is one of the most important interdependencies that we have focused on. Of course, recovery, productivity and activity can only be driven by having the staff, so LLR has focused heavily on Workforce. LLR is focused on retention, workforce flexibility, workforce development and culture & leadership. LLR is currently reviewing its financial commitments to Efficiency and Transformation projects. One interdependency that will be monitored closely is the interplay between pathway changes and Prescribing costs.

What are the key risks to delivery and how have you mitigated these?	LLR will further strengthen its governance arrangements for both planning and delivery into 2023/24. Principally, LLR will establish a System Strategic Planning Group and System Delivery Group and both will report into the LLR System Executive The System Delivery Group's purpose will be to drive delivery of the NHS LLR Operational Plan 23/24 and the relevant transformative plans outlined in the 5 Year Joint Forward Plan. Key responsibilities of the System Delivery Group are: • To act as the key system forum for reviewing delivery against system-level one- and five-year performance trajectories and transformative plans, holding the Chief Operating Officers and Senior Responsible Officers/programme leads (where relevant) to account and receiving assurance on performance improvement by exception. • To have oversight of performance & transformation related risks and issues that will impact upon delivery of 1 year or 5-year priorities. This includes identifying and presenting risks and issues at the meeting so that actions can be agreed, risks can be mitigated through an escalation approach via the LLR System Quality Group. It also includes the sharing of key issues and concerns raised by NHS England. • To review and ensure plans and performance trajectories embed and work towards addressing health inequity and deliver better outcomes. • To receive assurance on delivery but also participate in any deep dives or any associated audits as needed requested by the ICB Board or sub-committee. • To work with NHS England in line with the NHS England/ICB Memorandum of Understanding, as part of an integrated approach to driving performance. • To escalate areas of concern to the LLR System Executive/Clinical Executive as necessary following regular reviews of performance. The key delivery risks and mitigations of the 23/24 Operational Plan are as follows: 1. A surge in UEC demand has an adverse impact on elective activity. This will be mitigated, in part, by actions such as the establishment of the East Midlands Elective Care Centre, which will protect elective activity, increased planned activity at the Independent Sector and increased mutual aid 2. Unable to recruit and retain the level of workforce we are planning, leading to an increase in agency usage and staff sickness. The LLR One Workforce Plan will focus on retention, workforce flexibility, workforce development and culture and leadership. It is worth noting that this year, recruitment in LLR across our main providers has delivered to planned levels and is expected to continue in 2023/24. 3. Insufficient CIP delivery and / or drivers of the current deficit continue, leading to an adverse financial position and short-term decision-making. LLR is developing robust organisational cost improvement plans

	as part of the Operational Plan and has clear governance arrangements in place to monitor delivery via the LLR Finance Committee and System Delivery Group. In addition, LLR is also focussing upon the interventions required to deliver the 5 Year Joint Forward Plan – this will aim to achieve financial sustainability for the future. This will also be supported by a System Allocative Strategy and System Prioritisation Framework to guide investment and disinvestment decisions. 4. The Operational Plan does not deliver the required level of performance improvement. Our current plans continue to be developed with granular baseline information to monitor impact and are based upon schemes that have been successful in LLR. We have used this approach for determining impact of ERF schemes and additional capacity used for winter.

Elective care	
How will your system eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)?	**Vision:** To provide, timely, inclusive and convenient access to planned care that is accessible to all, regardless of ethnicity, postcode or background. **Strategy:** Over the next 3 – 5 years LLR will see a stabilisation of the waiting list, improved waiting times and additional capacity that will meet the needs of the local population as well as support on an East Midlands wide basis. It is built around strong delivery of eight key interventions linked to improving **Process, Productivity**, building strong **Partnerships** and **Capacity** that represents good value for money. Highlights for 23/24 include: • First phase of the East Midlands Elective Care Centre at the Leicester General Site • Building a second Community Diagnostic Centre at Hinckley • Continued reduction in long wait patients delivered with baseline funded elective recovery monies, access to national funds via specific allocations and the ability to generate additional elective recovery income. • Enhancing the referral support service, providing clinical triage, alternatives to secondary care, GP support and education.



Objectives:

The Operational Planning Guidance, released on 23rd December 2022, outlined twelve key objectives against a theme of recovery of core services and productivity. They are:

1. Deliver a system average of 106% of Value Weighted Activity
2. Eliminate waits over 65 weeks by March 2024
3. Increase productivity and meet the 85% theatre utilisation and day case expectations
4. Offer meaningful choice at point of referral and at subsequent points in the pathway, and use alternative providers if people have been waiting a long time for treatment including through the Digital Mutual Aid System (DMAS)
5. Reduction in O.P. Follow up by 25% against 2019/20 baseline by March 2024
6. Delivery of around 30% more elective activity by 2024/25 than before the pandemic
7. Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
8. Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition

	9. Maximise the pace of roll-out of additional diagnostic capacity, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely implementation of new CDC locations and upgrades to existing CDCs 10. Deliver a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostic investments and meeting optimal rates for test throughput 11. Increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24 (NHS England will publish separate guidance to support the increase GP direct access) 12. Deliver 120% of 2019/20 diagnostic activity levels The aim in 23/24 will be to maintain zero 104+ waits, deliver zero 78+ waits and deliver zero 65+ waits. As of January 2023; the cohort of patients who would be at 65+ by the end of March 24 is over just over 100,000 (88,000 on non-admitted and 14,000 admitted). This is a significant challenge and one that will require continued support through targeted access to funds from National and Regional Tier 1 programmes. Activity to deliver zero 65+ has been built into the activity plan and whilst there are productivity gains to be made the vast majority of the activity will be completed via insourcing, the independent sector or premium cost initiative lists. It is important to note that there is a worse-case scenario of c.9,000 patients based on current interventions and financial support in place. Risk based decisions will continue to be made particularly in Quarter 1 of 23/24 to ensure the pace and volume of activity that UHL and system partners are working at continues. Nationally, there is an expectation that productivity should be at 85% theatre utilisation and 85% for day case expectations. The Trust are working closely with the national Getting It Right First Time (GIRFT) team to learn from and gain practical support to deliver this. To offer meaningful choice at point of referral and use alternative providers, mutual aid and the independent sector have been significantly deployed over the last 12 months, this will need to continue throughout 23/24. This may require support from Regional and National colleagues to broker agreements and unblock barriers to delivery. Access to this support will be via Tier 1. Key headlines from the elective metric submission include: • Activity volumes will deliver of 106% VWA – Table 1 below • Zero 65+ by the end of March *with costs included in the deficit plan and ongoing targeted National Tier 1 support • 85% diagnostic 6-week standard in 6 out of the 7 planning modalities *with targeted funding support. Non-Obstetric ultrasound expected to deliver 70%. • Diagnostic activity at 111% of 19/20 • 2 Community Diagnostic Centres in place

- Delivery of PIFU to 3% against a target of 5% - knowing there is scope to improve this in the second half of the year.
- Increased use of A&G by 15% (Current trajectory for both Pre-referral Specialist Advice (A&G) and Post-Referral Specialist Advice is without growth)
- Further choice offered to patients via the Digital Mutual Aid System.

Table 1: Summary activity plan and VWA assessment.

ELECTIVE CARE	Activity			
POD	UHL	IS	Other NHS	**System Total**
2019/20 Baseline				
Day Cases	99,368	6,446	16,840	**122,655**
Elective Inpatients	12,561	1,580	2,961	**17,102**
Outpatient Firsts	196,314	11,064	41,572	**248,951**
Outpatient Procedures	106,671	2,462	25,465	**134,597**
2019/20 Baseline	**414,915**	**21,552**	**86,838**	**523,305**
2022/23 Forecast Outturn				
Day Cases	83,240	12,866	14,948	**111,053**
Elective Inpatients	12,254	2,091	2,691	**17,036**
Outpatient Firsts	164,975	18,172	39,103	**222,251**
Outpatient Procedures	97,949	3,800	20,821	**122,569**
2022/23 Forecast Outturn	**358,418**	**36,929**	**77,563**	**472,910**
As % 19/20 Baseline	86%	171%	89%	**90%**
2023/24 Plan				
Day Cases	93,180	13,616	18,136	**124,932**
Elective Inpatients	12,887	2,286	3,189	**18,361**
Outpatient Firsts	181,539	19,778	44,772	**246,088**
Outpatient Procedures	116,567	4,167	27,424	**148,158**
2023/24 Plan	**404,172**	**39,846**	**93,521**	**537,540**
As % 19/20 Baseline	97%	185%	108%	**103%**
VWA Elective Recovery Measure	103%	126%	110%	**106%**

With Coding and Counting

ELECTIVE CARE	Activity			
POD	UHL	IS	Other NHS	**System Total**
2019/20 Baseline				
Day Cases	99,368	6,446	16,840	**122,655**
Elective Inpatients	12,561	1,580	2,961	**17,102**
Outpatient Firsts	196,314	11,064	41,572	**248,951**
Outpatient Procedures	106,671	2,462	25,465	**134,597**
2019/20 Baseline	**414,915**	**21,552**	**86,838**	**523,305**
C&C at 22/23 ERF prices				
Day Cases	-12,038	-380	380	**-12,038**
Elective Inpatients	0	-51	51	**0**
Outpatient Firsts	-25,178	-570	570	**-25,178**
Outpatient Procedures	-783	-172	172	**-783**
C&C at 22/23 ERF prices	**-37,999**	**-1,172**	**1,172**	**-37,999**
2019/20 Baseline - Including C&C				
Day Cases	87,330	6,066	17,220	**110,616**
Elective Inpatients	12,561	1,529	3,012	**17,102**
Outpatient Firsts	171,136	10,494	42,142	**223,773**
Outpatient Procedures	105,889	2,290	25,636	**133,815**
2019/20 Baseline - Including C&C	**376,916**	**20,380**	**88,010**	**485,306**
2023/24 Plan				
Day Cases	93,180	13,616	18,136	**124,932**
Elective Inpatients	12,887	2,286	3,189	**18,361**
Outpatient Firsts	181,539	19,778	44,772	**246,088**
Outpatient Procedures	116,567	4,167	27,424	**148,158**
2023/24 Plan	**404,172**	**39,846**	**93,521**	**537,540**
As % 19/20 Baseline	107%	196%	106%	**111%**

without coding and counting:

ELECTIVE CARE	VWA	Activity
POD	IS (£)	IS
2019/20 Baseline		
Day Cases	£7,499	6,446
Elective Inpatients	£9,914	1,580
Outpatient Firsts	£2,008	11,064
Outpatient Procedures	£388	2,462
2019/20 Baseline	**£19,809**	**21,552**
2022/23 Forecast Outturn		
Day Cases	£15,257	12,866
Elective Inpatients	£13,345	2,091
Outpatient Firsts	£3,237	18,172
Outpatient Procedures	£479	3,800
2022/23 Forecast Outturn	**£32,319**	**36,929**
As % 19/20 Baseline	163%	171%
2023/24 Plan		
Day Cases	£16,147	13,616
Elective Inpatients	£14,586	2,286
Outpatient Firsts	£3,524	19,778
Outpatient Procedures	£526	4,167
2023/24 Plan	**£34,782**	**39,846**
As % 19/20 Baseline	176%	185%

	Delivery: The 2023/24 priorities and operational planning guidance reaffirms the goals for elective recovery set out in the Delivery plan for tackling the COVID-19 backlog of elective care which includes delivery by 2024/25 of around 30% more elective activity than before the pandemic. Elective recovery funding has been made available to each integrated care board (ICB) which for LLR is based on reaching a Value Weighted Activity (VWA) target set at 106%. The latest monthly VWA for LLR ICS is at 102% for October 22 (105% in September). LLR have ranked highly within the region ranking 1st from 11 systems for July: 2nd for August and 1st for September. This has been delivered through significant and targeted investment using £40m of Elective Recovery Fund monies. In 23/24 payments to providers will be made based on work completed with each patient seen/treated attracting additional payment from the resources available to the system (and a lower payment received if less work is done). Each Provider commissioner pairing has a separate target to deliver the 106% for LLR at a system level, for UHL the target is 103%. As such the UHL contract will be set at this level (103%) and under or overperformance will lead to less/more payment based upon national tariff prices. In 2022/23 the eight interventions were in their early stages of maturity yet successfully delivered: • A waiting list size as of January 23 of 124,638 against a peak of 130,000 in October 22 with a referral rate >100% in most months in 2022 • 100% cohort reduction in 104WW since March 2022 from 18,000 to Zero by end of March. • A 98% cohort reduction in 78WW since March 2022 from 49,000 to less than 1,000 by end of March • 100% of UHL's waiting list validation completed for 52+ • £40m Capital agreement of the East Midlands Elective Care Centre to be based at the Leicester General Hospital Site (LGH). • Capital investment in diagnostic capacity • Implementation of CDC 1 at the LGH with activity on plan against NHSE target. • Successful Business Case for CDC 2 at Hinckley • £40 Million Elective Recovery Fund monies to deliver highest or top quartile in the region for weighted value activity (WVA) against the 22/23 104% request. The planning assumptions, issues and risks remain relatively consistent with those observed in 22/23 across all aspects of planned care. They are: Planning assumptions: • ERF schemes continue • New recovery schemes are funded

	• Elective bed base is maintained • East Midlands Elective Care Centre operational • PCL activity baseline adjustment • Clock stops are consistent with weeks wait observed in 2022/23 • Winter impact minimal due to interventions in UEC plan • Tier 1 support to continue including access to specific scheme recovery monies • IS and Mutual aid support continues at levels agreed as a minimum Issues and risks: • ERF value in the baseline • Early access to other recover monies (Revenue and Capital) • Workforce gaps • Impact of emergency demand leading to cancellations. • Industrial action and increased pressure on emergency flow. • Potential of rejection of patients following OPA and pre-assessment at alternative providers (both IS and MA) • Reducing offers of mutual aid regionally • National shortage of theatre supplies/products • To summarise the aim in the elective operational plan for LLR in 23/24 (with the appropriate cost in the financial plan) will be to deliver the eight key interventions enabling zero 65+ week waits by the end of March 2024. It is important to note that actions and interventions will also be targeted to support early progress towards eliminating 52+ by the end of March 2025 and enable access to income over and above the 106% VWA target. Improvement support Team and GIRFT actions agreed in 22/23 are built into the trajectories. UHL and the system will continue to work with both teams to further improve LLR's benchmark position across all elements of elective care. Delivery of the elective care plan including diagnostics and cancer will be via a monthly Planned Care Partnership Group.

How will you deliver the elective activity target set for your system?

Intervention 1: Productivity

This intervention is in place to support delivery of 30% more elective activity by 2024/25 than before the pandemic and meet the 85% theatre utilisation and day case expectations. It is the most important intervention, with scope to deliver the greatest return both from a patient waiting time perspective and best value for money. The focus locally, regionally and nationally will be on improving on model hospital benchmarking and stretch to upper quartile performance.

Theatre Utilisation

The UHL Theatre Improvement Programme is targeting a return to pre-pandemic levels of productivity in 2023/24 (noting that there were also opportunities for improvement in this financial year). Key to this work will be the implementation of GIRFT principles such as improvements in theatre scheduling (including the concept of the Golden Patient), reducing time between operations and improvements to the preoperative process (which will reduce on the day cancellations). Patient communications are also key to this task, the implementation of Accurx text messages and calls to patients will ensure every available theatre slot is both required and utilised.

UHL has five projects led by the Medical Director and Deputy COO for Elective Care which will help to optimise Theatre Utilisation and improve efficiency. They are:

- Improve overall theatre utilisation to 85% by May 2023
- HVLC targets and Day surgery rates before May 2023
- On the Day Cancellations
- Average Case Per List (ACPL)
- Pre-operative Assessment (POA)

Further work to model the efficiency gains is yet to be completed across all components. However, for theatre utilisation improving the efficiency should have the below gains.

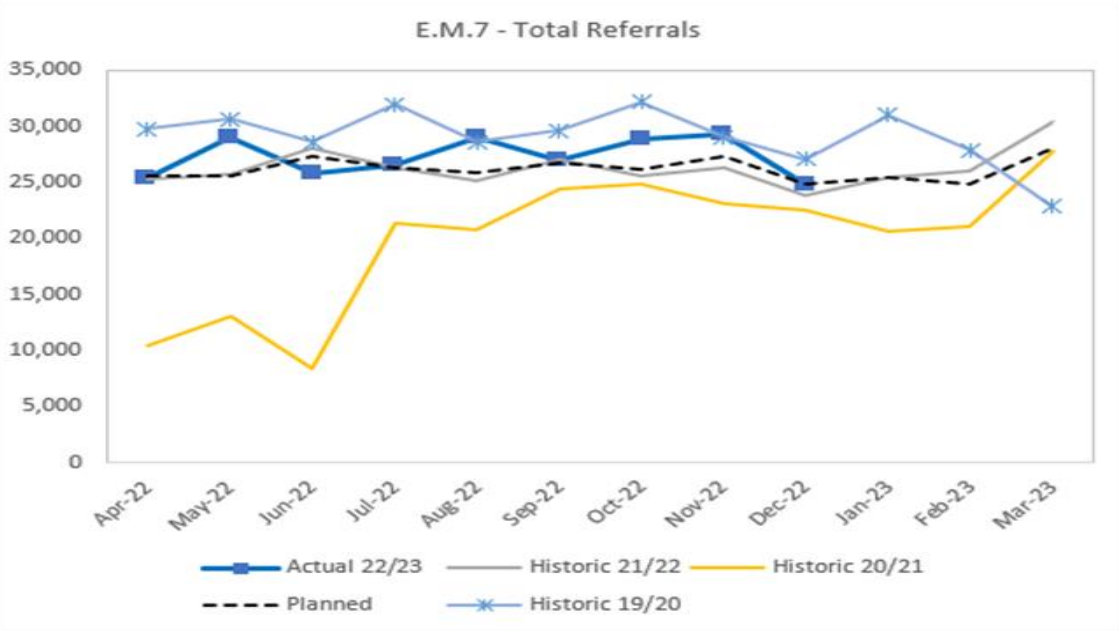
Scenario	Admitted clock-stops per week
Current run-rate (72% efficiency/utilisation)	1,234
Activity with 75% utilisation	1,285
Activity with 80% utilisation	1,371
Activity with 85% utilisation	1,457

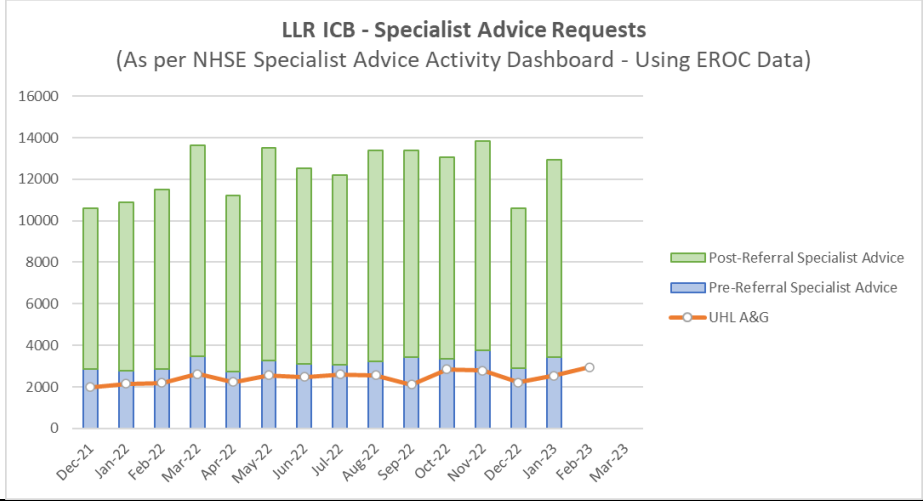
Outpatient Utilisation

As with theatre utilisation GIRFT and the National Outpatient Recovery and Transformation (OPRT) team have established a set of principles to tackle escalating demand for outpatient appointments and best use of clinic capacity.

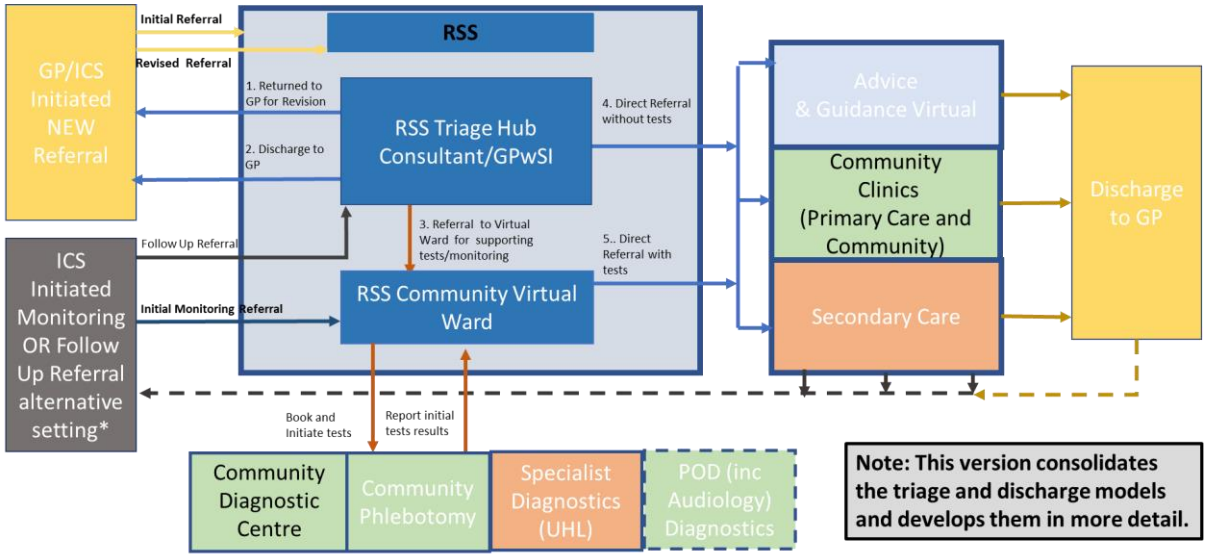
	The key projects established both within UHL and adopted across the system will focus on: • Demand and Capacity • Productive clinic templates • Remote consultation • Reducing DNAs • Communication with patients, identifying and working with under-represented communities **Intervention 2: Outpatient Transformation Plan** This intervention is in place to support the ask of a 25% reduction in Outpatient Follow up activity against the 2019/20 baseline by March 2024. The scale of this ask for 23/24 would be a reduction in follow ups of c.150,000. There have been significant improvements demonstrated through the UHL Outpatient Programme within 22/23 introducing new ways of working and a focused response to the planning guidance metric of reducing follow ups and implementing alternatives such as PIFU to allow for an increased delivery of New Outpatients. These initiatives have covered the following: • Robust validation using technology to communicate with patients avoiding the need for intensive clinical resource to undertake this task. The impact has been: ○ 76,515 non admitted patients contacted 4,200 were removed from the waiting list at the patients request ○ 31,738 Overdue Follow ups were contacted and 1,354 taken off 3,943 converted to PIFU ○ Assurance for those patients that they are still under UHLs care if they still require this ○ Offer of PIFU for those patients that are appropriate ○ Utilising clinic resource for those patients that need to attend and therefore shortening their wait time • Increased rollout of PIFU for both long waiters and those who attend clinic in person, the overall PIFU numbers have increased with a total forecast for the year of approx.18,000 patients converted to a PIFU pathway. • Increased rollout of Pre-referral Specialist Advice (A&G) with a total number of 32,000 delivered up until the end of Jan 23 with an overall conversion of 2.1% into secondary care • Increased rollout of e-triage which supports delivery of care outside of the acute setting as well as ensures patients have all relevant tests and investigations prior to referral • Access to health, focusing on DNA and the cause • RPA focusing on repetitive processes with PAS saving time for admin roles

	Building on the excellent progress made in 22/23 the advice and guidance, PIFU and virtual appointments will continue into 23/24 with an expectation that it will deliver: • Increased offer of PIFU to 34,000 across the year achieving 3% conversion of outpatients to PIFU • With the support GIRFT principles significantly increase PIFU performance from the second half of the year. • • Pre-referral Specialist Advice (A&G) of 37,900 and Post-Referral of 111,800 – 149,700 requests in total equivalent to 40 per 100 first outpatient attendances with a diversion rate of 30.7%. As well as this the Outpatient Programme will focus on • Continuation of validation using technology embedding the process on a bimonthly cycle • Expansion of e-Triage • In depth Quality Improvement Programme around Clinic Utilisation and Clinic templets to support the effective use of resource and ensuring new patients are seen in a timely manner • Focus on DNAs **Enhanced Referral Support Service (RSS)** RSS was established within LLR in April 2019, and since then it has triaged 176,566 GP referrals. There are two clear functions of RSS, which ensure that patients go to the most appropriate clinical setting for their treatment. The triage is done by a GPSI or consultant within the RSS SystmOne Community Unit and the RSS administrative team contacts the patient to offer choice. The graph below shows that referrals have exceeded plan significantly in 23/23.


E.M.7 - Total Referrals
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Actual 22/23
Historic 21/22
Historic 20/21
Planned
Historic 19/20


LLR ICB - Specialist Advice Requests
(As per NHSE Specialist Advice Activity Dashboard - Using EROC Data)
16000
14000
12000
10000
8000
6000
4000
2000
0
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Post-Referral Specialist Advice
Pre-Referral Specialist Advice
UHL A&G

At present RSS is focussed on Dermatology, MSK and ENT. For 23/24 a proposed clinical model has been developed to enhance the referral support service and extend it into 3 additional specialties, Cardiology, Respiratory and Gynaecology.
The proposed clinical model, which will be developed in three stages, will become an integrated model of initial referral management, including overseeing the presecondary care tests as well as managing patient discharge from secondary care to community /primary care.



* Secondary Care/Community Clinic-RSS or Secondary care-GP-RSS

This proposal will free up clinical capacity by:

- Triaging all referrals from primary care, either by a GPwSI or consultant, directing them to the most appropriate service with a proportion appropriately directed from acute to community services.
- Providing Advice and Guidance to Primary Care Clinicians.
- Overseeing the testing of patients prior to a Secondary Care referral. This is currently managed in Primary Care.
- Overseeing continued monitoring and testing of patients in the Community after their Secondary Care episode.

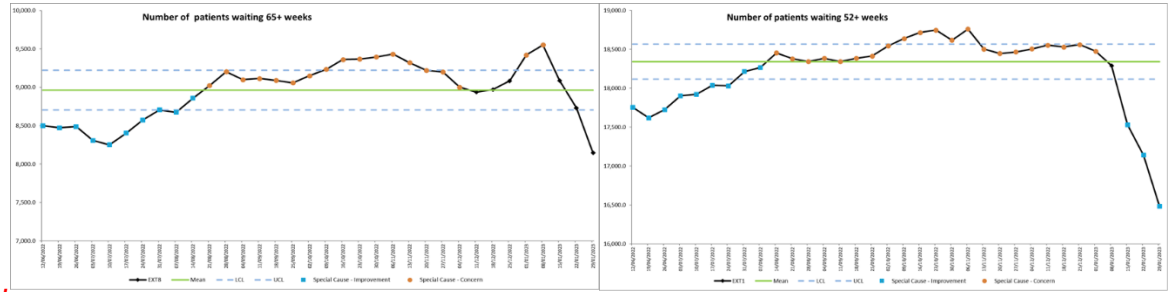
	It is likely that digital support will be required to deliver an enhanced RSS service aligned to many of the services offered by independent companies which can in themselves create an additional admin burden or cost to the system. The key aim will be to deliver an affordable model locally. The benefits which will be delivered by using this model • Be seen in the most appropriate setting which in many cases will be more local to patients and with shorter wait times in the community • Be managed more systematically at scale which will ensure that their monitoring appointments are arranged and attended. • patients should be able to get tests quicker and more conveniently as there will be a wider range of testing clinics to choose from • Reduce unnecessary steps in the patient pathway • Improve cost efficiencies as patients who do not need secondary care will be redirected to other less expensive services. • First appointments in secondary care will be avoided • Reduction of initial tests as not all referrals will go to Secondary Care • PCL rates for treatments tend to be about 10% -15% lower than tariff. • Free up primary care patient appointments • Activity deflected to appropriate non acute settings will free up clinical resource to reduce waiting lists • Manging tests in RSS will reduce administrative workload on primary care clinicians, freeing up time for patient care • There would be savings arising on unnecessary tests as once triaged not all referrals would require testing. • By managing the test booking as an administrative function then it can be delivered by Admin staff and not Clinicians. • By reviewing test results using agreed parameters this can be done using administrative staff. Only where results are shown to be outside those agreed parameters would the result be escalated to a Clinician, Primary or Secondary as appropriate for further review and consideration. • These efficiencies would effectively replace clinical time with administrative time, thereby enabling more patient facing clinical appointments within Primary Care. **Intervention 3: Pathway Changes** Alongside targeted OP productivity and innovation there is an established programme of pathway redesign which should effectively support delivery of all the national asks in the operational plan. This

	intervention will work through all aspects of process, capacity and partnership working to deliver efficient and high-quality models of care. Six clinical areas with high volume and long waits have been identified for pathway review and redesign. They are: • Ophthalmology • ENT • Gynaecology • General Surgery • Urology • MSK/Orthopaedics To ensure that each area undergoes an end-to-end pathway review, a clinically led task and finish group has been established within each speciality area which includes primary and secondary care clinicians. The remit in the first instance of each specialty pathway review is to focus on: • **Prevention** - Identifying what is already available and should be available to the population of LLR to prevent either becoming ill or to prevent further deterioration the condition/illness. • **Referral management** - Reducing variation - Identifying referral variation across primary care and working with those outlier practices to improve their referral management. Improving referral process – reviewing local pathways and referral forms to reduce inappropriate referrals and ensure that the patient sees the right person in the right place first time. • **Virtual triage -** The use of an enhanced referral support service will be considered for each specialty area • **Alternatives to secondary care -** Each area will be reviewed for treatment and care that can be provided outside of a hospital setting such as specialist community clinics, enhanced primary care services or directed to Community Pharmacy Consultation Service. (CPCS) • **Follow up in the community - Alternatives to secondary care** where follow up appointments can be provided, if required, to patients in the community either from primary/community care clinicians or remotely where it is safe to do so.

	• **Education and Information for patients and GPs -** Identifying and developing self-management education / resource that is available to patients. Identifying any gaps or opportunity for education and training for GPs or GPWSI's. Anticipated benefits • Through a combination of improved referral management and triage process, it is expected that an additional 20,000 referrals will be deflected from secondary care during 23-24. • In addition, patients will be treated in the right place first time, preventing patients going into a secondary care setting when they can be appropriately treated in the community. **Intervention 4. Validation of Waiting Lists** LLR has one of the longest and largest waiting lists in the country. Good progress has been made in 2022/23 with technical and clinical validation including the use of AccuRx and text messaging communication service. £100k was received from national monies in 22/23 to support this reduction and continue the work into 23/24. This intervention is in place to support delivery of the elimination of waits over 65 weeks by March 2024 and to provide meaningful choice of alternative providers if people have been waiting a long time for treatment including through the Digital Mutual Aid System (DMAS). It is a critical intervention in terms of strengthening current processes and utilising capacity appropriately. In the "Next steps on elective care for Tier One and Tier Two providers" 25th October 2022 outlined 3 key aims for validation: **1.** By 23rd December 2022: Any patient waiting over 52 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted. **Completed by 13th January 2023 and highlighted as one of the best within the region.** 2. By 24th February 2023: Any patient waiting over 26 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted. **To be completed by 10th March 2023.** 3. By 28th April 2023: Any patient waiting over 12 weeks on an RTT pathway (at 20 April 2023) who has not been validated* in the previous 12 weeks should be contacted. **On track for delivery**. The actions in place to deliver this are as follows and are overseen by the Deputy COO for elective care and include general actions to improve validation such as:

- Understand baseline position on validation from WLMDS
- Include technical validation dates in WLMDS submission
- Include digital validation dates in WLMDS submission
- Batch messaging to go live in AccuRX
- Improve message content using behavioural science
- Include date of last patient contact in WLMDS submission
- Review how data is captured in relation to dates for clinical validation / application of P codes
- Explore possibility of capturing date reviewed for mutual aid as clinical validation date

Graphs to show the impact that the validation intervention has had in 22/23.



The expectation for this work in 23/24 is that UHL hold a 'clean' waiting of patients who are fit, ready and able to proceed with the next step in their elective pathway.

Intervention 5: Additional Capacity

Historically, LLR have lacked robust demand and capacity modelling to clearly evidence capacity gaps and underpin investment decisions. This intervention is in place to support CMG's and the wider system to have confidence in understanding the root cause for any D&C gaps and inform actions that will offer best value for money and impact for patients and staff. This will be delivered both by in-house solutions and with the support of external consultancy.

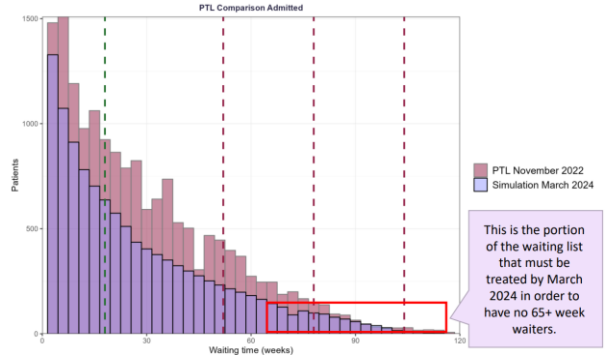
2023/24 will see the first phase of the East Midlands Elective Care Centre (EMECC) project opens at LGH from May 2023. This will see two modular theatres on site with one operational and the other used as a recovery area until the refurbishment of the Brandon Unit is complete (expect 24/25). In the first phase the activity will be General Surgery and Urology with almost 3,000 patients being treated in 23/24. The modelling work that we have commissioned demonstrates a 30% reduction on waiting lists for the specialties that will be using the hub, at the point that it is fully operational.

Once fully operational, EMECC will see over 350 inpatients, treat over 16,000 patients in a day case setting and more than 100,000 patients will be seen in outpatients each year.
In addition to EMECC, the Community Diagnostic Centres and capacity within the independent sector or via mutual aid; work commissioned by LLR in January 2023 with EDGE Health is supporting the system to understand at the earliest opportunity what the impact of current schemes and interventions will be. This modelling looks to:

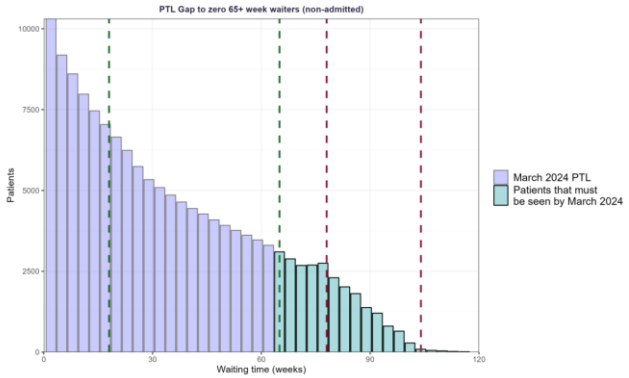
- Define the system-wide baseline activity and waiting list, by specialty
- Quantify the gap to achieving the target waiting list of zero 65+ week waiters by March 2024
- Identify areas where increases in PCL, independent sector (IS) and out-of-county (OOC) activity would bridge this gap.

The time-series graphic below shows the residual for long waits under *do nothing* conditions and at the current run rate for the admitted PTL.

Summary	November 2022	March 2024	Difference
Total PTL	17,297	12,507	-28%
52+ week waiters	2,967	1,783	-40%
78+ week waiters	748	477	-36%
104+ week waiters	151	20	-87%



Summary	March 2024
Total PTL	144,832
65+ week waiters	21,703
Percentage of total PTL	15%



	More detailed work has been commissioned at a specialty level with the key aims being to: • Provide a forecast of demand and capacity for each of the four specialties, including assessing the level of intervention required to meet waiting list targets • Hand over sufficient guidance and expertise to the specialty teams such that they can take this modelling forward internally in future This piece of work will continue beyond the planning round deadlines and underpin business case submissions and investment decisions in the future. **Intervention 6: Mutual Aid** The formal national mutual aid programme has been in place since April 2022 with LLR improving its processes significantly in year with a clearly defined SOP in place to work to. It remains a key component of the LLR elective recovery plan and will form the basis of future partnership working. In 22/23, real success was evidenced particularly for Orthopaedics working with GIRFT and ULHT from their Grantham site and with Northamptonshire for a range of specialties. With the support of national funding LLR in late 22/23 has set up a team to facilitate mutual aid (and IS) activity removing much of the burden from existing operational teams. For 23/24 the expectation is that use of the National Digital Mutual Aid System (DMAS) will support a wider and more systematic approach to mutual aid. UHL through validation will identify how far patients are willing to travel and any co-morbidities they may have. Appropriate patients will be "uploaded" with the expectation that providers with capacity will accept. In 22/23 this has been in the main with IS providers. **Intervention 7: Use of Independent Sector** In 22/23 to support the reduction in long wait patients, activity in the Independent has significantly surpassed historical volumes. LLR have extended the number of providers they are working with (linked to DMAS) utilising providers who could offer a more complex patient case mix or support with high volume total pathway work. Multi-year or longer-term agreements are currently in discussion, with indicative activity plans expected to be agreed before the end of March 2023. The movement in IS activity and cost is shown in Table 2 below. **Table 2 Independent Sector plan for 23/24.**

ELECTIVE CARE	VWA	Activity
POD	IS (£)	IS
2019/20 Baseline		
Day Cases	£7,499	6,446
Elective Inpatients	£9,914	1,580
Outpatient Firsts	£2,008	11,064
Outpatient Procedures	£388	2,462
2019/20 Baseline	**£19,809**	**21,552**
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Outpatient Procedures	£526	4,167
2023/24 Plan	**£34,782**	**39,846**
As % 19/20 Baseline	176%	185%

Patient Care Locally (PCL)

PCL is a community interest company which includes an alliance of general practitioners providing clinical services within primary care and the local community across LLR. PCL work in tandem with the LLR ICS to identify what patient care needs, such as minor procedures, can be carried out and looked after in local, primary care environments, reducing the need for an outpatient or day case procedure in an acute setting.

This contract has grown from £6.5m in 19/20 to £9.2m in 22/23 with a forecast 15% increase in activity for 23-24. Our strategy is to move simple procedures into this provider to free up capacity for the backlog of complex work within UHL. As the patients are without complications this is done at a below tariff cost.

During 22-23, ERF funded several pathways and services that moved activity out of secondary care:

Service	Description	22-23 activity year to date forecast	23-24 activity plan
Dermatology Acne Service	All Acne referrals directly triaged to primary care via RSS for patients over 16.	1,624	1,839
Echo	Referrals from GPs sent directly to PCL	3,133	3,243
Image Guided Injections	Patients seen by PCL (3 sub-contractors) and returned to UHL for follow up	271	344
MSK Community Clinics	One-stop community clinic pilot commenced in 2022, to reduce the number of patients being directed to UHL that can be seen on an alternate pathway in the community.	1,050	1,051
Breast Pain Pathway	Removing patients from 2ww secondary care referrals when the only symptom is breast pain. Patient examined and family history assessment carried out in primary care clinics	504	477
Total activity		**6,582**	**6,954**

Working with PCL to shift activity from secondary care into a primary care setting. Good progress made over last 12-18 months on Triage / OP procedures / Dermatology. Worked well when lead clinician fully engaged. 3 key actions to support more of this:

1. Expand referral assessment
2. Identify patients 18-52 weeks to transfer
3. Ensure all capacity is well utilised and kit not sat idle in community settings

Intervention 8: Additional Income

The Elective Recovery Fund (ERF) is designed to support NHS healthcare systems to move back to and beyond pre-pandemic levels of activity, eliminate long waits, improve access to diagnostics and deliver cancer standards. The total allocation in 22/23 was £39.9m to deliver 104% of Value Weighted Activity (VWA). The full amount was committed with key schemes including insourcing of vanguard theatres at the Glenfield, investment in pre-op, increased use of PCL and other independent sector providers. Circa.80 schemes and programmes of work throughout the year have supported delivery of zero 104+ waits by the end of March 23, a significant reduction in 78+ waits and a VWA of 105% in September (best in region) and 102% for October (4th / 11 systems).

	For 23/24 the same level of elective recovery monies is expected to be included within the baseline for LLR with the opportunity to generate additional income for performance over 106% VWA. A confirmed list of schemes for 23/24 is available with pre-commitments such as: • The East Midlands Elective Care Centre £4.1m • Continuation of the Vanguard Theatres £6.6m All schemes from 23/22 have been reviewed and exit plans in place for all schemes not being carried forward in 23/24. All CMGs and non UHL schemes have submitted proformas through their existing business case routes for any schemes wishing to be carried forward into 23/24. Given the level of delivery in 22/23 has been in the regional top quartile for VWA, confidence in delivery of schemes remains high. With the right focus on productivity, process, and additional capacity to enable income over and above this level to be secured. Oversight of ERF schemes has been via the ERF Board chaired by the System Director of Planned care. The expectation for 23/24 will be a focus on value for money (VFM) as part of the Planned Care Partnership Group.

Cancer

How will your system reduce the number of patients waiting over 62 days in line with the provider level requirements? **Requirements can be found on the NHS Planning FutureNHS collaboration Platform > Supporting Materials > Cancer**	**Vision:** Our LLR vision through collaborative partnership working is to maximise the early diagnosis and treatment for all suspected cancer patients leading to increased survival rates following cancer diagnosis. Our core aims are to: • achieve the FDS by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days. • Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028. • Reduce the numbers of patients waiting longer than 62 days as a key priority Currently we are close to meeting the FDS standard with 74.9% of patients being assessed and informed of their cancer status within 28 days. On 31st March 2022, 528 patients were waiting over 62 days. Our trajectory indicates that we will not achieve our 22/23 submitted plan of 250 patients waiting longer than 62 days by March 2023. Having reached 952 patients at the highest point on the 8th of November 2022, with NHSE support to UHL as a Tier 1 Trust, a trajectory was developed to have an exit point on 31st March 2023 a backlog of 517 patients, revised down from 548 patients. UHL is expecting to overachieve against this revised exit point due to a current positive performance. Current planning guidance is that UHL will need to deliver 309 patients in our backlog by March 2024 in order to show a 'fair share' allocation of a reduction in patients waiting from 22/23 levels.

Cancer Strategy - Draft
Timely, Inclusive and Convenient Access to Cancer Pathways

Year 1 – 23/24

- Have less patients waiting longer for treatment through an improved 62 day position
- Stabilise waiting list management
- Deliver FDS target of 75% within 28 days at March 24
- Implement a GP led brain pathway

See patients quicker

- Implement best practice timed pathways
- Embed Non Site Specific pathway
- Implement and maintain priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result), skin (teledermatology) and prostate cancer (best practice timed pathway) Increase quality of GP referrals
- Utilise technology to the patient's advantage
- Recognising patient diversity in our engagement

Year 2 – 24/25

- Have a fully functioning multisite robot provision
- Expand the Targeted Lung Health Checks (TLHC) programme and ensure sufficient diagnostic and treatment service capacity to meet this new demand.

Treat patients quicker

- Tracking efficiently to minimise PTL footprint
- Champion Next Step Navigators in each tumour site
- Right size Cancer Centre resource
- Review and expansion of Osborne Building
- Radiotherapy LINAC replacement
- Improve our 7 day measure for diagnostics
- Improve access to specialist theatres
- Develop our theatre robot capacity
- Understand our capacity constraints in each tumour site, with mitigation plans developed
- Utilise alternative methods (Cytosponge, colon capsule) of treatment

Year 3 – 25/26

- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028

Living with & beyond Cancer

- Introduce a Psychological Support service within LLR
- Expand our prehab offer within LLR
- Continue the expansion of Patient Stratified Follow ups
- Expanding our Macmill an footprint at LRI
- Embed surveillance services for Lynch syndrome, BRCA and liver
- Work with regional public health commissioners to increase colonoscopy capacity for the extension of the NHS bowel screening programme to age 54+
- Developing a post pilot GRAIL offer

Productivity / Processes / Capacity

	Action to improve our performance against the 62-day waits will include:- Implementation and maintenance of priority pathway changes for lower GI, skin and prostate cancer, building upon the work we have done in 22/23. We will continue to utilise Skin Analytics AI technology and review the impact on referrals and activity as well as impact on whole pathway and performance metrics quarterly. Sites in the first phase are Hinckley, Melton, Loughborough, and the City. Other sites will be planned for the next phase. Transformation workplans and engagement are in place and work within lower GI is progressing. We will continue to progress implementation of the FIT pathway across LLR. We will make maximum use of wider local capacity by utilising an increased offer from local private providers for cancer diagnostics and procedures. These will include prostate biopsies, urodynamics and skin procedures. We intend to increase and prioritise diagnostic and treatment capacity, including ensuring that new diagnostic capacity (particularly through community diagnostic centres) is prioritised for urgent suspect cancer. We will increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% We will implement the Targeted Lung Health Checks (TLHC) programme in LLR and ensure sufficient diagnostic and treatment service capacity to meet this new demand. We will also recruit new project managers and dedicate resource fully to this new programme. We will continue to commission key services which underpin progress on early diagnosis, such as non-specific symptoms pathways, which we launched in January 2023. Further progress on Lynch syndrome, BRCA, liver and our NHS bowel screening programme extension will continue. We will increase public awareness of genomics as well as access to genomic services including genetic counselling, risk assessment and genetic testing. We will ensure enhanced screening and risk reduction is available for individuals at increased risk of cancer, particularly those with inherited cancer syndromes, leading to decreased morbidity and mortality. We will invest in Histology services by expanding the laboratories and upgrade the facilities used in dissection and preparation. Currently 70% of samples are reported within 7 days however pathology services are at a step change due to the increasing volume of cancer pathway work. After replacing our surgical robot at the Leicester General Hospital in 2022, we will advance our Robotic Strategy by receiving a second surgical robot, this time at the Leicester Royal Infirmary. This will provide

	a home for Colorectal, upper GI and Head & Neck Robotic Assisted Cancer Surgery, allowing more dedicated time on our original robot for Urology and Gynaecology. We will include specialised commissioned services such as chemotherapy and radiotherapy in our 23/24 planning, which includes expansion of workforce to increase chemotherapy slots for LLR. Due to an increase in approved NICE regimes, specifically the developments of immunotherapy treatments the amount of activity for Oncology has increased year on year as the new regimes change and people live longer, alongside an increase in referrals from all tumour sites. The service intends to transfer care closer to home via home care to support the increase in follow up demand. Oncology, Haematology and Radiotherapy will recruit to 30+ posts at multiple levels across all parts of the MDT which will allow improvement in multiple areas, including maximising resource and capacity to reduce any increased waiting times for patients to receive treatment. Key investments include 8.2 additional nurses and 2 new medical oncologists. Radiotherapy, challenged by demand outstripping capacity and aging equipment will address this via the LINAC replacement programme, due to be operational in May 2024. We will review the physical space allocated to Oncology and look to utilise alternative community providers where acute expansion may be constrained. We will work closely with Children's and Young People's Cancer Commissioning to ensure alignment of objectives and understanding of ongoing work to support our local health population, especially during the transitional period from CYP to adult cancer services. We will conduct a review of the brain pathway which will reduce the need for outpatients in LLR. We will right size the workforce within our Cancer Centre to ensure timely tracking and more effective management of patients on their cancer pathway. This will also include next steps co-ordinators in all relevant tumour sites to ensure all cancer patients are kept informed of the next steps in their cancer treatment plan as well as validating the patient pathway. We will participate in CNS workforce review being undertaken across the East Midlands to identify opportunities for maximising / increasing clinical capacity . Working in collaboration with the East Midlands Cancer Alliance we will undertake; **<u>Prostate and Community Pharmacy pilot</u>** The pandemic impacted the number of people being diagnosed with, and starting treatment for, prostate cancer These projects support a recovery in prostate cancer referrals and treatment. The evaluation of the prostate case finding projects will also inform other case finding approaches.

	Colon capsule endoscopy When used effectively, CCE releases capacity in the LGI FDS pathway and surveillance services, minimising the use of theatre time. Alliances will continue to support CCE delivery, including maximising evaluation uploads, so CCE can be effectively evaluated as a diagnostic tool in the lower GI cancer pathway and further decisions made about its long-term role in the delivery of LGI services. **Early Diagnosis for Liver cancers** Liver cancer rates have more than doubled over the past decade and are continuing to rise. NICE Guidance recommends 6 monthly ultrasound surveillance for those with cirrhosis, but current delivery of this recommendation is extremely mixed. Cancer Alliances will take a lead role in improving liver surveillance services, and in identifying more people at high risk of liver cancer, to diagnose more liver cancers at an early stage. **Cyto sponge** Endoscopy remains one of the services most affected by the pandemic and subsequent pressure on services. Using Cytosponge as a triage tool in secondary care has potential to release capacity of endoscopy services by discharging patients at low risk (routine and surveillance) and ensuring patients at high risk can be prioritised effectively. Delivery of the pilot services will continue until the evaluation is published, followed by a transition arrangement from national programme support to BAU commissioning. **Pancreatic cancer** Currently most patients at high risk of developing pancreatic cancer are not aware of their risk and are not receiving surveillance services as per NICE Guidance 85. Delivery will ensure compliance and help improve early diagnosis rates for one the least survivable cancers with a high proportion of late-stage diagnoses (77.3% of staged Pancreatic cancers were diagnosed at stage 3/4 in 2019). **GIRFT recommendations** The (GIRFT) lung cancer report highlighted significant variation in access to lung cancer treatments and provided recommendations to improve this. The purpose of this work is to implement 3 priority recommendations from the lung GIRFT report to reduce variation in treatment and improve outcomes. The Bowel, Prostate, Oesophago-Gastric and Breast cancer in older women annual clinical audit reports, have highlighted significant variation in access to cancer treatments and provided recommendations to improve. The NHS Cancer Programme Clinical Advisory Group, supported by analysis on the extent and impact of variation across audit recommendations,

	have selected one priority recommendation from each cancer audit report, to prioritise to reduce variation in cancer treatment. **<u>Patient engagement</u>** Evidenced effective involvement of people and communities is a statutory duty. This must go further than consultation styles of engagement and ensure people and communities have an equal opportunity to influence and make decisions as partners, and to coproduce plans and interventions to better suit the community. UHL to re-launch the Personalised Care Project Group to underpin this aim.
How will your system meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template' and include specific reference to:* • *the expansion of diagnostic capacity to meet expected levels of growth, including prioritising new CDC capacity for urgent suspected cancer.* • *implementing and maintaining priority pathway changes for lower GI (80% referrals FIT tested), skin (teledermatology) and prostate cancer (best practice timed pathway).]* Actions to improve our FDS pathway will include a combination of prevention and screening objectives including supporting improved awareness of the importance of the screening programmes, to facilitate better informed choice via supported targeted interventions among patients known not to engage. We will decrease age ranges for our bowel screening programmes and undertake various awareness campaigns. We will recruit a project manager to support exploratory work on staging data to align data sources and understand the impact of our work. This will also be supported and links made with population health management and health inequalities. We will offer every patient diagnosed with cancer the following: A personalised care and support plan utilising a holistic needs assessment; End of treatment summary; Cancer Care review; Health and wellbeing interventions. We have implemented our personalised stratified follow-up (PSFU) remote monitoring for several tumour sites, including prostate which is a proven model and will now be remote monitored for 10 years The plan in 23/24 is to consolidate and embed breast, colorectal, prostate and

	endometrial personalised stratified follow up pathways, which is aligned to EMCA priorities. Work will progress with the pathology department to support PSFU. **Primary Care** • Increasing the use of FIT testing for lower GI pathway referrals. • Screening uptake across the system for bowel, breast, and cervical cancers. • Implementation of safety netting within primary care. • Patient education and GP education and general health promotion for primary and secondary care. • To work with public health to ensure integration of Public Health and health promotion and ICB for patients using cancer champions/connectors with targeted health advice • Increase PSA monitoring for black men with a family history • Implement lung health checks and scoping incidental findings within Primary Care. Specifically for actions within primary care. • Use the teaching moment potential for learning about cancer screening and symptoms following a two week wait pathway showing that the patient doesn't have cancer. • To understand the causes of exceptionally low 1 year bowel cancer survival in Leicester City • We are working as a task and finish group which meets 6-weekly to ensure there is co-ordination from public health and local authorities, looking at population health management and health inequalities • Lowering the age of symptomatic FIT testing • Employing a project manager for 2 years in the ICB to support increased use of FIT testing with Primary Care. • Video texting targeted population health-based screening projects. • Employing project manager to look at health inequalities within LLR concentrating on uptake of screening • Improve patient safety netting given the increased diagnostic load • Create and promote education events/resources for primary clinicians including GP's ANP's and PA and paramedics (the entire workforce). • Employ a project manager for 2 years to look after lung health project and work across the system.

	• Create and pilot a resource via video text to be delivered at the end of the two week wait non converter pathway • Auditing bowel cancer emergency presentations and two week wait referrals using the national cancer diagnosis audit tool and sharing outcomes with City PCN's
How will your system increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028?	**<u>The following objectives will support the earlier diagnosis of cancers (type 1 and 2 by 2028) as well as increased survival rates overall of 75% by 2028.</u>** **Health inequities, prevention, and screening** • Work to actively remove barriers to inequalities thereby providing the best outcomes for our patients regardless of race or ethnicity, removing the inequalities and variation in referrals. • Work as a system to ensure that the services we provide through Cancer Pathways and support, both now and in the future, deliver equitable outcomes for all patients across LLR and that our diverse population is acknowledged when changes are made. • Support improved awareness of importance of the screening programmes, to facilitate better informed choice via supported targeted interventions among people known not to engage. • Better informed choice leading to an increase in uptake of screening programmes contributing to earlier diagnosis and treatment • Support the national Bowel Cancer Screening Programme (BCSP) lowering of the eligible age range from 60-74 years to 50-74 years by 31/03/2025. • UHL BCSP are midway through their age extension roll-out and currently invite eligible people age 56-74 years, with age 54 years to be included in 2023-24 • Potential NHS England national awareness campaign during bowel cancer awareness month, April 2023. • UHL Bowel Cancer Screening posters are currently displayed on the back of toilet doors in the Highcross Shopping Centre, and the UHL team have been given opportunity to provide public facing engagement via a stand at the Vaccination Store on Friday/Saturdays. The team are intent on factoring this into their future work plan if capacity permits. • This contributes to raising awareness with all people, awareness supports all eligible people to make an informed choice about their individual participation or not. • Creation of LLR ICS Strategy with inclusion of health inequalities throughout the document • Continuing the black breast DNA pilot and implementing the preferred pathway- addressing black patients who DNA. Women from the Black African/Black Caribbean community will be contacted to be advised of the drop-in centres taking place across the city

	• Implementation of a bowel screening tool to increase bowel screening and work closely with GP practices to understand their local health population • Implement the Cancer Champions programme • Launch the cervical cancer text project • Extend the Charnwood screening project • Continue the Colorectal 1-year Survival project • Support UHL Bowel Cancer Screening Programme work in collaboration with Dr. Randev to take forward the video text project work with a Leicester City PCN. • PCN to develop their own short video in most popular patient spoken language, Gujarati, which can be texted to patients reported as non-responders by the Eastern Bowel Hub. • Project will take forward lessons learnt from cervical screening video text project and drive forward the digital plan to engage with patients in an easier way. • Raising awareness in the community for black men in that they are at high risk of prostate cancer and need to come forward for a test • Learning disabilities cervical screening video text project for implementation in the Melton area **Diagnostics** • Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% • Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition • Maximise the pace of roll-out of additional diagnostic capacity, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely implementation of new CDC locations and upgrades to existing CDCs • Deliver a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostic investments and meeting optimal rates for test throughput • Increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24 (NHS England will publish separate guidance to support the increase GP direct access) • Reducing overall waiting list and ensure 85% of patients receive a diagnostic test within 6 weeks by March 24, and 95% by March 25 • Deliver 120% of 19/20 activity to reach NHSE operational guidance targets • The narrative will focus on MRI, CT, NOUS, DEXA, ECHO & Endoscopy • The tests will also increase capacity for cancer and GPDA patients

	• Cancer TAT is currently at 75% request to report within 7 days, Aim by end of FY 23/24 to be 85%. • Support FDS target • Increase utilisation of current capacity • Develop PCN cardiorespiratory diagnostic spokes • Prioritise the high-volume modalities with high % of long waiters • 1st stage – increase productivity through current rooms – (insourcing/room opening hours) • 2nd stage – impact of CDC/LLR Community activity • 3rd stage – modular solutions where required to increase baseline capacity • Ongoing – recruitment for clinical/support staff • Implement clinical decision support tool (iRefer) to increase appropriateness of referrals • Deliver cardiorespiratory diagnostics at a PCN level **Genomics** Leicestershire, Northamptonshire and Rutland (LNR) Genomics medicine service will become a cancer genomic centre of excellence, focusing particularly on: 1. Maintaining and increasing access to genomic services including counselling, risk assessment and testing 2. Ensuring increased access to diagnostic cancer genetic testing 3. Increasing access to somatic (tumour testing) 4. Ensuring enhanced screening is available for individuals at increased risk of cancer particularly those with inherited cancer syndromes This will lead to increased awareness of cancer surveillance and genomics among the general population, as well as appropriate risk stratification of the LLR population and identification of those at increased cancer risk. Appropriate risk stratification will enable targeted surveillance leading to earlier detection of cancer, and increasing the percentage diagnosed at stages 1 and 2, thereby meeting the objective of 75% by 2028.

	Identifying cancer carriers at the point of cancer diagnosis will also enable targeted cancer treatment leading to reduced morbidity and mortality. Benefits include: • Risk reduction leading to less cancer diagnoses • Earlier detection of cancers • Increased cancer cure rate • Decreased morbidity and mortality We will also: Optimise service management and administration support Expand genetic counselling team Combat national geneticist shortage Recruit a clinical psychologist for genomics Develop mainstreaming team of genomic associates for consenting Ensuring the genomics service has adequate management enables appropriate access to funding, administrative support and optimisation of clinical time enabling delivery of objectives. Appropriate management enables the necessary operational support for the development of projects such as the LS hub. Expansion of the genetic counselling team enables the education and support of clinicians leading to mainstreaming. There is a national shortage of geneticists – training numbers are being increased and within LNR job profiles are more adaptable. Developing a team of genomic associates will enable consenting and testing at the point of diagnosis, something which is not currently possible in various specialities due to lack of capacity – this is particularly true in breast cancer. 1. Maintain and increase access to genomic services including counselling, risk assessment and testing a. Develop electronic family history questionnaires increasing patient accessibility to genomics and optimising clinical time

	b. Work with ICBs to develop risk assessment services in secondary care c. PPV work to tackle disparities d. Consider offering BRCA testing to all individuals of Ashkenazi Jewish ancestry due to the significant incidence (1 in 40) 2. Increased access to diagnostic cancer genetic testing a. Educate and support surgical and oncology colleagues to provide mainstreaming – enabling increased access to germline testing 3. Increase access to somatic (tumour testing) leading to optimisation of cancer treatment and identification of inherited cancer carriers a. Support screening all colorectal cancer and endometrial cancers for Lynch syndrome b. Support somatic testing for prostate cancer 4. Ensure screening is available for inherited cancer syndrome carriers a. Maintain cancer carrier registry b. Develop and run LS expert hub c. Provide genetic-expert GP support for cancer syndrome carriers d. Provide LS carriers with a personalised app to help track screening 5. Work with ICBS to develop risk assessment services Agree priorities 6. Continue ongoing work with gynaecology and colorectal teams towards mainstreaming 7. Work with breast teams to enable mainstreaming and BRCA testing 8. Develop Lynch syndrome expert centre to ensure carriers receive appropriate screening 9. Create cancer carriers registry to track all BRCA, Lynch and other cancer syndrome carriers and ensure appropriate screening 10. Work ICBS to ensure colonoscopic surveillance is available to those at increased risk Funding required from ICBS for: • Colonoscopic surveillance – currently very significant waiting lists, no electronic recall and significant risks • Whole Body MRI imaging for Li Fraumeni carriers • Risk assessment services – such as family history clinics to assess risk of breast/colorectal for patients who do not meet criteria for referral to genomics. There are currently no local services for this group of patients Support needed for genomics services to ensure objectives can be delivered.

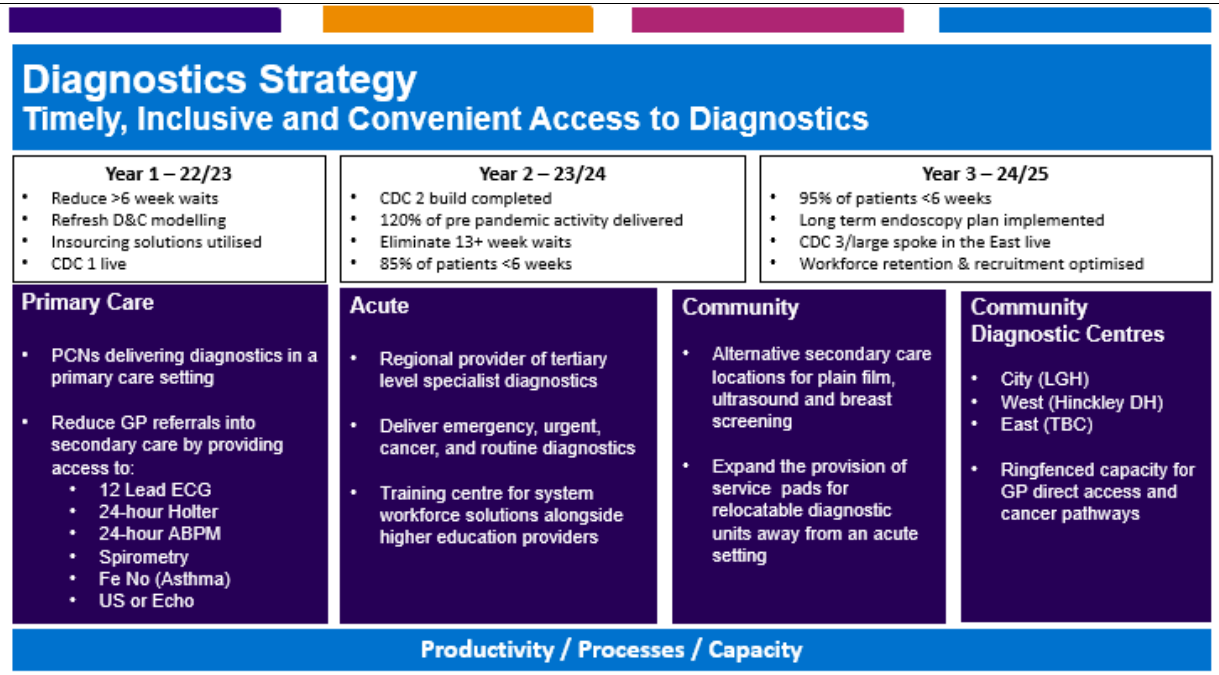
	Actions: 1. The first operational meeting for the LS expert hub will occur Feb 2023 2. From April 2023 virtual MDTs will occur as part of the LS expert hub 3. Phenotips (electronic questionnaire) software continues to be in trials and will be rolled out in 2023. 4. Continue educating clinicians and expand on support provided by genomics service, within colorectal, gynaecology and urology NB BRCA carriers have breast screening through the VHR which needs to continue. At present there is no BRCA carrier clinic which is something that needs to be developed in future In order to deliver service management and genetic counselling support LNR are working with the genomics unit (GU) who are taking over from specialistic commissioning for genomics from April 23. Currently a number of posts within LNR are funded temporarily through the GMSA (Genomic Medicine service alliance) a trust business case is being developed to hopefully provide substantive posts, as well as to develop a team of genomic associates (GA) **Primary Care** • Increasing the use of FIT testing for lower GI pathway referrals. • Screening uptake across the system for bowel, breast and cervical cancers. • Implementation of safety netting within primary care. • Patient education and GP education and general health promotion for primary and secondary care. • To work with public health to ensure integration of Public Health and health promotion and ICB for patients using cancer champions/connectors with targeted health advice • Increase PSA monitoring for black men with a family history • Implement lung health checks and scoping incidental findings within Primary Care. Specifically for actions within primary care.

	• Use the teaching moment potential for learning about cancer screening and symptoms following a two week wait pathway showing that the patient doesn't have cancer. • To understand the causes of exceptionally low 1 year bowel cancer survival in Leicester City • We are working as a task and finish group which meets 6 weekly to ensure there is co-ordination from public health and local authorities, looking at population health management and health inequalities • Lowering the age of symptomatic FIT testing • Employing a project manager for 2 years in the ICB to support increased use of FIT testing with Primary Care. • Video texting targeted population health-based screening projects. • Employing project manager to look at health inequalities within LLR concentrating on uptake of screening • Improve patient safety netting given the increased diagnostic load • Create and promote education events/resources for primary clinicians including GP's ANP's and PA and paramedics (the entire workforce). • Employ a project manager for 2 years to look after lung health project and work across the system. • Create and pilot a resource via video text to be delivered at the end of the two week wait non converter pathway • Auditing bowel cancer emergency presentations and two week wait referrals using the national cancer diagnosis audit tool and sharing outcomes with City PCN's **Risks:** **Health inequalities, prevention, and screening** • System challenges due to COVID19 backlog and thus cancer backlog • Lack of time and resources across the system to focus specifically on health inequalities and new projects • Lack of trust amongst community groups due to general perception of NHS, being let down by previous project work with no outcomes or lack of relationship maintenance, no contact during COVID19 vaccine programme, no incentivisation available

	• Ensuring accessibility needs of the population e.g., language, disability etc are being met • Fear of speaking about cancer amongst community groups and cancer patients • Lack of effective and reliable data • Core 20 Plus 5 delays • No evidence of futureproofing • Cancer data is on a two-year delay, so it may not be possible to establish a trajectory that will identify if we will reach 75% of cancer cases diagnosed by stage 1 or 2 by 2028. **Diagnostics** • Workforce and supporting recruitment • Ongoing revenue support • Timescales on CDC2 **Genomics** • Individuals at increased risk of colorectal cancer cannot access adequate colonoscopic surveillance leading to a significant risk of increased morbidity and mortality due to missed cancer diagnoses • Individuals with Li Fraumeni Syndrome (TP53) in Leicestershire cannot access whole body MRI screening contrary to guidelines. National and International Guidelines - Cancer Genetics Group (ukcgg.org) This leads to a significant risk of increased morbidity and mortality due to missed cancer diagnosis. LLR is an outlier in not providing this screening. • Without mainstreaming there will be a delay in the identification of cancer carriers meaning that cancer treatment will not be optimised. • There is a national shortage of geneticists, and our team is depleted. It is vital that LNR work to expand this team. Without adequate management for the service operational tasks must be conducted by the clinical team meaning there is less time to deliver a clinical service or the above objectives. **Primary Care** • Funding • Workforce • Capacity • Engagement with key groups and patients

	• Appropriately measure the outcomes and how we manage this

Diagnostics	
How will your system increase the percentage of patients that receive a diagnostic test within six weeks (in line with the March 2025 ambition of 95%)?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template' and include specific reference to: the expansion of diagnostic capacity including through the CDCs programme, as well as the work to improve diagnostic productivity through digital investments in pathology and imaging networks and through diagnostic services reaching optimal utilisation rates [1]]* *[1] CT: 3-4 scans per hour, MRI: 2-3 scans per hour [2], NOUS: 3 scans per hour, Echo: 1 scan per 45 mins, including reporting, and Endoscopy: 95 % of planned endoscopy lists taking place. For acute sites with a proven higher than average case mix complexity, the optimal range for MRI is 1-3 scans per hour.* **Vision:** To provide, timely, inclusive, and convenient access to diagnostics utilising capacity from primary care, the acute, community hospitals and Community Diagnostic Centres. **Strategy:** Over the next 3 – 5 years the strategy will deliver a reduction in 6+ and 13+ week waits for a diagnostic test, will build on additional capacity both within UHL and across the community sites and will see a sustainable plan implemented for Endoscopy and other high-volume modalities. Like elective care It is built around improving **Process, Productivity**, building strong **Partnerships** and **Capacity** that represents good value or money.



Objectives:

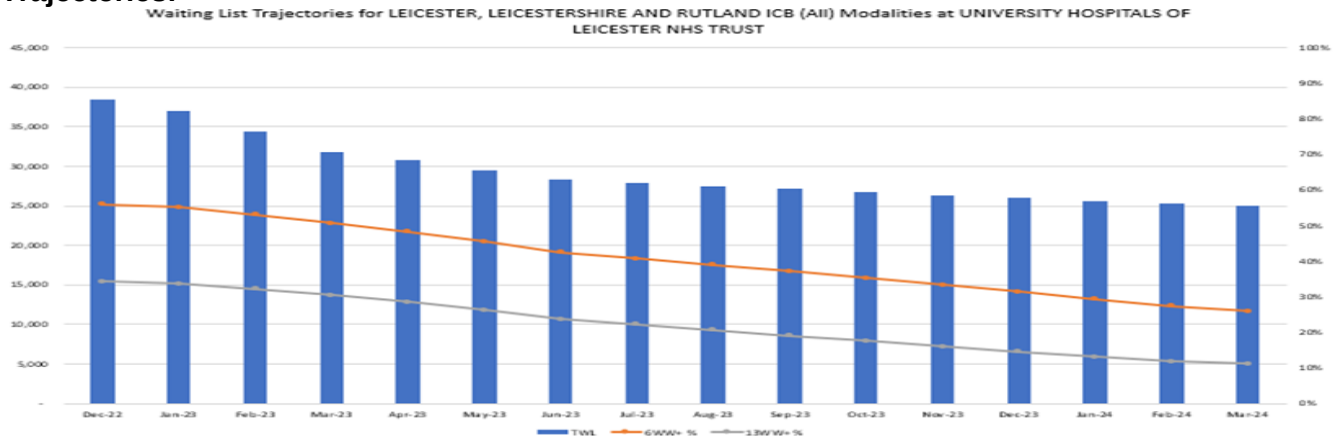
Although it does not explicitly state this in the Operational Planning Guidance, we will use 120% as a benchmark for improvement. In addition, the national ask is:

- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2024 ambition of 85%
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
- Maximise the pace of roll-out of additional diagnostic capacity, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely implementation of new CDC locations and upgrades to existing CDCs
- Deliver a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostic investments and meeting optimal rates for test throughput

- Increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24 (NHS England will publish separate guidance to support the increase GP direct access)

Delivery:
There are currently 43,307 patients waiting for a diagnostic test in LLR, with 55.7% (24,148) of patients waiting over 6 weeks. There are also 13,912 (32.1%) patients who are waiting over 13 weeks for their diagnostic test. Leicester General Hospital (LGH) has one live CDC, which has delivered 24,00 additional tests since April 2023, with activity delivered in MRI, NOUS, DEXA, and CT. LLR ICB also commissions LLR Patient Care Locally (LLR PCL) to deliver NOUS & ECHO activity in the community.

Trajectories:



The draft trajectories have been modelled with the support of EDGE and built on the followings set of assumptions:

- Baseline capacity continues (current volume of activity observed)
- Any known additional capacity coming online – Insourcing, etc
- Demand remains consistent with that observed in 22/23
- Growth of between 0 and 6% depending on the modality
- Targeting of additional capacity on longest waiters first

	The key interventions that will support delivery are:
	• Prioritise the high-volume modalities with high % of long waiters
	• Increase productivity through current rooms – (insourcing/room opening hours)
	• Outsourcing endoscopy booking - 120 patients per month extra being booked
	• Increase the activity with current CDC (LGH) and begin activity from CDC 2 (Hinckley)
	• Begin endoscopy provision within LGH CDC, increasing capacity by 4,000 patients per year
	• Conversion of a relocatable CT to a cardiac enabled modular reducing acute pressures
	• Continue insourcing solutions where required to meet demand
	  ○ We are currently insourcing 375 NOUS scans and 150 ECHO scans per week
	  ○ CT insourcing will begin 13th Feb to support staffing shortages
	• Ongoing recruitment for clinical/support staff
	• Implement clinical decision support tool (i-Refer) to increase appropriateness of referrals
	• Deliver cardiorespiratory diagnostics at a PCN level
	
	The key tasks that will be progressed in the next 12 months include:
	• Contract with insourcing providers on an ongoing basis where required to mitigate workforce risks
	• Increase in community diagnostic provision
	• Outsource booking for endoscopy services
	• Complete capital business case for endoscopy
	• Implement I-refer to support GPDA
	• Improving patient safety by avoiding unnecessary radiation exposure
	• Reduction in the number of targeted inappropriate imaging requests
	• Increasing radiology reporting capacity by streamlining the vetting pathway
	• Providing information to referrers at the point of access to support training and education, and
	• Faster vetting of urgent studies such as 2-week wait referrals, preventing delays in booking; whilst freeing up senior radiographer and radiologist time
	
	With the above interventions LLR are projected to have fewer than 10% 13WW patients and 26%> 6WW by March 2024. This would put the system in a position to achieve the March 2025 target of 95% patients receiving a diagnostic test within 6 weeks. We know the ask will be to deliver zero 13 weeks at a faster pace, it will be delivered in some but not all modalities. Early modelling suggests January 24 for Endoscopy and a residual for NOUS and DEXA (based on current actions) by March 24.

The trajectories broken down by modality in comparison to 19/20 data can be seen in the below table (UHL only). The interventions will result in 111% delivery of 19/20 activity in 23/24.

23/24 as % of 19/20	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	23/24 vs 19/20
Magnetic Resonance Imaging	117%	121%	127%	120%	114%	121%	118%	122%	121%	109%	105%	124%	**118%**
Computed Tomography	118%	110%	117%	109%	115%	116%	110%	111%	117%	107%	119%	135%	**115%**
Non-obstetric ultrasound	122%	110%	120%	102%	106%	103%	95%	102%	110%	94%	107%	129%	**108%**
DEXA Scan	189%	114%	125%	151%	174%	128%	156%	150%	140%	118%	131%	207%	**144%**
Cardiology - echocardiography	85%	75%	87%	75%	85%	79%	75%	89%	98%	88%	83%	115%	**85%**
Endoscopy total	135%	145%	136%	118%	119%	128%	114%	123%	129%	117%	132%	167%	**112%**
Total	**119%**	**111%**	**119%**	**107%**	**111%**	**111%**	**104%**	**110%**	**115%**	**103%**	**110%**	**132%**	**111%**

LLR also commission NOUS & ECHO in the community, below includes the system position vs the 23/24 plan for activity.

Demand for ECHO at UHL over the last 6 months is 1,600 patients, which is lower than the 19/20 demand figure (2,200), hence confidence in delivery of 85%. Activity within the community has increased by 300 patients per month since 19/20 which has supported UHLs waiting list management. UHL are currently insourcing Echo which will deliver an additional 150 scans per week until 31st March, this may be extended if required subject to recruitment.

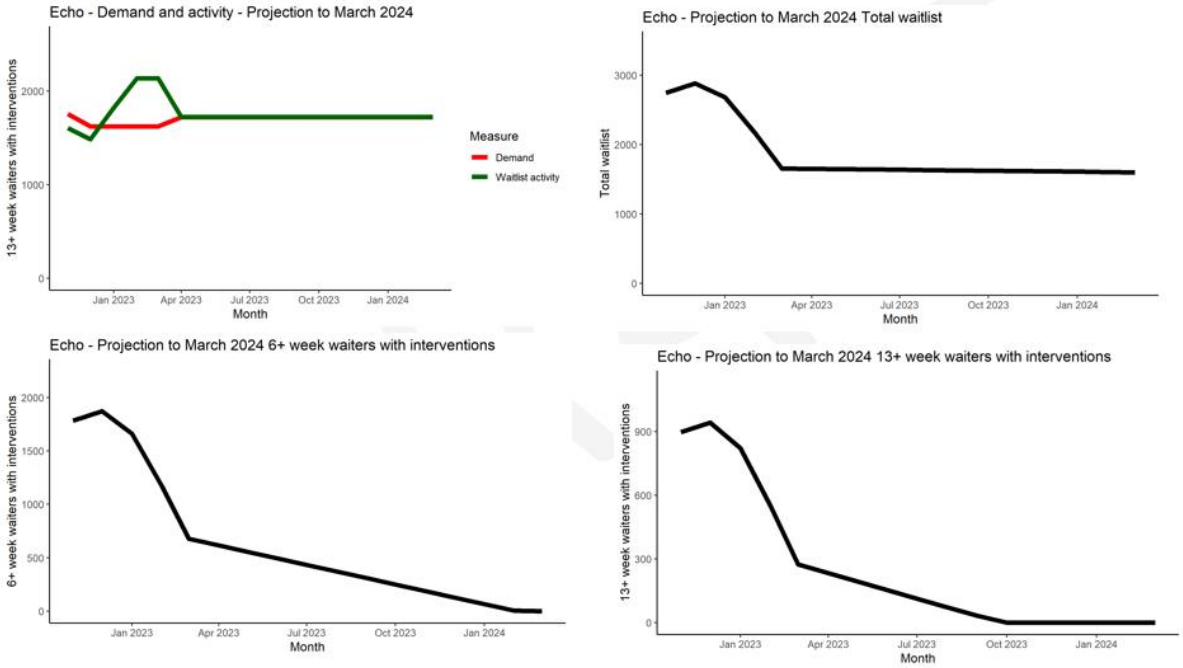
The below graphs highlight the NOUS & ECHO position when including community provision, contracted by Patient Care Locally (PCL).

		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total
Total 19/20	Total NOUS	8448	9299	8608	9290	8835	9039	9998	9267	8578	10056	9056	7522	107996
Total 23/24	Plan	10486	10486	10486	9510	9801	9741	9741	9801	9647	9741	9682	9861	118983
	%	124%	113%	122%	102%	111%	108%	97%	106%	112%	97%	107%	131%	110%

		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total
Total 19/20	Total ECHO	2649	2970	2571	2950	2735	2905	3055	2650	2404	2867	2808	2231	32795
Total 23/24	Plan	2539	2539	2539	2613	2670	2640	2640	2668	2597	2637	2608	2695	31383
	%	96%	85%	99%	89%	98%	91%	86%	101%	108%	92%	93%	121%	96%

The graph below highlights the impact of delivering 95% of system ECHO provision on our waiting lists.

Echo activity and waits: projections to March 2024



Financial Requirements

In 22/23 UHL and the LLR system benefitted from significant capital and revenue support. £5m revenue was received via CDC monies and £3.4m capital via national underspends or cancer related diagnostic funding.

Table 1 below outlines the main priorities for the multi-year strategy and includes capital and revenue into 23/24. This list was submitted as part of a Secretary of State exploratory request to expand additional diagnostic capacity 1st Feb – March 2024. LLR submission 12/01 Capital (£16.7m) and Revenue (£16m). The submission made on 12/01/2023 aligns to CDC requirements and known capacity gaps – including workforce

Two key interventions to further reduce 6+ week waits in diagnostics which are included in the ask are:

- Capital and revenue to support an additional DEXA (current trajectory >65% 6WW March 2024) – this would result in 150 additional DEXA and delivery of standard.

- Endoscopy capital plan approved to develop four additional rooms as evidenced in the demand and capacity model.

Location	Additional Capacity (Modality) FYE	Date from	Date to	Rev Cost 23/24	Capital Cost 23/24
Loughborough Hospital	Additional DEXA - 5,000 Scans	Jun-23	Mar-24	£ 350,000.00	£ 234,000.00
UHL sites	MRI Insourcing - 5,000 Scans	May-23	Mar-24	£ 635,000.00	
UHL sites	CT Insourcing - 8,000 scans	May-23	Mar-24	£ 768,000.00	
UHL sites	NOUS Insourcing - 21,000 scans	Mar-23	Mar-24	£ 735,000.00	
UHL sites	MRI Increase to 12-hour day 7 days a week - 12,000 scans	Aug-23	Ongoing	£ 2,000,000.00	
UHL sites	CT Increase to 12-hour day 7 days a week - 22,000 scans	Aug-23	Ongoing	£ 2,200,000.00	
Glenfield Hospital	Acute CT Scanner - 22,000 scans	Aug-23	Ongoing		£ 2,000,000.00
LGH	5,000 Endoscopy procedures	May-23	May-24	£3,000,000	£100,000
System	I-refer - improve imaging referrals	Jul-23	Ongoing	£ 50,000.00	£ 300,000.00
System	Booking staff	Jun-23	Ongoing	£ 250,000.00	
Leicester General, Loughborough Hospital, Market Harborough	4 Additional endoscopy rooms (Endo Capital Business Case) - 12,000 procedures	Jun-23	01/03/2024 Ongoing service	£ 4,000,000.00	£ 11,140,000.00
System	Additional Endoscopy Equipment - Productivity Increase	Jun-23			£ 1,000,000.00
UHL Sites	Endoscopy Insourcing - 2,500 procedures	Jul-23	Mar-24	£ 1,000,000.00	
System		Jun-23	Ongoing	£ 250,000.00	
Glenfield Hospital	Echo insourcing - 6,000 scans	Mar-23	Mar-24	£ 700,000.00	
Glenfield Hospital	Portable Echo machine to increase inpatient efficiency	May-23	Ongoing		£ 60,000.00
Glenfield Hospital	3 Echo Machines	May-23	Ongoing		£ 180,000.00
Glenfield Hospital	Renovation to build 2nd reporting room	Oct-23	Ongoing		£ 500,000.00
Glenfield Hospital					

Risks and Issues

- Workforce and supporting recruitment
- Large vacancies in clinical and administrative roles. Currently utilising the independent sector to mitigate risks
- Funding for international recruitment and UHL career progression to mitigate elements of workforce risk

	• Ongoing revenue support • Long term funding for the increase of baseline capacity • Timescales on CDC2 - NHS PS project plan completion Q3 24/25 • NOUS – continue to insource • DEXA – additional DEXA required to reduce currently waiting list **Planning Assumptions**: • Diagnostic ERF schemes continue • New Recovery schemes are funded • CDC continue to be operational, and revenue supported • PCL activity baseline adjustment
How will your system deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template' and include specific reference to: improving pathology and imaging networks productivity, including through digital diagnostic investments and optimal rates for test throughput, and the expansion of diagnostic capacity including through the CDCs programme]* More locally the aim is to deliver the required % of 19/20 activity to reach NHSE operational guidance waiting list targets – this may be less than 120% for certain modalities. The focus will be on MRI, CT, NOUS, DEXA, ECHO & Endoscopy as these equate to 90% of the total DM01 waiting list. We will Increase capacity for cancer and GP Direct Access patients and improve our cancer turnaround target from 75% request to report within 7 days to 85% by March 2024. This will support delivery of the faster diagnosis standard in cancer. The aim is to increase utilisation of current capacity through protocol reviews and increasing booking provision and develop PCN cardiorespiratory diagnostic spokes to ensure patients have access to non-invasive diagnostics closer to their home. • Prioritise the high-volume modalities with high % of long waiters • 1st stage – increase productivity through current rooms – (insourcing/room opening hours) • 2nd stage – impact of CDC/LLR Community activity • 3rd stage – modular solutions where required to increase baseline capacity • Ongoing – recruitment for clinical/support staff

	• Implement clinical decision support tool (iRefer) to increase appropriateness of referrals • Deliver cardiorespiratory diagnostics at a PCN level
How will your system increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template', and should refer to draft guidance on direct access which is available on the NHS Futures Collaboration Platform]* GPs in LLR are currently able to refer patients straight to test for several imaging modalities, including ultrasound, X-ray, computerised tomography (CT), and magnetic resonance imaging (MRI). However, variability in testing capacity and primary care knowledge has limited GPs' use of direct referral. LLR is also working to open Community Diagnostic Centres (CDCs) 7 days a week to provide additional capacity to ensure GPs have increased and swifter access to more diagnostic imaging tests. LGH CDC is planned to deliver 58,000 additional tests in 23/24, with Hinckley CDC adding further capacity in 24/25. The increase in the use of direct access tests will be phased. Beginning in early 2023, our focus is on increasing the use of specific direct access tests for adults who have concerning symptoms, but do not meet the threshold for referral under the urgent suspected cancer diagnosis pathway. Currently over 20% of cancer diagnoses are made in people referred for investigation on non-urgent pathways. Our aims in phase one are to reduce: • the time it takes for adults who have concerning symptoms but do not meet the criteria for urgent referral to receive a cancer diagnosis • the number of GP and specialist attendances before investigations are requested for these patients. LLR will leverage NHSE who we have developed a set of data metrics to monitor progress and measure outcomes. Regular Diagnostics Data Hub collections will enable us to monitor rates of GP direct access uptake by the ICB. The second phase begins in Q2 2023 and LLR will work with NHSE to make a wider range of direct access tests available. It is important to note LLR already has the below as GPDA pathways. • X-ray

	• CT chest • CT abdomen and pelvis • Ultrasound abdomen and pelvis • Brain MRI. In line with NHSE guidance, LLR will look to roll out iRefer to support GPDA. iRefer is Clinical decision support systems (CDSS) tool that guides clinicians through the process of referral for medical imaging by assisting with differential diagnoses using the RCR iRefer guidelines. This tool can improve the quality of referrals from a variety of referrers from both primary and secondary care by helping direct clinicians to the most appropriate imaging. This tool can also help reduce inappropriate referrals. iRefer CDSS Fits in with both the NHS Long term plan “Using CDS to help Clinicians supply best practice in managing health and conditions. GIRFT also recommended iRefer in their report:-“We recommend that the iRefer online tool is used more widely to support radiology referrals and that trusts follow the best practice examples we identified to help reduce the volume of investigations of low clinical value they undertake. These approaches should help to reduce the demand for such imaging, freeing up resources for higher-value tasks. In line with NHSE guidance, LLR requires funding in 23/24 to support the rollout of iRefer. The piece of work will be completed in partnership with East Midlands Imaging Network, who have already supported health systems to roll out the technology in both a primary care and acute setting. Please see the key timelines below. • Recruitment of 1WTE Project Manager to support the GPDA pathways April 2023 • Procurement Phase – 1st June 2023 • Deployment Phase 1st July 2023 – January 2024 (6 months)

Productivity and efficiency

Describe the systematic approach you have taken to understand where productivity has been lost across the system due to the pandemic. What are the key areas that have been identified as reducing productivity?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template' and include specific reference to:* • *confirmation of whether the system had undertaken a review of productivity as part of recovery planning. If a productivity review has not been completed, please confirm that this has been scheduled.* • *quantification (where possible) of the key areas that have been identified as reducing productivity in your system.]* The system has an efficiency target over 4% included within their financial plans. All organisations are all taking a PMO approach to support and ensure delivery. **System Approach:** To ensure we can deliver stretching deficit it is proposed at a number of task and finish groups are set up reporting into System Executive and assured by key ICB Committees 1. Improvement across emergency care pathway 2. Management of planned care (PIFU and OP f/ups) 3. Access to Care thresholds 4. Workforce growth constraints 5. ICB internal opportunities (including running costs)

	UHL UHL is planning to boost productivity in order to support delivery of 30% more elective activity by 2024/25 than before the pandemic and meet the 85% theatre utilisation and day case expectations. This piece of work consists of two distinct workstreams; Theatre Utilisation and Outpatient Utilisation. All of the detail behind these workstreams in discussed in the Electives section, but can be summarised below: *Theatre Utilisation* UHL has five projects led by the Medical Director and Deputy COO for Elective Care which will help to optimise Theatre Utilisation and improve efficiency. They are: • Improve overall theatre utilisation to 85% by May 2023 • HVLC targets and Day surgery rates before May 2023 • On the Day Cancellations • Average Case Per List (ACPL) • Pre-operative Assessment (POA) *Outpatient Utilisation* The key projects established both within UHL and adopted across the system will focus on: • Demand and Capacity • Productive clinic templates • Remote consultation • Reducing DNAs • Communication with patients, identifying and working with under-represented communities. **LPT** LPT are developing a plan for 23/24 building on existing work and bringing within a structured framework. The Plan will focus on: • Enhancing Value Group – forum to identify opportunities • Return on investment – increased activity where investment has been made • Unwarranted variation between and within teams • Reviewing face-to-face v virtual contacts to maximise capacity and flow

	• Redesigned multi-disciplinary, multi-organisational neurodevelopmental service to reduce duplication / increase capacity • Continuous skill mix reviews to increase capacity, improve patient experience and address skill shortages. Existing initiatives include ▪ AutoPlanner - minimise travel time to increase capacity per session. ▪ Post-pandemic working practices reviewed - opportunities for safely increasing capacity realised. ▪ Review of estate to maximise available capacity ▪ Self-referral for MSK and community podiatry services - supports efficiency in primary care.
What actions will you take to restore underlying productivity?	*how the system will support a productive workforce including taking advantage of opportunities to deploy staff more flexibly.* Our workforce transformation priorities include the development of an LLR 'One Workforce', which will deliver on several key transformational aims, including integrated workforce planning and transformation, education and training, rotational placements, apprenticeships etc. Aligned to the 'One Workforce' development is our system-wide retention plan, which encompasses health and wellbeing offers, EDI and leadership programmes, talent management, coaching, mentoring and buddying. The LLR Pathway Design Groups/Collaboratives have a clear remit of service redesign/new ways of delivering care, identifying new ways of working, growing new skills/skill mix, utilising new roles. Specific actions to support a productive and flexible workforce are: • Mitigating the risk of not being able to fully recruit by integrating health and care teams at locality level, supporting our ability to reduce multiple visits at organisational level, easing workload across the teams and flexing resource where demand requires it

	• LLR Workforce Sharing Agreement to enable seamless movement of staff across the system • Increased utilisation of the Digital Staff passport • Cross-organisational employment models between providers, including flexible contracts • Rotational roles and placements across all settings • New roles spanning the system, for example Nursing Associates and Physician Associates • We have established the LLR Reserves service and other temporary staffing models, such as staff redeployment and student deployment/placements, that have been deployed during winter pressures, Industrial Action, during surge etc. We are currently scoping other sustainable and affordable temporary/flexible staffing models going forward, as part of the 'One Workforce' development. • Multi-organisational discharge hubs using innovative workforce practices to enable the sharing of staff across organisational boundaries • Virtual Wards – 7 (of 11) new virtual wards, in addition to the existing Covid and COPD wards, have been mobilised, with integrated working across acute, community and social care - patients are reporting benefits, such as a reduced number of 999 callouts and ED attendances • Pathway One Intermediate Care Model pilot, which streamlines hospital discharge to community and social care, through rapid assessment within 48 hours post-discharge, reducing unnecessary physio assessment or care provision, will continue into implementation *How you have assured yourself that expected productivity increases are in line with planned workforce growth?* UHL have created combined workforce models to close critical service gaps e.g. Urgent Treatment Centre external provision supported by UHL employed GPs; use of Vanguard theatres supported by UHL clinicians; use of insourcing theatre teams to enable additional theatre capacity where UHL surgical capacity is available. Capacity is frequently limited by the availability of theatre workforce, utilising a third-party supplier enables surgical activity to continue and will maximise the productivity of surgeons. Subject to the approval of a Full Business Case, 2023 will see the introduction of an East Midlands Elective Care Centre providing a dedicated workforce to deliver high volume, low complexity activity, adopting new ways of working to maximise productivity. Within Cancer services, ongoing clinical reviews of priorities will be carried out, to ensure available resource is utilised appropriately and minimise wastage and downtime. We will continue with utilisation of the Independent Sector, the LLR Alliance and Primary Care for streamlining pathways and shortening

	waiting times, improved utilisation of existing capacity, and exploring opportunities to deliver additional capacity i.e. WLI, weekend and evening work, depending on funding within each tumour site to support. For Diagnostics there is significant capital investment for capacity and therefore associated workforce for endoscopy, ultrasound and cardio technicians. UHL's five-year workforce plan will be based on: 1. Future bed modelling 2. Maximising theatre productivity for low acuity to 3 session days 6 days per week 3. Acuity associated increased staffing for nursing 4. East Midlands Elective Care Centre Staffing (will be a subset of 2 above) 5. Improving outpatient efficiency 6. Emergency flow expansion. The highly successful recruitment of international nurses (1100 since 2017) will continue during 2023/24 and beyond, as well as a continued focus on recruitment to HCA roles, towards a zero-vacancy target.
What key changes will you make to improve operational efficiency within your system?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template' and include specific reference to the efficiency measures within section 1H of the 2023/24 priorities and operational planning guidance as well as other key opportunities across your system.]* Each organisation within the system has a 4-5% efficiency target included within their financial plans. They are all taking a PMO approach to support and ensure delivery. The governance behind this is described in more detail in the panel, below. Design Groups and Collaboratives were asked to submit Business Cases to fund Efficiency and Transformation projects. In total, 161 Business Cases were received by the system to consider for funding. Cost pressure/investments contained within the ICB plan are being cross checked with System Business cases to ensure completeness. The Operational Delivery Group (ODG) has led a review of their areas to identify opportunities to contain the financial pressure, including a review of growth assumptions, funding options and efficiency. Exec-led focussed sessions will be organised to identify cost drivers and further opportunities, while contract envelopes to be reviewed alongside emerging ERF

	guidance. Ultimately, the plan is establish a cohort of projects and programmes which will help to deliver efficiencies, both in-year and across future years. Furthermore, providers are planning to reduce Bank and Agency use and spend. Currently, the priority is to make clinical areas safe by growing the workforce in unsafe areas, so there will be requirement to use Bank sand agency for a period of time, before this can be reduced.
What mechanism has your system put in place to ensure your planned efficiency can be delivered recurrently in full in 2023/24?	*[Please reference the HFMA's self-assessment materials on putting core elements in place to support board assurance over financial sustainability]* The LLR System has a formal governance route in place for the workup, delivery and monitoring of planned efficiencies. All of these elements are key to also providing the necessary assurance on the delivery of the efficiencies. The System PMO team support individual Collaboratives/Design Groups in drawing up ideas and then putting in place plans for the delivery of efficiencies. This is done via centrally held tools and templates coupled with formal and informal meetings with Collaboratives/Design Groups. To ensure a full System lens is applied, the System PMO works in partnership with the PMOs of UHL and LPT. The plans are then formally taken through the monthly and quarterly Transformation Assurance Groups which sees colleagues from across the System monitoring the delivery and providing support and challenge where necessary. The quarterly TAG is led by an Executive panel to provide more scrutiny and support to the plans. Assurance is provided upwards to the ICS Finance Committee and System Executive Committee.

UEC Recovery plan narrative

UEC recovery plan overview	
To deliver the ambitions in the UEC recovery plan systems will need to come together to develop robust implementation and delivery plans. Provide an overview of your initial plans for implementing the UEC recovery plan.	**Vision** The vision for Urgent & Emergency Care (UEC) both within and beyond Leicester, Leicestershire and Rutland (LLR) is to provide, **timely**, high-**quality** care, in the **right place** for our patients and communities. A strategy is in development which over the next 3 – 5 years will see a reduction in ambulance handover delays, more patients being seen and treated in the most appropriate setting for their condition and additional capacity that will meet the needs of the local population. It is built on the delivery of key interventions linked to improving **Process & Productivity**, building strong **Partnerships** and investing in additional **Capacity** that represents good value or money.

Mission

The Operational Planning Guidance, released on 23rd December 2022, outlined three key standards that will improve outcomes and experience. They are:

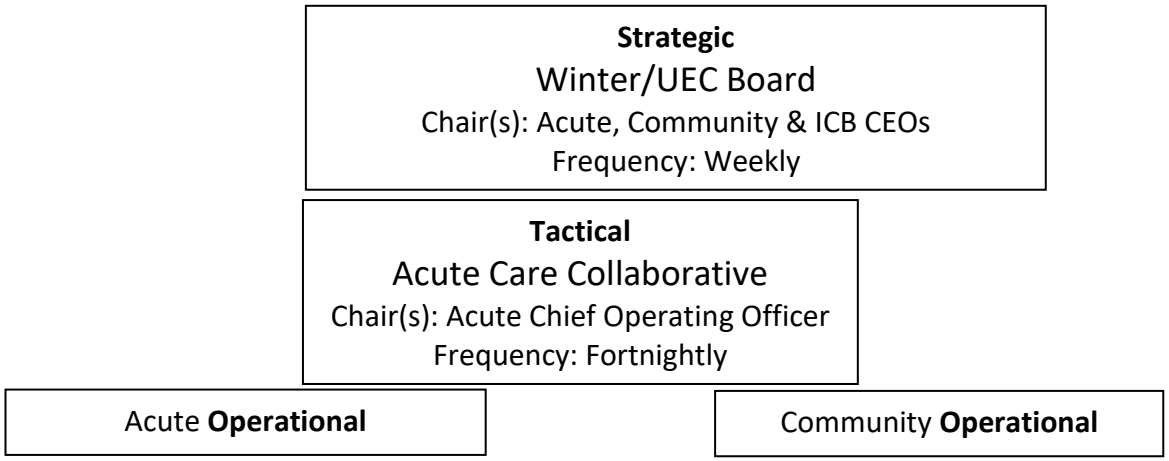
1. 76% of patients in the Emergency Department (ED) seen within 4 hours
2. Improve Category 2 ambulance response times to an average of 30 mins across 2023/24
3. Reduce Adult General & Acute (G&A) bed occupancy to 92% or below

- Additionally, our drive to maintaining improvement in and further reducing ambulance handover delays will continue.

	Delivery In 2022/23 the system has successfully delivered improvements including: • A reduction in lost hours due to delayed ambulance handovers from 4478 hours in December 2022 to 1308 hours in January 2023, through a range of interventions, including the implementation of co-horting facilities outside of ED • Opened an additional 40 beds on acute sites (Ashton & Ward 22) in August & September 2022 • Opened community bed surge capacity • Provided additional capacity for Urgent Treatment Centre (UTC) capacity across the system and on the acute sites • Extended hours of unscheduled care hub to reduce Category 3 & 4 patients waiting for ambulances • Implementation of Rapid Flow and Onboarding processes to balance risk across the acute sites • Created additional capacity in the form of a pre-transit hub on the acute sites to reduce over-crowding in ED (January 2023) Whilst the system remains particularly challenged, the pace at which we have delivered improvement in 22/23 will carry on into 23/24. Our focus in 2023 will be on: - Improving our processes and productivity - Continuing to improve our partnership working, across health and social care - Increasing capacity, that represents value for money and appropriately responds to our demand

Governance

The below structure is a basic overview of the governing structure of Urgent and Emergency Care across LLR.



Objectives

The three key targets set by NHSE are described above. To deliver on these national objectives, the LLR system will focus on key interventions that are linked to **Process & Productivity**, **Partnerships**, and increasing **Capacity** that represents good value for money. This will be delivered through key areas of focus.

Planning Assumptions

This list is not exhaustive and will be amended for the final submission of activity plans. The current assumptions include:

- Growth rates for non-elective care remain consistent with 22/23
- Incidence of Covid-19 and IP requirements remain in place
- Length of Stay (LOS) remains consistent with 22/23
- The delivery of an 85% day case rate in the elective operational plan, and subsequent impact on beds
- The interventions for Winter 23/24 will not impact on elective care recovery

	Risks & Issues The risks and issues remain consistent with those observed in 2022/23, these include: • Access recovery monies (revenue and capital) • Workforce gaps • Industrial action and increased pressure on emergency flow • Increase in covid levels for both patients delaying operating by 6 weeks and impact on sickness levels of staff • National shortage of materials (supplies/products) to increase capacity UHL and LLR are committed to sharing a UEC plan for 2023/24 by the end of March 2023.

Provide an overview of the assumptions that you have made in relation to your workforce plans.	Responses should include specific reference to:
	
	How your workforce plans are aligned to the ambitions outlined in the UEC recovery plan, including occupancy, intermediate care, and an overall increase in capacity across the system.
	
	• **Key priorities are transforming primary and community care pathways, to reduce emergency attendances and hospital admissions, including:**
	  • Training community nurses in urgent and emergency care
	  • Ongoing recruitment of Primary Care ARRS roles, including Paramedics (which may be rotational posts with EMAS)
	  • 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

	• **Virtual Wards** – 7 out of 11 virtual wards have been mobilised (in addition to existing Covid & COPD VWs) - 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; benefits reported by patients include a reduced number of 999 callouts and ED attendances. • **EMAS** – reviewing strategic divisional plans; Paramedics/Trainee Paramedics have consistently grown since March 2022 • **LLR Exemplar Retention Programme** – incorporating Health & Wellbeing Offers, EDI and Leadership programmes, training & development (for example 'Charnwood' MDT training, to enhance the skills and wellbeing of the team, thereby supporting portfolio and career pathways, leading to improved retention of those staff) • **Development of 'One Workforce'** - a sustainable, long-term, system-wide, integrated solution (strategic priority), through partnership working and co-production - based on complete health & care pathways (e.g. Home First, Discharge) • Expanding the **flexible workforce** – new roles/skill-mix, rotations/apprenticeships/placements; LLR Workforce Sharing Agreement; Digital Staff Passport, Temporary staffing, e.g. LLR Reserves, Redeployment etc **UHL** • 5-year workforce plan with a key component of Emergency Flow expansion – for example staffing 4 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 whole 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. Staffing models have been designed for this purpose and included within the revised workforce establishment. In addition staffing models have been included in our establishment which include expansion of the discharge lounge facility, GPAU and EFU which will be phased from August. • The multi-organisational practices of discharge hubs are being enabled by innovative workforce practices to enable the sharing of staff across organisational boundaries.
The UEC recovery plan sets out the ambition to reach a minimum of 76% A&E (all-type) performance against the four-hour standard. **What impact will your plans have on overall time spent in A&E for admitted and non-admitted patients?**	Responses should include specific reference to: • planned improvements in mean time in department for admitted patients and the key actions that will deliver this • planned improvements in mean time in department for non-admitted patients and the key actions that will deliver this **1. <u>Improve processes & productivity</u>** The elimination of conveyance to ED of patients who can be seen in alternative settings, or their own home and reduce EMAS hear and treat activity by 20%, by offering a single integrated access point to direct Health Care Professionals to community response services where clinically appropriate. This will be delivered by: ○ Review current consultant connect and bed bureau offer to develop a single Clinical Bed Bureau ○ Integrate current Clinical Navigation Hub, Pre-Transfer Clinical Discussion & Assessment, Urgent Crisis Response, Unscheduled Care Coordination Hub, Home Visiting and HCP support line into a single point of access Eliminate unwarranted variance in admissions and outlying length of stay through embedding criteria to admit and reside across ED and bed-based areas. Reduce the number of patients discharged after 5pm from acute sites, with focussed interventions on the standardisation and digital enablement of board rounds, the roll out of criteria led discharge and process improvement across multi-disciplinary teams.

	Further develop the System Control Centre within LLR to oversee flow and capacity and support improvement programmes. **2. <u>Admission avoidance</u>** Reduce the number of patients waiting for assessment/treatment in ED through appropriate streaming, to both on and off-site alternatives clinically appropriate to need. This will be delivered by: o Increase capacity for ED to stream patients into including UTC capacity and Community Pharmacy services Support all clinically appropriate patients to access the right care in the right place first through further developing high performing SDEC provision across specialities. This will provide easy to access alternatives to ED/CDU across the acute trust. This will be delivered by: o Support the acute trust to develop robust in reach and streaming processes and practices. o Support the development of SDEC pathways across all specialities which are consistent and meet operating standards and which have good reporting mechanisms. **3. <u>Improve access to out of hospital services</u>** Discharge 85% of pathway 2 and 3 discharges within 48 hours, and 90% of pathway 1 discharges in 24 hours, achieve 65% simple discharge by 5pm and embed SAFER principles through further developing a single integrated discharge team incorporating acute and community health, adult social care, patient transport services and voluntary services. This will be delivered by: o Develop a physical Integrated Discharge Hub which incorporates existing UHL discharge teams, the community discharge hub and patient transport coordination, to reduce complexity of process and enable timely simple and pathway discharges, including the most complex needs within expected timescales. o Right size NEPTS provision (transport) **4. <u>Pathway implementation of virtual care</u>** Embed and expand the current Virtual Ward provision to deliver increased occupancy from current performance of 40%. This will be delivered by both increasing the number of patients stepping up into

	Virtual Ward care and exploring specific interventions with acute services that have a length of stay exceeding the national benchmark and exploration of partnership support to provide a Virtual Ward for frailty patients. **5. <u>Pathway transformation</u>** Reduce the number of patients waiting in ED for more than 12 hours for onward care with robust and consistent speciality in-reach, pre-transfer assessment hub and appropriate use of cohorting, rapid flow and boarding. This will be delivered by: o Expand current discharge lounge provision at LRI site o Develop permanent cohorting facilities at the LRI site of up to 20 spaces **6. <u>Additional capacity in different care settings (acute, UTC & social care)</u>** Right size acute and community bed position to support flow, reduce outlying and elective cancellations. This will be delivered by: o Expand bedded capacity at the Glenfield Hospital by October 2023 o Establish a respiratory support unit at the Glenfield Hospital o Define a sustainable intermediate care model of provision across UHL and LLR Reduce type 3 and 4 attendance at ED by providing easy to access alternatives for patients with lower acuity need. This will be delivered by: o Establish a new UTC in the City by October 2024, with additional UTC capacity in place by winter 2023 o Review and replace our existing UTC/UCC offer into a streamlined pathway which is easy for our people to navigate and access.

Virtual wards

Provide an explanation of your baseline virtual ward capacity plan as of 1 April 2023

The work of our Home First collaborative sets out to develop and improve services that will keep patients managed well in their own home and support earlier discharge.

In 2022/23 we are set out our ambition and plans for virtual wards, building on the successes already in the system.

The ambition from NHSE was for 40-50 VW beds per 100,000 population by December 2023 for LLR this would have been 408-510 VW beds with 80% utilisation by September 2023.

Our original plan was to increase the total number of virtual ward bed numbers to 200 by December 2022, and from this create a manageable trajectory towards achieving between 408-510 VW beds across LLR by December 2023. Due to a number of challenges such as Clinical capacity and inability to recruitment to specific clinical staff, LLR currently have 100 virtual ward beds across COPD, Covid, Asthma, community acquired pneumonia, Ambulatory Jaundice, AF and diabetes. Our current overall utilisation is between 40-50%.

Planned and actual phasing of virtual ward numbers

Original plan 22/23

No of Beds per Ward	July	August	Septembe	October	Novembe	December	January	Feb	March	April	May	June	Jul	Aug	Sept	Oct	Nov	Dec
Frailty				20	25	30	35	40	45	50	60	70	80	90	100	100	100	100
Bronchiectasis				8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
Community Acquired Pneumonia				40	40	50	60	60	60	60	60	60	60	60	60	60	60	60
Asthma				40	40	40	40	40	40	40	40	40	40	40	40	40	40	40
COPD	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33
COVID	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33
Diabetes	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14
Cardiology STEMI				8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
Surgery – Elective Colorectal Resection				16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
Palliative Care				10	10	10	10	10	10	15	15	20	20	20	20	20	20	20
Ambulatory Jaundice				10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Cardiology Atrial Fibrillation	10	15	20	25	30	35	40	45	50	50	50	50	50	50	50	50	50	50
HF	5	5	10	10	10	30	30	30	30	30	30	30	30	30	30	30	30	30
Haematology				10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Total No of Virtual Ward beds	**95**	**100**	**110**	**277**	**287**	**327**	**347**	**357**	**367**	**377**	**387**	**402**	**412**	**422**	**432**	**432**	**432**	**432**

Revised plan for 23/24

No of VW Beds per Ward Revised	Meds	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Frailty	UHL/LPT										10	10	15	15	20	20	20	20	20
Bronchiectasis	UHL							8	8	8	8	8	8	8	8	8	8	8	8
Community Acquired Pneumonia	UHL					15	15	15	20	25	30	35	40	45	50	55	60	60	60
Asthma	UHL					5	10	10	15	20	25	30	35	40	40	40	40	40	40
COPD	N/A	40	40	40	40	40	40	40	40	40	40	40	40	40	40	40	40	40	40
COVID	N/A	20	20	20	20	20	5	5	5	5	5	5	5	5	5	5	5	5	5
Diabetes	N/A	7	7	7	7	10	10	15	20	25	30	30	30	30	30	30	30	30	30
Surgery – Elective Colorectal Resection	UHL							5	5	10	16	16	16	16	16	16	16	16	16
Palliative Care	UHL/LPT							5	10	10	15	15	20	20	20	20	20	20	20
Ambulatory Jaundice	UHL							10	10	10	10	10	10	10	10	10	10	10	10
Cardiology Atrial Fibrillation	N/A	5	5	5	5	15	15	20	20	25	25	25	25	25	25	25	25	25	25
HF	Uhl								5	5	10	15	20	20	25	25	30	30	30
Haematology	UHL							10	10	10	10	10	10	10	10	10	10	10	10
Total No of Virtual Ward beds		72	72	72	72	105	95	143	168	193	234	249	274	284	299	304	314	314	314

The LLR Virtual Ward Programme continues to be recognised as an enabler to support additional acute bed capacity, however utilisation in certain Virtual Wards has seen a slower uptake than initially anticipated. The following has been recognised as challenges and indicates plans to address:

Challenges	**Plans to address- 23/24**
Current virtual wards are too specific (both in condition of the patient and the clinical team oversight)	Review VW SoPs for those VWs where utilisation has not increased to support clinical needs. Review and adapt current workforce to ensure roles can meet the skills required to manage clinical needs. Scope a “generalised medical” VW, enabling the ability to be flexible in its delivery model

	Patients declining to go on to a Virtual Ward pathway (when identified as appropriate) due to lack of confidence with technology	Demonstration of equipment at ward level, as part of discharge planning. Review the type of equipment available which includes the use of wearable devices.
	Original focus being to step patients down	Where appropriate, mobilise step up pathway for current VWs from primary care, EMAS, community planned/unplanned services.
	Lack of awareness and confidence across clinical teams	Share case studies including positive outcomes. Provide in-reach into the acute to on-board appropriate patients. Promote and raise awareness with ward level staff including senior clinicians.

In 2023/24 our priorities are to:

- Complete a systematic review by pathway of the number of beds required and the benefits being achieved/to be achieved
- Support the VW programme by a centralised hub (reducing multiple access routes) to monitor and support patients to capture deterioration and offer treatment at its earliest point
- Streamline access to support reduced inflow (step up avoidance of admission)

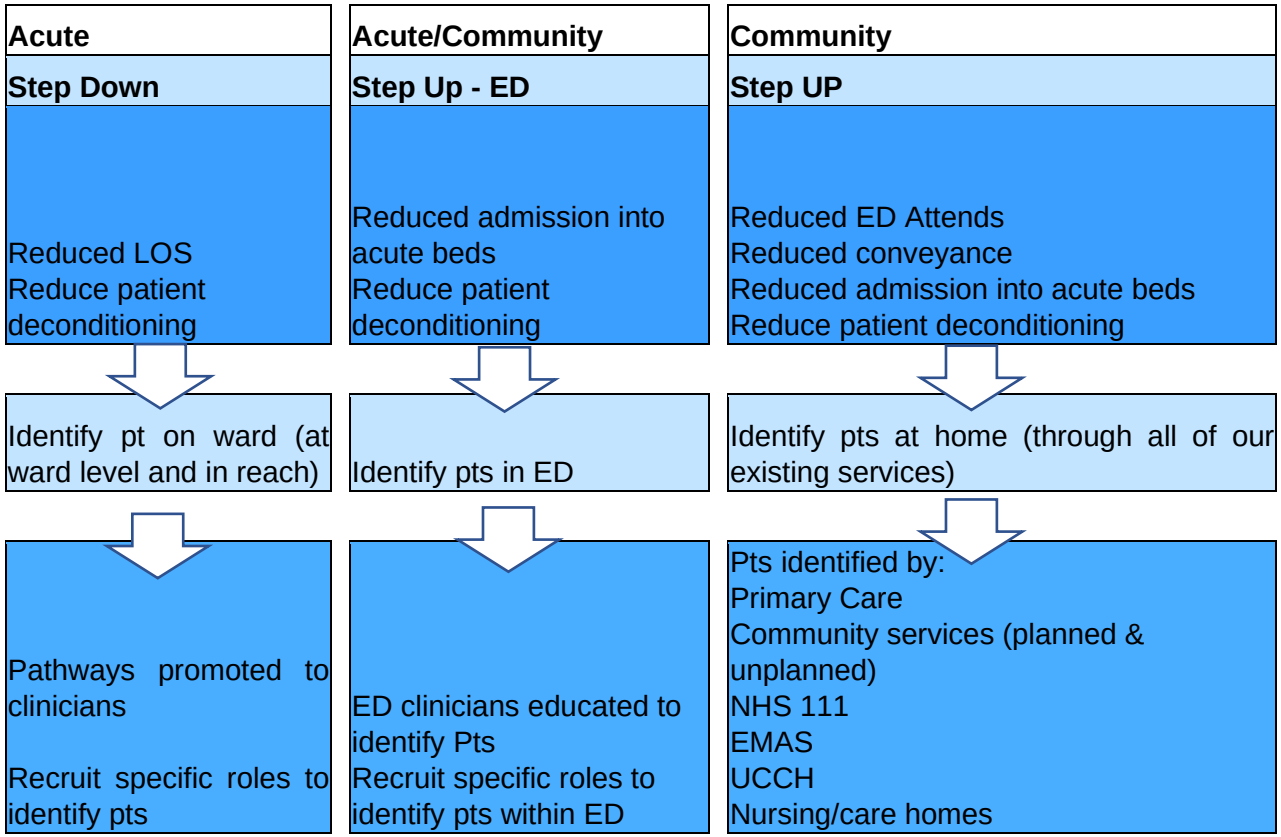
In doing so, we will make the following improvements:

- Manage more 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 as expected from NHSE • Upstream benefits to elective care and LTC patients • Our plans are to 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 • UCR + model • Tech Enhanced Living Service (e.g., in nursing/care homes)
Provide an explanation of how virtual wards will develop to avoid admission to hospital.	Responses should include specific reference to: • Assumptions related to the daily number of over-night admissions avoided over and above your 2022/23 position. • Assumptions related to specific points of referral expected to increase to meet this ambition e.g., increase referrals from care homes. • Assumptions made regarding case mix, pathways and conditions and how including these in virtual ward pathways will support plans to deliver admission avoidance.

- Provide detail of how these plans link back to the overall planning submission – specifically workforce plans.

Virtual Wards – patient cohort streams



	Supported by generic (non-disease specific) virtual wards • Generic Medical Ward • Generic Surgical Ward To further enhance this model through an enhanced level of medical oversight and remote monitoring to develop a Home First plus model which will enable more patients to be discharged early into the service. To take this work forward we will: • Use a PDSA approach towards rapidly stepping up the Home First model to respond to current demands and test the concepts of Home First+ and UCR+ by: • Consultant/ medical input (through our existing PTCDA – Pre-Transfer Care Discussion Assessment service which offers consultant input to community practitioners) • Clinical audits to identify cohort of patients currently admitted to hospital and what needs could be met in a virtual ward model. • Exploring remote monitoring provision, where applicable, to support better patient outcome and efficiencies • Testing use of some current remote monitoring tools within the system to determine impact they could have in this model To deliver the required medical oversight for our Home First+ frailty virtual ward model in addition to scoping use of acute geriatrician and consultant outreach support, we are also scoping a range of other options including use of PCN employed paramedics, ANP outreach from community hospitals.

Provide an explanation of how virtual wards will develop to support timely discharge from hospital.	Responses should include specific reference to: • Assumptions related to the daily number of patients supported to leave hospital in a timely way over and above your 2022/23 position. • Assumptions related to specific points of referral expected to increase to meet this ambition e.g., increase referrals for certain specialties or hospitals. • Provide detail of how these plans link back to the overall planning submission – specifically workforce plans. In 2023/24 our priorities are to: • Complete a systematic review by pathway of the number of beds required and the benefits being achieved/to be achieved • Support the VW programme by a centralised hub (reducing multiple access routes) to monitor and support patients to capture deterioration and offer treatment at its earliest point • Streamline access to support reduced inflow (step up avoidance of admission) In doing so, we will make the following improvements: • Manage more 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 as expected from NHSE

	• Upstream benefits to elective care and LTC patients • Our plans are to 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 • UCR + model • Tech Enhanced Living Service (e.g., in nursing/care homes) *Workforce*: 7 out of 11 virtual wards have been mobilised (in addition to existing Covid & COPD VWs) - 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; benefits reported by patients include a reduced number of 999 callouts and ED attendances
Provide an explanation of how virtual wards will reach 80% utilisation at a minimum by the end of September 2023	Plan for delivering 80% utilisation of virtual ward capacity. If 80% will not be met provide the utilisation expected by the end of September 2023. Currently the VW programme is achieving between 40-50% occupancy. Completion of a systematic review has enabled us to implement a plan that looks to achieve 80% occupancy by September 2023. The following will support the delivery: A centralised hub to monitor and support patients to capture deterioration and offer treatment at its earliest point. Streamlined access to support reduced inflow (step up avoidance of admission)

	• Expansion of VW pathway criteria to include step up component (Primary Care, UCR, EMAS) will help reduce unplanned admissions by detecting and dealing with deterioration early in disease trajectory. • VW in reach into acute wards and ED- Reduce length of stay on planned acute admissions, increasing throughput through both virtual and physical virtual wards. • Introduce technology for those patients that are at risk of readmission- proactively monitoring for early decline and onboarding to VW as and when appropriate. If aiming to exceed 80%, provide an outline of the ambition and month expected to achieve. Our aim to meet the 80% occupancy by September 2023, the monitoring of the programme will review where we may be able to exceed this however our focus is to increase our occupancy by each month to meet the target set. Assumptions made regarding case mix and the extent to which capacity will be scaled for frailty, acute respiratory infection, and other key pathways Each pathway has reviewed their current offer including the standard operating procedure. For those pathways that have already mobilised, criteria has been reviewed and tweaked to be more inclusive of the patient cohort to meet the clinical need. For our key index wards, in reach support will be mobilised into the acute to help increase awareness and confidence around the programme. Plans in place to scale capacity in these wards as soon as referrals increase, workforce plans support the delivery of this. Approach to ensuring standardised virtual wards offer across the ICS for all patients and plans to tackle unwarranted variation Our offer continues to be a consistent LLR offer for all patients. The bi-weekly monitoring of the programme enables regular review of each pathway to ensure this is standardised. Each pathway will continue to seek patient experience and look at where there may be a gap/s in meeting patient needs. This will be further supported by an independent evaluation which will support the improvement of our access, delivery and impact.

Expand new services out of hospital and avoid admission to hospital

How will your system improve quality and consistency of Urgent Community Response services, including consistently meeting or exceeding the 70% 2-hour urgent community response standard, maintaining full geographic coverage 8am-8pm 7 days a week, and maximising referrals from 111 and 999?	Responses should include specific reference to: • How systems will maintain full geographic coverage at a minimum of 8am-8pm 7 days a week, extending beyond these core hours as demand necessitates, and continue to cover all 9 clinical conditions or needs, including level 2 falls, in line with the national 2-hour guidance • How systems will increase the number of 2-hour UCR referrals from all key routes (including primary care and care homes) with a particular focus on 111 and 999/ambulance services, Technology Enabled Care (TEC) / pendant alarms companies and self-referrals • Plans to improve data quality and completeness of the monthly data submission to the community services dataset (CSDS) • Assumptions related to the daily number of over-night admissions that you expect to be avoided over and above your 2022/23 position. The Home First offer provides a 2-hour urgent community response (meeting the 9 clinical conditions) to support patients who would otherwise be admitted to hospital, mobilising a health and social care response in the patient's own home and supporting their needs until the patient can be stepped down to other services. Home First also provides integrated rehabilitation and reablement within 2 days of referral, with a focus on increasing peoples functioning to regain independence. The Home First offer is available 7 days 7am-10pm, with continued crisis response provision (nursing and social care) out of hours. Home First offers a no wrong door approach and responds to anyone it can requiring care to avoid avoidable admissions or facilitate discharge. Supported by an MDT approach the Home First offer maximises best use of the most appropriate responder from across the agencies. Recognising LLR had several access points which made it challenging for EMAS colleagues in determining who they needed to call when an urgent response was needed. EMAS refer and treat performance was low, often because there was limited awareness around the full extent of our community offer. Our unscheduled care coordination hub (UCCH- Creating a single point of contact) was mobilised which is represented by all services (Nursing, therapy, mental health,

paramedic, and social care), as an MDT with live visibility of the EMAS stack. The mobilisation of this has enabled the following:

- UCCH has supported 3,214 clinical conversations from April to December 22, 3149 (98%) of EMAS activity has been diverted from the EMAS stack
- Potentially 1189 ED avoidances over this period
- Early analysis of patient outcomes (when reviewed where they are 72 hours and 30 days after UCCH interventions have shown that 2732 (85%) patients have remained at home either with or without on-going community support.
- Significant impact on EMAS's ability to respond to Cat 1 & 2 calls (in LLR) within the performance standards.

Engaged with private pendent alarm providers, having recognised their default position was often 999 when residents activated their technology. The actions taken:

- By June 22- scoped of all current pendant alarm providers identifying their current response mechanisms and determining where default response plans were to call EMAS
- Identified top 3 with default to 999 for initial phase
- From August 2022- Onboarded 3 additional pendant alarm providers with direct access to UCR provision for response
- By November 2022- Tested and evaluated activity impact of additional pendant alarm provider referrals into UCR to roll out to additional pendant alarm providers

Having successfully implementing a direct pathway into UCR services for three of these organisations, we have demonstrated the following:

- Reduction of calls to EMAS and a 5% increase of pendent alarm referrals into UCR
- increased awareness of the UCR offer and enabling community services to implement planned and unplanned support for these residents at the earliest opportunity
- 10% reduction in falls

- Improved outcomes for patients, enabling ED avoidance and patients remaining in their normal place of residence

Since September 2022 we have been achieving 92.8% for our 2-hour response and 78.7% for our 2 day (on our local reporting dashboard). Prior to this our performance was showing below 70% therefore demonstrating significant improvements to meet our UCR target.

Some of the actions we have taken include:

- Enhanced internal systems and implemented training for all staff, thus improving data recording and quality. Leicestershire partnership trust have worked closely with the national team to ensure SystmOne functionality works to accurately capture 2 hour and 2-day response and are now fully reporting to CSDS
- Mapped our demand and capacity to ensure we have the adequate resources within teams with the right skill set, knowledge, and experience to deliver UCR
- In April 2022 we implemented a single point of contact (phase 1- with visibility to the EMAS stack). In November 2022 we extended this to community services, ensuring referrers had one single number to make referrals into UCR
- Made the offer as inclusive as possible, promoting a “no wrong door” approach and enabled self-referrals where appropriate
- Extended our County and Rutland falls response service to March 2023
- Increased access within 111, 999 and self-referrals

Although we recognise the improvements that have been made in exceeding the UCR target moving into 2022/23 we will work on sustaining our current 2 hour and 2 day response by working with each provider (at the earliest opportunity) to identify where challenges (seasonal variation, workforce etc) may occur, monitoring monthly reporting and addressing issues before they have an impact on the overall delivery.

Workforce

LLR has ensured increased workforce capacity in line with activity increases and support skill and competency development in line with the 9 clinical conditions. LLR continues to invest in this delivery model growing the community workforce to ensure increasing numbers of patients can receive these care responses as quickly as possible to support more delivery of care closer to home. During 2022/23 we have continued to build on previous investments to further grow our community nursing and therapy workforce including the Home First UCR model. This recurrent investment of £3.1M has increased the community workforce by 99wte nursing and therapy staff and further to this we have invested in a 24wte increase in crisis response workers in Leicestershire County Council through BCF.

Our LLR Home First workforce plan is key to enabling ongoing sustainable delivery of our Home First offer including UCR and rehabilitation and reablement. The plan gives an overview of our current workforce across health and social care delivering the Home First offer, addresses sustainability and sufficiency to meet local population health demand and outlines workforce development plans. Building on functional mapping we have specifically looked at opportunities for health and social care staff to take on parts of one another's roles to further support capacity, efficiency, and job satisfaction.

<u>Equipment</u>

As part of our home first approach more and more people with more complex needs are being cared for at home. Within the UCR model the provision of community equipment is essential to support many people to stay at home. The Integrated Community Equipment loan service (ICELS) is demand driven, and the overall contract has seen an increase of £700K on previous years with an outturn of £6m. This contract is funded jointly by health and social care and covers equipment across a wide range adults and children's services, but growth in Home First approaches is a key contributor to the growth in demand.

	Quick access to appropriate equipment is an essential part of the UCR model in managing more people in this way, and therefore further growth in workforce has been matched with appropriate growth in equipment resources. The ICELS recall and triage team are also essential to ensure return of equipment, reducing demand on clinical teams to chase and ensuring equipment is available for those patients that require it. In 2022/23 there has been investment in workforce within the equipment and therapy service to deliver training, increase equipment provision and triage to staff in provider services and in the domiciliary market to address the following: • Implemented four workshops to increase awareness around equipment provision, training on new equipment and how implementation of various pieces of equipment can support care providers to reduce the number of staff required when delivering care • Use appropriate equipment and improving manual handling techniques to support providers to support patient level care in a responsive manner • Reduce the number of care staff (1+) required to provide care- embedded a “single handed care” ethos • Provided essential pieces of equipment to fifteen care providers and reduced deterioration in functioning abilities In 2022/23 we have continued to review UCR in terms of its criteria, accessibility and feedback received from professionals, patients, informal carers and the public. Monitoring UCR activity, broken down at each provider level to show the demographics it is serving has enabled the ability to address and put in plans for any health inequalities as they occur. Actions include but not limited to:

	• Worked with VCSE organisations such as reaching people, Age UK, Citizen's Advice, community faith groups and VISTA to deliver literacy programmes, language support (written and verbal), benefit maximisation amongst traditionally excluded groups. • Held webinars in areas where information may not be easily accessible to promote awareness of UCR services that can support populations when needed • Increased our technology offer to include non-mean tested standalone equipment to ensure UCR is part of the response plan when support is required in a crisis Our plan in 2023/24 is to continue to work with the LLR Prevention and health inequalities reduction board to support action at place, including: • Co- production- engaging with our local communities when 1. Considering changes to pathways, 2. Seeking views where there is unwarranted variation, 3. Designing or enhancing offers of care delivery and 4. Evaluation • Implement independent evaluation teams to explore feedback from those using UCR to enable continuous improvements for those requiring a 2 hour and 2-day response • Data driven- analysis of activity including source of referrals and outcomes achieved once a care episode has ended to make improvements where needed By continuing to work on existing plans, expending where required and sustaining our delivery model, in 2023/24 we will: • Work with NHS Digital and the national team to support CSDS reporting from all three local authorities across LLR and our out of hours provider (currently only LPT are fully reporting)- by December 2023 • Work with an additional nine pendent alarm providers, ensuring an equable and consistent approach across LLR- By August 2023 • Implement a tier 1 (supported by community first responders) and tier 2 approach (clinical response), ensuring the continuation of our 8-8, 7 day falls response service, covering the full geographical area (currently in place until March 2023)

	• Provide essential pieces of equipment and delivery workshops to a further sixty care providers- By September 2023 • Develop joint health and care roles- this will support “making every contact count”, reduce duplication in home visits and increase our ability to share our workforce across health and care, supporting our UCR demand. In addition, Clinical apprenticeship roles in therapy are being developed for unqualified staff – mapped to TI3 role and to be able to work across health and social care in the City and possibly County. Degree Apprenticeships for TI4s to train to be OT or PTs are in place and expanding • Development of a system wide learning and development offer to complement organisational L&D efforts strengthening the potential and capacity of the existing LLR Workforce comprising of both universal training open to all health and social care staff with a key focus upon sustainability, cultural integration, digital upskilling and health and wellbeing in addition to topic specific clinical awareness training • Further exploration of Home First Multi-Professional Teams/ co-location/ collaborative working to ensure consistent working practices and to promote better integration of the LLR workforce as well as care pathway delivery improvements • Co-design of a responsive system wide Home first career pathway encouraging more effective integration and sharing of future workforce capacity by collectively developing the pipeline through championing of new roles and shared training & development. We have already during covid demonstrated effectiveness in doing this- In 22/23 we mobilised City social care UCR capacity to support into county where there have been significant workforce gaps • Further increase our 2 hour and 2-day workforce by an additional 120 wte roles to support our UCR step up/down model- By June 2023 • Embed a culture of “Think Tech First” by using health and Care Technology and improving its overall offer to the people of LLR • Increase 25% of referrals by September 2023 from 111, 999, Primary care and self-referrals- accessible already, but it is recognised that the awareness of UCR services and how to access within 111, primary care, self-referrals and 999 is still not consistent across LLR

	• Alignment with our pre-transfer and clinical decisions and assessment service which offers consultant geriatrician assessment of patients that would otherwise be conveyed to hospital and referral into our UCR services where appropriate- by October 2023
How will your system scale up falls and frailty services based on our learning from this winter, and ensure they are joined up with other services, including ambulances, UCR services and social care?	Responses should include specific reference to: • How systems will increase the number of self-referrals into falls response and falls prevention services in line with the Operational Planning Guidance ask, and ensure these services are joined up with other services and providers to allow for direct and/or onward referral? • The current coverage of EHCH and Proactive Care within their footprint, and plans to continue to expand these ways of working to ensure people both currently experiencing and/or who are at risk of falling / living with frailty receive proactive community-based care • Assumptions related to the daily number of over-night admissions that you expect to be avoided over and above your 2022/23 position. **Intermediate care** Vision: NHSE's vision is that by December 2025 all people in an acute or community hospital, who need further support to recover, will have access to high quality therapeutic community recovery services in an appropriate setting within 1 day of no longer requiring acute or community hospital care. People should be able to access the right level of high-quality service provision they need in a timely manner.

	LLR are working with the NHSE Intermediate Care Program team to develop a National Framework for Intermediate Care Services across England. Our ambition is to build on our current successes to be national leaders in this area. Mission: We currently benchmark as the second highest ICS nationally for reablement outcomes with 90% of people accessing reablement services still at home 91 days after discharge. We benchmark third highest in the Country for pathway 1 social care delays, and 88% of patients return to their usual place of residence following a short in-patient stay in our bed-based Intermediate Care service. We are consistently achieving the national Urgent Crisis Response standards and are working to develop this further to support the model for our step-up Virtual Ward model for people living with frailty. We are proud of the strong interprofessional relationships between health and care partners in our system, and our ambition for the next 18-24 months is to have fully implemented a non-selective home-based Intermediate Care model across LLR. Objectives: • to further reduce the number of patients discharged into short-term residential care (Pathway 2) by 20% over the next 12 months. • to increase the number of patients discharged home (Pathway 1 and 0) by 20% over the next 12 months. • to achieve no more than 50 patients, requiring discharge pathways 1, 2 and 3, still in UHL who no longer meet the criteria to reside. Strategies: Through continuing to strengthen relationships, and jointly investing in integrated service provision with providers and commissioners across the health and care system, we aim to improve outcomes and

	independence for the population of LLR through the joint commissioning of a comprehensive Intermediate Care model. The focus of intermediate care across LLR over the last 24 months has been on supporting people requiring discharge from hospital, however we intend to redress this balance by developing services that prevent admission and support people to live well at home for longer. We are further developing pathways for primary care to directly access community hospital and home-based intermediate care to prevent unnecessary admissions to hospital. <u>Tactics:</u> Since the pandemic, and the subsequent revision of the national discharge guidance in March 2022, we have substantially increased the size and function of the LLR discharge hub which has helped streamline pathways and get more people Home First. All investment into the hub so far has been non-recurrent, therefore, a key priority to ensure the sustained improvement of discharge performance is to secure recurrent investment. Many of LLR's Home First services are funded through Better Care Funds administered at each of the three Health and Wellbeing Boards. To ensure cohesion and equity of access across LLR, a system review of ICB investment into the three BCFs is planned over the next 18-24 months. **Action 1**: review ICB investment in the 3 LLR BCFs to enable recurrent commissioning of the LLR discharge hub by April 2025 Whilst LLR benchmarks well nationally for reablement outcomes, it is currently unclear how many people have access to therapy at home, that is, we cannot say accurately how many people currently access fully integrated home-based Intermediate Care. We are currently piloting a home-based IC model in Charnwood, Loughborough, which will be formally evaluated in March 2023. On successful evaluation, it is the intention to roll out the model, in a phased way, across LLR. **Action 2a:** Evaluate the Charnwood home-based Intermediate Care pilot in March 2023. **Action 2b:** On successful evaluation of the pilot, roll out the home-based Intermediate Care model across LLR by April 2025

	Issues and Risks: Inability to secure non-recurrently funding for the discharge hub risks failure to sustain improvement in reduction of LOS for patients requiring health and care supported discharge packages (Pathway 1, 2 and 3) Uncertain costs associated with home-based Intermediate Care model until the evaluation is complete in March 2023; this may impact on ability to implement across LLR. **Enhanced care in care homes** **What has been delivered to date** • 100% PCN alignment of care homes • 100% (self-reported) delivery of EHCH PCN DES in majority of PCNs • Remote monitoring pilot in Rutland (WHZAN) to help support earlier signs of deterioration in patients through clinical observations. • Focus working group with LLR's top 16 care homes with the highest number of conveyances to ED and regular uses of 999 implemented to 1. Identify current working practice, gaps in training and process used to support patients when support is required and 2. Implement tailored plans to support care homes to reduce 999 call outs and potential ED conveyances • 80% of our Restore Mini training (physical deterioration and escalation tool) has been rolled out within care home market • Identification and robust action plan to address variation across place and PCNs when looking at the support being delivered to care homes • Mapped and scoped the requirements for digitisation Our plan in 2023/24 is to continue to work with the PCNs and Care homes to support plans and actions agreed, including:

	• Implement regular review and evaluation to monitor if the steps introduced have helped reduce 999 call outs and supported for patients to receive the care they require in their care setting. Thus, enabling continuous improvements for those care homes requiring a response from alternative care pathways • Data driven- analysis of activity including which alternative care pathways have been used and outcomes achieved once a care episode has ended to make improvements where needed • Increase the number of care plans being completed and to ensure the quality of these care plans enable the right interventions to take place for patients By continuing to work on existing plans, expending where required and sustaining our delivery model, in 2023/24 we will: • Identify how we can measure whether the MDTs taking place supporting patients in the manner required- By May 2023 • Work with an additional nine pendent alarm providers, ensuring an equable and consistent approach across LLR- By August 2023 • Reduce variation across the care homes to ensure ENCH is being delivered as required- July 2023 • Evaluation of the Whzan pilot to determine if the intended impact has been achieved. Consider further roll out into remaining care homes if benefits demonstrated- By June 2023 • Enable all care homes to refer directly into the virtual ward pathways as an alternative to ED admission- By August 2023 • Delivery of a falls campaign. Including training to support patients who are at risk of falls or have fallen and ensuring the LLR falls service is utilised, resulting in a reduction of falls related calls to 999. By August 2023 • Digitisation -IT infrastructure to support the ability to access care records in a timely manner, also supporting care home staff to seek support from primary care. By November 2023

	Keeping people well: Managing Long Term Conditions, Multimorbidity and Frailty Much of the difference in life expectancy and healthy life expectancy, both between communities within LLR (due to health inequity) and when we compare LLR to other places and regions, occurs because of the prevalence, growth, and impact of long term conditions, multimorbidity and frailty. **Population Health Management approach** Our approach to keeping people well focuses on using a Population Health Management approach (see 3.2) to **case-find and diagnose people with a long-term condition early**, optimise their care to delay further deterioration or development of further disease and ensure that they are supported in the right place with the right care in a crisis. **Effectively managing multimorbidity and frailty** We know from our local insights that, once a person develops more than a single long-term condition, the care they receive can become fragmented as different specialist care professionals look after different diseases. People have told us that they want to be looked after by the same health and care professionals, with continuity where possible. We will deliver a **structured and holistic care plan for people with multimorbidity and/or frailty,** covering a range of interventions, provided in a local care setting, where possible, with the person's named GP supported by a care coordination function. This will be a pre-cursor to the launch of the **proactive care approach** through primary care networks in the next few years. The proactive care approach will include, for example, structured medication reviews, care planning, assessment for wider needs such as assistive technology, support for remote monitoring, personalised care packages and a crisis plan, and will integrate the proactive and reactive offers of support across health, care and wider community services. Whilst people will be identified through the risk stratification process, the person's GP will retain clinical judgement about inclusion in this cohort. This service will be available for any person with five or more long term conditions or those with a clinical frailty score of 7. This system has been in use across parts of LLR since 2015 and our local evaluation has shown a significant increase in patient reported outcomes such as feeling in control of their long-term condition, as well as lower emergency admissions for the cohort.

More recently, primary care networks have been resourced to provide support to this cohort of patients in a comparable manner. Wrapping this up into one framework will support our providers to deliver care and our patients to understand what support is available to them in a holistic manner.

This focus on structured, check-listed care is not new; simply a way to support our patients to access preventative care earlier and to ensure that they, and their support network, know what to do when a crisis occurs.

Summary of key interventions
The table below, summarises the key interventions we intend to make, over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex X to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan

Intervention	Timeline
1 Drive up primary care identification of diseases to expected prevalence levels	Year 1 & 2
2 Improve disease management in Primary care	Year 1 & 2
3 Expand self-management and self-care programmes	Year 1 & 2
4 Implement an anticipatory care framework	Year 1 to 5
5 Reduce the prevalence of an initial LTC leading to multimorbidity	Year 3 to 5
6 Reduce the prevalence of LTCs	Year 3 to 5

Implementing Proactive Care @ Home
The COVID-19 pandemic has displaced much routine primary care. There is a risk that disruption of proactive care for people living with long-term conditions, such as Type 2 Diabetes, hypertension, CVD, COPD and asthma, results in exacerbation and complications in these conditions. This could add further demand for unscheduled care in primary care, emergency, and hospital admissions.

	We are supporting Primary Care teams across the LLR system and providing proactive care frameworks for the management of long-term conditions, based on new pathway development, virtual consultations, digital solutions, and optimal use of the wider Primary Care team. The frameworks, developed by University College London Partners (UCLP), are a tool to help restore routine care, post Covid-19, by prioritising patients at highest risk of deterioration, with pathways that mobilise the wider workforce and digital/tech, to optimise remote care and self-care, while reducing GP workload. The frameworks focus on how to do things differently at scale: they enable practices to prioritise clinical activity by stratifying patients who are at highest risk; they deploy the wider workforce to reduce the workload for GPs; and they improve the personalised care offer for patients. The 6 frameworks include atrial fibrillation, high blood pressure, high cholesterol, type 2 diabetes, asthma, and COPD. 1. Comprehensive search tools to risk stratify patients – built for EMIS and SystmOne. 2. Pathways that prioritise patients for follow up, support remote delivery of care, and identify what elements of long-term condition care can be delivered by staff such as Health Care Assistants and link workers. 3. Scripts and protocols to guide Health Care Assistants and others in their consultations. 4. Training for staff to deliver education, self-management support and brief interventions. Training includes health coaching and motivational interviewing. 5. Digital and other resources that support remote management and self-management. LLR was one of four National NHSX pilot sites for Proactive Care @ Home and we will use the learning from the pilot phase as we support primary care with recovery and restoration which includes identification and support for practices who show the greatest build-up of unmanaged LTC patients through inequalities in QOF, which has been exacerbated due to COVID; engaging with all our GP practices; using the frameworks to transform how LTCs are managed in primary care and ensure our patients stay at home, with a well-managed condition for as long as possible. The core principles of the frameworks and our programme are: 1. Virtual by default 2. Mobilising and supporting the wider workforce (including pharmacists, HCAs, other non-clinical staff) 3. Step change in support for self-management 4. Digital innovation, including apps for self-management and technology for remote monitoring

	Expected benefits *1 From Reactive to Proactive Patient Care* The approach demands a shift in our ability to deliver care from reactive to proactive care, which helps us to get closer to our patients and work together with them more effectively to plan and give them better health outcomes. Proactive care aims to keep patients at home and avoid stepping up to acute or emergency services. *2 Reduction in GP workload* By optimal use of the wider Primary Care team, e.g., Healthcare Assistants, nursing associates and Pharmacists, we can release GP time for complex care in a time of unprecedented demand. *3 Patient Choice and Satisfaction* Keeping patients out of the hospital by caring for them in new ways is central to how the health and social care system wants to work going forward and is what patients consistently say they want. Nationally, patients receiving proactive care describe high satisfaction levels with the approach: comments such as 'we are very grateful for all the support we've had' are common.
Provide details of other plans: - **to expand services out of hospital** - **to avoid admission to hospital, attendance at A&E** - **to support patients to leave hospital in a timely way** - **other improvement programmes related to admission avoidance and reducing length or stay that are not covered by other narrative questions.**	Responses should include specific reference to: • Plans and assumptions associated with supporting high intensity users of urgent and emergency care services. • Assumptions related to admission avoidance capacity funded from 2022/23 winter capacity funding - monitored by the BAF to date - and the extent to which this has been maintained in to 2023/24. Where the baseline plan has not maintained capacity, please provide scheme specific detail. • Assumptions related to the daily number of over-night admissions or, daily number of patients supported to leave hospital in a timely way, that you expect to be avoided over and above your 2022/23 position. Much work is taking place to avoid admission to hospitals and to expand out-of-hospital and Community services. Some of this work has been described in the Virtual Wards and Home First sections of the narrative. However, there is more that can be done, albeit reliant on funding. To this end, LLR ICS was asked to submit a list of schemes of projects that, if funded, would generate additional capacity within the system. While a list of pre-dominantly new schemes was submitted, some existing schemes were submitted. The rationale for this is that these schemes significant and

	demonstrable benefits, but were funded only on a non-recurrent basis. Without recurrent funding, these schemes will be unable to continue and to deliver these benefits, if left unfunded. Below is an outline of the schemes that have been proposed as part of the Additional Capacity Investment submission on Friday 17th February. To compliment this work, significant work is planned and has been delivered in Primary Care.

ɜme type	Provide a brief narrative of the scheme, and how it will support the ambitions of the UEC recovery plan.	Is this a new scheme or is this increasing capacity within an existing scheme/service?	What are the workforce requirements to deliver the scheme? How will they be met?	What are the estates implications of the scheme?
Beds - G&A	Modular additional ward pending new build	New	Recruitment - substantive based on Clinical model	Modular build
Urgent Treatment Centre	Building reconfiguration to provide single 24/7 City UTC	New	Recruitment - substantive based on Clinical model	Building reconfiguration at LGH
Beds - G&A	2 x 28 bed wards on Glenfield site to be developed 23/24 for opening 24/25	new	Increased staffing - revenue costs	New build
Beds - G&A	2 x 28 bed wards on Glenfield site to be developed 23/24 for opening 24/25	new	Increased staffing - revenue costs	New build
Beds - intermediate care	52 additional CoHo beds to deliver Intermediate care though refurb and utilisation of uncommissioned space	Re commission mothballed space	Recruitment - substantive based on Clinical model	Refurb
Improving patient flow	Additional step down capacity to improve flow within the urgent care system and release capacity within G&A beds	Re commission mothballed space	Increased staffing - revenue costs	Refurb
Beds - other	Stroke Rehab beds moving to Community from UHL to provide 28 additional beds in the system	New	Recruitment - substantive based on Clinical model	Modular build and planning permission
Admission avoidance - other	Pre Transfer Clinical Assessment Decision service to avoid conveyance of complex patients from care homes/own home, utilising alternative community pathways	Previous PDSA not recurrently funded	Geriatrician/GP time - already sourced	N/A
Reducing length of stay	Respiratory Support Unit	New	Recruitment - substantive based on Clinical model	N/A
Admission avoidance - other	Neighbourhood UTC/UCC/MIU appointments to support primary care plus and avoid low acuity attendance at ED	New	Recruitment - substantive based on Clinical model	N/A
Improving patient flow	Additional ambulance LRI and GH	New	Recruitment - substantive based on Clinical model	N/A
Improving patient flow	Ambulance Handover aligning demand and capacity	New	Recruitment - substantive based on Clinical model	N/A
Admission avoidance - other	Expansion of Clinical Bed Bureau	New	Recruitment - substantive based on Clinical model	N/A
Beds - intermediate care	Ashton Care Home - to May 23	New	Staffing based on Clinical model	N/A
Beds - intermediate care	Care Home Capacity beyond May 23	New	Recruitment - substantive based on Clinical model	N/A
Improving patient flow	Discharge Support and Lounge	New	Recruitment - substantive based on Clinical model	N/A
Improving patient flow	Enhanced rehab and reablement	New	Recruitment - substantive based on Clinical model	N/A
Improving patient flow	MIaMI	New	Recruitment - substantive based on Clinical model	N/A
Improving patient flow	POD - Cohorting Units	New	Recruitment - substantive based on Clinical model	N/A
Improving patient flow	Elite BUS / Staff for Cohort unit for 12 weeks	New	Staffing based on Clinical model	N/A
Improving patient flow	Pre Transfer Unit	New	Recruitment - substantive based on Clinical model	N/A
Improving patient flow	Modular unit discharge hubs	New	Recruitment - substantive based on Clinical model	N/A
Other	Staff safety - external units security	New	Staffing based on Clinical model	N/A
Beds - G&A	Paediatric winter capacity	New	Staffing based on Clinical model	N/A
Virtual wards - admission avoidance	Integrated frailty pathway for multi-morbid and frail patients - a GP-led MDT within ED to support facilitated discharge home with support via 2 hour UCR rather than an acute bed based service	New	GP, ANP and social care led service, supplied by local PCN's, supporting workforce development and long term sustainable learning	None

	Primary Care The last three years have seen unprecedented demand on health and social care services. Primary Care amongst others have had to make significant changes to the way they deliver services to adapt and respond to the COVID-19 pandemic. As we recover from this, we are now faced with several different challenges which includes increase in the demand for primary medical care. Despite the challenges in LLR our General Practice in their Primary Care Networks (PCNs) were pivotal to the successful delivery of the mass COVID Vaccination Programme working in partnership with public health, local authority, community pharmacy, local NHS Providers and volunteers. Primary Care colleagues supported changes in a way in which it delivered services to ensure essential services were delivered in the height of the pandemic. For LLR ICB, the Primary Care Plan for 2022/23 focussed on the following 5 key priorities: • **Access:** tackling the variation in number of appointments delivered, type of appointments available and how people can access their practice including opening times and online access • **Workforce:** understanding the scale of the challenge in terms of GP workforce and how we maximise the use of the wider clinical roles available through PCNs • **Delivering on key Long-Term Conditions (LTC) indicators and reducing the prevalence gap –** closing the gap on long term detection and optimisation in primary care • **Primary Care Network Development –** developing our PCNs so that they become an effective way of delivering an integrated approach to managing the health of our population at a local level • **Quality –** reducing variation in quality of care provided and experience for our patients. Improving the resilience and sustainability of our practices. Seeing an overall improvement in patient experience. • During 2022/23, LLR ICB successes include (but not limited to): • 165% growth in CPCS referrals in December 2022 from previous month • As of November 2022, LLR ICB Practices delivered 4% more appointments above trajectory equating to 187K more appointments • 65% practices delivering at 2019/20 levels or above • 100% of PCNs are delivering Enhanced Access as of 1 October 2022

	• 33% growth in Clinical Pharmacist ARRS role between April 2022 and November 2022 • 82% of LLR Practices are utilising CPCS • Developing a framework to support commissioning services above core GMS contract in Primary Care LLR ICB Primary Care Transformation Board 2023/24 operational priorities, will continue to focus on expanding capacity to improve access and optimise local health outcomes, addressing health inequalities and embedding the General Practice Access Recovery Plan which is yet to follow. We will continue to use a QI-based approach to improving outcomes for our patients, working across health and social care to co-produce the plan, identifying and agreeing our strategic deliverables. This will be governed by a well-established Primary Care Transformation Board which will develop into a Primary Care Collaborative during 2023/24, bringing together key stakeholders to jointly lead the transformation of Primary Care in LLR. We will ensure that plans are clinically led and developed with strong engagement from colleagues and key stakeholders across the ICS. Our approach to communication and engagement is set out in in this document and will encompass: • Clinical leads across System, Place, Neighbourhood and PCNs • Executive team and cross-directorate key partners • LMC colleagues • Local Authority partners through the Place-based delivery groups Following the release of the Fuller Stocktake report in May 2022, LLR ICBs priority in 2023/24 will be to build on and strengthen the Integrated Neighbourhood Teams to deliver the key domains identified within the report and the next steps for integrating primary care and developing the overall primary care strategy. Our approach will be detailed in Implementation of Fuller Stocktake Report section. The strategic priorities for LLR ICB still remain as those within the 2022/23 plan, however the workstreams have been redefined in line with achievements this year, national and local influence, and new areas of opportunity. The following areas will be of focus in 2023/2024: • **Primary Care Access & Variation** • **Resilience and Sustainability** • **PCN Development**

	• **Implementation of Fuller Stocktake Report** • **Workforce / Leadership** • **Communication and Engagement** LLR ICB are committed to delivering the best health and care services for the population and like many areas are facing a number of challenges within Primary Care. However, we endeavour to continue to integrate and transform services, taking the positive learnings from the pandemic aligned with national and local intelligence. LLR ICB strategic priorities for Primary Care aim to deliver the following **key trajectories:** • 100% of practices deliver above 2019/20 appointment levels across general practice • Increase the number of GP appointments by 1.6% in 2023/24 based on current registered population • A minimum of 50% of practices deliver 70% face to face appointments resulting in • All practices are delivering minimum of 75/1000 clinical appointments • 60% of practices are delivering a minimum of 48% same day appointments as per England average, reducing the need for urgent and emergency care • 100% of LLR practices are utilising CPCS by March 2024 • Increase referrals by a minimum of 20% based on Nov 2022 position to achieve at least 60% of IIF target (+8k referrals in 2023/24) • Increase usage of CPCS from NHS 111 by 10% (baseline tbc) • Maximise the additional ARRS funding allocation in 2023/24 (additional £6mil) • 100% participation and delivery of Enhanced Access by PCNs • Every PCN will submit a plan on delivery of IIF and which areas they will invest in to improve outcomes. • Develop a five-year strategy to integrate primary care and deliver models of care as per the Fuller Stocktake report • Increase in LD and SMI Health Checks in Primary Care • Continue to detect, diagnose, and manage key Long-Term Conditions (LTC) to improve QOF delivery and close the gap on LTC prevalence (more detail within LTC section)

	Creating capacity to meet demand • In 2022/23, a local target was recommended and agreed through the Access Working Group that all GP practices deliver a minimum of 75 clinical contacts per thousand population for GP and 'GP equivalent' consultations. As of November 2022, 100% practices are delivering this minimum standard (based on a crude benchmark exercise). This will continue to be monitored but overlayed with usage of urgent and emergency services and delivery of PCN DES and OQF to quantify improved patient outcomes. • In 2023/24, a key action will be to audit multiple practices (single site, multi-site, partnerships etc) to firstly understand the current demand in general practice which includes number of calls, walk-ins and processes in place to manage this demand. Currently this data is not captured causing a hinderance in truly understanding on the day demand. This data will be analysed to determine which 'models' work most effectively in 'stack management' by maximising all pathways 'outside' general practice such as CPCS, utilising the ARRS roles effectively and in turn GPs and practice/specialist nurses can manage/proactively manage most complex, multi-morbid patients reducing the need for urgent and emergency care. This information will enable the ICB to work with practices to 'test' different delivery models taking into account population needs and practice structures to inform future design and support better management of existing capacity. This will also enable practices to deliver adequate routine and same day appointments based on need. This will be form part of the LLR Five Year Forward Plan. • Continue to increase usage of CPCS to support demand management in general practice and wider services such as NHS111 and urgent and emergency care/treatment centres (UEC/UTC). LLR have seen a reduction in referrals to the service in 2022/23 and this due to a variety of reasons which include workforce challenges in community pharmacy and the referral pathway, however following the funding allocation for the PharmaOutcomes software licenses this year, we anticipate that referrals will increase and LLR aim to become one of the highest users of the service again in the region. Referral pathways from local urgent care services are in development and will contribute to the referral targets. A working group has been established with all key stakeholders to manage this workstream and collaboratively mitigate and risks and issues that arise as well as support providers in utilising the service. • Maximising the use of NHS App to book appointments and prescription ordering, online consultations, and electronic repeat dispensing.

	• Self-Care –continue to invest in communication and engagement with patients and public on increasing confidence to managing their health and using other services such as pharmacist for minor ailments. Specific events facilitated to support seasonal issues such as Flu, Vaccinations, managing common ailments in children etc. • Active Signposting, including consideration of "talk before you walk" models to support appropriate service use across the week, particularly on Sundays where the service offer will change from 1st October 2022. This is being linked into the enhanced access work. <u>Digital First – Key Actions</u> • **GP Connect**: All GP practices provide a minimum of 1 appointment per 3,000 population for NHS111 to directly access. 100% engagement was achieved by March 2022, and the PCTB Dashboard reporting will ensure that this is maintained. • **Variety of online consultation platforms ("OCVC") which will support enhanced access**: All GP practices offering a variety of virtual, face to face, telephone or video consultations according to patient preference and the nature of the presenting clinical condition. • **Digital Access**: This is a key area of focus, and learnings from the recent patient survey has shown that it an important factor is the patient population profile across LLR. We will work closely with our engagement and communications colleagues to ensure that our digital access points are fit for purpose for the patients it serves. We will look at national data and insights to identify areas whereby practices may require additional support to become more digitally enabled for their patients. We will also consider the patient needs across areas of LLR, noting the population in Leicester is young, ethnically diverse and deprived in parts, with Leicestershire and Rutland hosting a predominantly ageing population. Understanding these barriers is key to developing a digitally enabled primary care across LLR. It is key that digital enablement is implemented alongside strong patient engagement and education. When considering digital access, it is important to note the wider picture of access within primary care, understanding where digital access is both appropriate and of need, enabling savings and benefits to both patients and practices.

	• **Online appointment booking**: All GP practices offering access to online appointment booking via the NHS App and / or local electronic clinical system equivalents as per the Enhanced Access DES requirements • **Online prescription ordering**: All GP practices offering access to online prescription ordering via the NHS App and / or local electronic clinical system equivalents. • **Electronic Repeat Dispensing (ERD"):** We will work with Medicines Optimisation colleagues to increase the number of patients eligible for ERD, thereby reducing the number of telephone calls made monthly to request medications. • **Cloud-Based Telephony**: We will continue our collaboration with IM&T colleagues to support the roll out and maximising the use of cloud-based telephony. We will be working with PCNs and practices to start to review their models of delivery based on the implementation of cloud-based telephony. <u>Consistency of the General Practice offer and parity of access.</u> • As per the network contract DES, LLR ICB successfully mobilised Enhanced Access delivery across all PCNs from 1 October 2022. This will continue to be monitored through the contract in 2023/24. • Primary Care Future Funding Model – the implementation of the levelling up funding formula from 1st July 2021 has ensured that those practices received funding based on their populations and where there are gaps received increased investment. The harmonisation of service provision from April 2022 onward has removed disparity of service provision across LLR and disparity of payments for additional services. It is anticipated that this will reduce the need for patients to access higher acuity services for lower acuity clinical conditions. In 2023/24 we will commence the work to map outcomes to service delivery so that we can ensure that what we have what we have implemented has created parity and is supporting delivery of key outcomes relating to improvements in disease prevalence, QOF, and improvements in care planning. To support commissioning of additional services in General Practice, a commissioning framework has been developed to ensure a consistent approach is undertaken for a new service/pathway and that it is accessible and equitable across for the population of LLR. In April 2023.

Planning assumptions (linked to the numerical 'Demand, capacity and flow' numerical submission)

Provide an explanation of assumptions made in relation to unmitigated occupancy across elective and non-elective G&A beds.

The main assumptions behind this are:

- To achieve 92% occupancy, UHL has a gap of circa 350 beds (unmitigated)
- 92% occupancy modelled at midday, rather than midnight
- Schemes that require recurrent funding in to 23/24 take it to 248
- Assumes escalation areas are not used for bedded capacity
- Uses 22/23 YTD actual LOS (excluding 0 Day)
- That the trajectory for growth in Virtual Ward beds holds true

Provide an explanation of your opening G&A bed capacity position for 2023/24.

The table below describes the bed deficit (unmitigated), the capacity opened across the system in LLR (102 beds) and planned mitigating actions for UHL bed capacity in 23/24.

Scheme	Number
Bed Gap	**-350**
Recurrently fund capacity opened in 22/23 (LLR)	102
Productivity (LOS, D/C, etc. Virtual Ward)	35
Glenfield Modular ward	26
Glenfield Two Wards	56
Service moves to facilitate increase in medical beds	24

Provide an explanation of the G&A occupancy level that the ICS needs to maintain to achieve a minimum of 76% A&E performance against the four-hour standard (all-types).	• To achieve 92% occupancy, UHL has a gap of circa 350 beds (unmitigated) • 92% occupancy modelled at midday, rather than midnight
Provide an explanation of planning assumptions made regarding intermediate care (step down) capacity and use of the Adult Social Care Fund and Better Care Fund	Since the pandemic, and the subsequent revision of the national discharge guidance in March 2022, we have substantially increased the size and function of the LLR discharge hub which has helped streamline pathways and get more people Home First. All investment into the hub so far has been non-recurrent, therefore, a key priority to ensure the sustained improvement of discharge performance is to secure recurrent investment. Many of LLR's Home First services are funded through Better Care Funds administered at each of the three Health and Wellbeing Boards. To ensure cohesion and equity of access across LLR, a system review of ICB investment into the three BCFs is planned over the next 18-24 months. **Action 1**: review ICB investment in the 3 LLR BCFs to enable recurrent commissioning of the LLR discharge hub by April 2025 Whilst LLR benchmarks well nationally for reablement outcomes, it is currently unclear how many people have access to therapy at home, that is, we cannot say accurately how many people currently access fully integrated home-based Intermediate Care. We are currently piloting a home-based IC model in Charnwood, Loughborough, which will be formally evaluated in March 2023. On successful evaluation, it is the intention to roll out the model, in a phased way, across LLR. **Action 2a:** Evaluate the Charnwood home-based Intermediate Care pilot in March 2023. **Action 2b:** On successful evaluation of the pilot, roll out the home-based Intermediate Care model across LLR by April 2025 **Issues and Risks:** Inability to secure non-recurrently funding for the discharge hub risks failure to sustain improvement in reduction of LOS for patients requiring health and care supported discharge packages (Pathway 1, 2 and 3)

	Uncertain costs associated with home-based Intermediate Care model until the evaluation is complete in March 2023; this may impact on ability to implement across LLR.