Leicester, Leicestershire
and Rutland

Planning for a resilient winter across the LLR health and care system

October 2024

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A proud partner in the:

Leicester, Leicestershire
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Health and Wellbeing Partnership

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Introduction

This plan introduces the approach adopted by the Leicester, Leicestershire and Rutland Integrated Care System (LLR ICS) to plan for resilience across our health and care services through winter 2024/25. This plan is set in the context of what is predicted to be a difficult winter; all health and care services are expecting the negative impact of the cost-of-living crisis, national GP collective action and sustained surges in demand to impact on the resilience of services and therefore the patient and staff experience of receiving and delivering care across Leicester, Leicestershire and Rutland.

The LLR ICS has continued to work together to plan for this winter, using intelligence from patient and staff feedback, our own data modelling and that of public health, and best practice from other areas to implement as efficient and effective a system across health and care as possible within this context.

Objectives

The primary objective of the LLR Integrated Care System is to work in partnership to ensure people receive the right level of care in the right location this winter, enabling an improved quality of experience & outcomes and improved flow across departments, organisations, sectors and the LLR system.

The national requirements for a safe winter require every Integrated Care System to focus on two key areas:

1. Supporting people to stay well
2. Maintaining patient safety and experience

The LLR ICS will seek to meet these national objectives through delivery of this plan and the priority actions detailed within it. However, the risk to both the financial plan and delivery of a safe winter remains the highest risk for every organisation across health and care across the ICS.

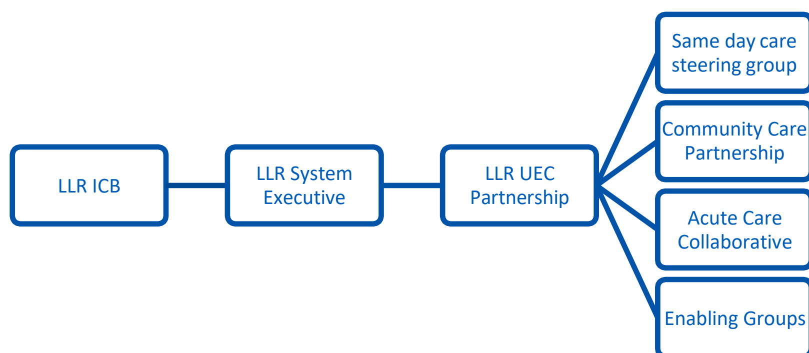
Delivery of these will ensure performance is as per trajectories for the six metrics outlined in the national UEC recovery plan:

- Reducing ambulance handover delays
- Reducing admitted and non-admitted time in EDs, with an intention of reducing long waits, particularly for mental health patients
- Maintaining average G&A core capacity across the year at the level achieved in the last quarter of 2023/24
- Improving length of stay for all admitted patients (specifically emergency admissions with a length of stay of 1+ day)
- Reducing average delays post discharge ready date
- Improving length of stay in NHS commissioned community beds

Delivery against these will also support the elective delivery plan for LLR, covering both elective care and urgent cancer care.

Governance & leadership

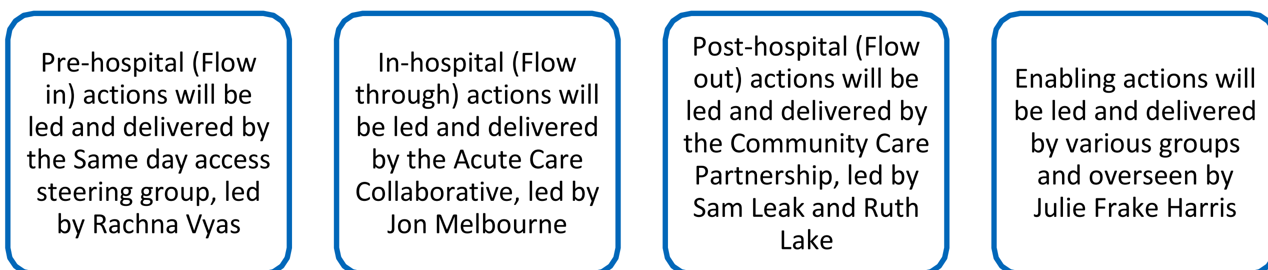
Effective leadership, agility of action and robust governance processes are essential components of this plan. This plan will be led by the UEC Partnership, under the leadership of Richard Mitchell, Chief Executive of Leicester Hospitals and will report on a monthly basis into the Leicester, Leicestershire & Rutland Integrated Care Board through the System Executive.



This plan will be managed by the LLR UEC System Lead in partnership with the leadership team for UEC.

A LLR UEC Clinical Director has been appointed and they will work alongside system partners to ensure clinical expertise is at the forefront of this plan.

The plan itself is set out in four areas, covering pre-hospital services, in-hospital services, post-hospital services and enabling services.



Each group will report in the LLR UEC Delivery Group on a weekly basis, reporting on both actions taken to deliver 'inputs' and against the impact against the outcome originally modelled in the Winter Plan. This will enable the leadership team to assess and augment plans in an agile manner and will also consider the impact of as yet unknown scenarios such as GP collective action.

Operating model for the Winter

The leads for each action will meet weekly with the LLR UEC System Director on **Tuesdays** to confirm and challenge progress and agree reporting / any escalations to the UEC SRO group every **Friday**. The Clinical Executive will meet as planned monthly but will stand up additional meetings as needed to ensure decisions made through the LLR UEC Partnership are clinically safe and within appropriate governance.

A short set of papers will be circulated every Tuesday, comprising of the following:

1. Key intelligence from national and regional departments
2. Performance against metrics
3. Escalations / actions required from partners to improve performance / achieve objectives of the key actions
4. Support required from the LLR Clinical Executive

The full metrics / performance pack will be circulated as an appendix, for information only and a project management function will be in place via the system PMO.

Our approach to the Winter Plan

Our approach to winter planning this year has been data driven, using both historic and more recent trends to understand and model predicted demand through last winter. Whilst this happens annually at UHL, over the last few years we have taken the opportunity to demand model both LPT and social care to understand any clear capacity gaps and therefore align actions to mitigate against these. The process undertaken is outlined below.

1. Understand the whole-system **demand model and capacity needed** for ‘safe winter’, modelled on southern hemisphere flu experience and local pre-COVID / summer ‘24 demand.

This has been modelled in a similar manner to the SAGE approach taken through COVID. System alert levels 0-4 have been built, with assumptions made on a range of occupancy levels, predicted demand, delivery of mitigations etc. Each scenario has then been tested at organisation level and at system levels, showing a fuller picture of where resulting gaps may be.

2. Cross reference the current 2425 urgent and emergency care plan with an understanding of drivers of increasing demand and **agree priority evidence-based interventions**, mitigating gaps using monies already allocated to UEC schemes whilst meeting national requirements outlined in the winter letter.

This year’s winter plan was written in April 2024 as part of the 2024-25 UEC system plan. A bed gap was predicted at this point in time, with further work ongoing to mitigate gaps through summer 24. Since this plan was written, every part of the system has seen increasing demand, further increasing pressure on the system. To understand how to strengthen the plan, a clinically led winter workshop was held in September 2024, with further priority plans agree for scoping, implementing between October 2024 and January 2025.

The NHS England Midlands Winter Risk Summit, held on 14th October 2024, has identified three key priorities:

i. A comprehensive Frailty model – clinical leads will lead a range of task and finish groups to strengthen the model in pace. Expected improvement cycles to be in place by 30th November 2024.
ii. Escalation processes – to ensure a robust system response to escalation, a clinical and operational response to risk, timely mitigations and embedding learning. Improvement cycle in place w/c 14th October, review w/c 28th October 2024.
iii. Discharge flow and timeliness – clinical leads will lead improvement cycles covering key aspects contributing to this – internal professional standards relating to criteria to admit, criteria to reside and criteria-led discharge. Expected improvement cycles to be in place by 30th November 2024.

These plans are expected to deliver against recommendations in the national improvement guides, recently released by NHS IMPACT and contribute to the six metrics outlined in the national UEC recovery plan.

3. Understand and define **triggers / actions for 'critical' scenarios** such as elective take down and actions to spread risk across the system

The LLR system has already faced one critical incident in October 2024. Learning from this episode has shown that the current escalation process requires strengthening, both of escalation processes and oversight at system and Trust levels. The learning from this event have been applied, with new standard operating procedures in place, clear escalation triggers to the LLR UEC System Director and named oversight lead for the system since October 14th 2024. This is tested daily with the current escalation levels across the system and will be reviewed again w/c October 28th 2024.

The Clinical Executive will also lead a system risk summit in October 2024 with the aim of ensuring the clinical leadership across the system are both clear on and are actively supporting delivery of the mitigating actions outlined to reduce the risk within the system. This will include providing assurance against the 'fundamental standards of care', including adherence to the principles for providing safe and good quality care in temporary escalation spaces. Further work is also continuing to assess and review the triggers for the implementation of the 'W45' min handover protocol, and the review of admission/discharge thresholds in such scenarios.

Each of these three components comprises the strengthened LLR Winter Plan.

The Winter Plan

Part One: Understanding demand and capacity

Detailed demand and capacity modelling has been undertaken, looking at various drivers of demand, including inflow into the Emergency department, length of stay in acute and community hospitals, variation by day of the week and time of the year and occupancy levels in both community and acute bed bases.

Summary of findings 2023/24:

Who is accessing services?

- Younger people are more likely to access 111 and UCC/UTC and older people are more likely to access Emergency Department and become inpatients
- There is a clear deprivation gradient with people from more deprived areas having higher Emergency Department and Non-Elective admissions rates
- White ethnic groups have higher attendance than average, Asian ethnic groups have lower rates

Flow in

- There have been increases in flow into the urgent care system at or above population growth (Emergency Department & 111 at population growth (4%), GP practice 6% above population growth

Flow through

- Non-Elective admissions have grown by 15% between 2021/22 and 2023/24. This has been most marked in emergency care (115%) and general medicine (31%)
- NEL admissions with 0 length of stay has increased by 34% in line with SDEC and other same-day access – this is not reflected in our planning figures and therefore counted in our overall admission growth.

Flow out

- Patients are staying longer in hospital, in 2023/24 there was an increase of 18% in occupied bed days
- 42,800 days were lost to discharge in 2023/24, a combination of internal Trust and external delays.
- Our ‘medically optimised for discharge’ patient numbers awaiting complex plans have remained at an average of 120 across c2000 acute and community beds

Source: Urgent and Emergency Pathway Analysis (April 2021/22 – 2023/24)

Month 1-5 activity data for UHL for 2024/25 is showing an increase on month 1-5 activity data for 2023/24

There have been increases of:

- 8.5% increase in ED attends (58 extra per day). This is the gross performance, noting streaming and re-direction away from LRI ED to community based UEC services of
  - 3,502 in M1-M5 2023/24, and
  - 4,543 in M1-M5 2024/25.
- 16.3% increase in non-elective admissions, 39 extra per day (29 0LoS, 10 1+LoS)
- 36.8% growth in 0LoS, 6.4% growth in 1+LoS
- At month 4, workforce paid hours (excluding overtime) has increased by 8.2% which is the equivalent of 1,175 WTE extra per month: (from 17,346 WTE to 18,521 WTE). Over the same period workforce pay bill has increased by 9%

M5 YTD	**2023-24 YTD**		**2024-25 YTD**	
POD	**Activity**	**Cost £**	**Activity**	**Cost £**
A&E Type 1&2	*104,315*	*18,650,544*	*113,141*	*20,293,187*
A&E Type Other	*0*	*0*	*0*	*0*
A&E Total	104,315	18,650,544	113,141	20,293,187
APC Non Elective	36,618	89,497,028	42,592	98,792,967
APC Day Case	*37,997*	*24,176,245*	*41,617*	*27,530,372*
APC Elective Inpatients	*4,756*	*16,170,398*	*5,825*	*19,403,946*
APC Elective Total	42,753	40,346,643	47,442	46,934,317
OP First	78,812	16,718,459	79,239	16,713,208
OP Follow Up	152,990	15,595,460	163,490	16,791,117
OP Procedures	56,676	9,823,418	70,701	11,990,904
Total	**472,164**	**190,631,551**	**516,605**	**211,515,700**

Based on this analysis, a range of scenarios have been modelled, ranging from best case to likely case to worst case – 0%, 5% and 10% growth in bed requirement across the winter months. In summary:

1. Predicted demand assumes three scenarios of growth of bedded patients based on peak winter levels of activity and predicted patients waiting in the emergency department and other areas for a bed. This provides a total predicted demand model of between 1,970-2,128, with the particular pressure in Emergency Medicine and Cardio-Respiratory.

2. The model includes potential ward closures due to Infection Prevention and Control measures of between 28, 56 and 84 acute beds. These estimates are based on experience in previous years.

3. A range of mitigations have been agreed through the winter plan including additional bedded capacity at UHL, LPT and across care home providers, additional non-bedded capacity in Home First services, including virtual wards, and additional capacity in primary care and mental health services. In the bed model, impact has been modelled between 50% and 75% of the total impact which could be seen, ranging from 96 beds to 120 beds.

The scenarios modelled are summarised in Appendix A with the assumptions for each detailed alongside. The accuracy of the model is somewhat compromised this year, with the addition of 'same day emergency care' activity coded as an emergency admission. This means that the model will over-estimate the bed requirement as up to as many as 30% of patients would be expected to go through same-day emergency care pathways and therefore not require an overnight bed.

Regardless of the accuracy of the model, the UEC Partnership accepts that the current plan will not mitigate the full bed gap at the peak of demand without full delivery of the actions agreed, with further work needed to strengthen resilience against all scenarios.

Part Two: The action plan

Benchmarking

Funding

The actions prioritised therefore focus on three areas across the pathway, each looking at an increase in capacity in areas of demand – UTC capacity, bedded capacity and non-bedded care capacity. Whilst productivity and process improvements are largely within the gift of the system to resource or release, funding for any capacity increase (as per the NHS winter directive) has not been factored into the 2024/25 plan and will therefore need to be managed within our system position.

No additional funding is expected to be forthcoming from the national teams across the Department of health and social care.

Actions and impact – original 24/25 UEC Operational plan

Our 24/25 UEC operational plan for the ICS was based on the ten high impact actions outlined as part of suite of documents released with the national UEC recovery plan. Steady progress has been made against these, with the majority of the interventions on track; these have been summarised below for assurance.

High impact intervention	Progress against metrics	Further opportunity	Governance
Same Day Emergency Care: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.	Current SDEC figures provided by UHL estimate: 745 (Cardiorespiratory) 650 (Surgical) 160 (Ward 9 ENT, Maxillofacial etc.) 1200 Medical SDEC Total: 2755 As a % that equates to 34.5% of NEL activity. ▪ Data being sought to confirm direct access vs access via ED	Yes – standardise services / increase direct access / launch frailty SDEC. Impact TBC	Same day access steering group
Frailty: Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.	▪ Pre-transfer service for frail patients in place, 1333 patients seen in M1-6 2425. 907 ED attends and 6,141 bed days saved ▪ Falls response service in place, 1,613 patients / 85% non-conveyance rate M1-6 2425 ▪ Care home response service in place, NEL reduced from 8,389 in 19/20 to 4,698 in 23/24	Yes – provide service at scale in community / join up internal Trust offers via Frailty SDEC Impact of c15 less ambulances per day	Same day access steering group
Inpatient flow and length of stay (acute): Reducing variation in inpatient care and length of stay for key pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.	▪ Improvement from April 24 - 52.6% of all discharges before 5pm to 53.9 (September 24). Target to improve up to 10% across winter (source National ECIST discharge infographic) ▪ Current discharge before noon plan (33%) vs actual (26.4%). Sept 24 ▪ Reductions in LOS for 7/14- and 21-day patient groups	Noon (33%) / 5pm (80%) metrics in place but improvement needed, Community Hospital transfers earlier in the day, Improvement underway to meet and improve again Peer comparison metrics (7/14- and 21-day LOS)	Acute care collaborative

High impact intervention	Progress against metrics	Further opportunity	Governance
Community bed productivity and flow: Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.	Target for discharge before noon is 40% current performance is at 32%. Discharge before 5pm is currently 84% against a target of 90%	Yes – There has been a drop in performance and LPT are working with the transport provider to improve collection times to regain a position of hitting the target of 40%.	Community Care Partnership
Care Transfer Hubs: Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.	▪ LLR Discharge Hub in place as per plan ▪ 78% of P1-3 same day discharge plans were provided to UHL by 12noon, supporting same day discharge in Sept 24	Yes – 'lost' discharges have reduced but opportunity remains Impact – 5-7 acute beds released daily	Community Care Partnership
Intermediate care demand and capacity: Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.	▪ Targets set in relation to P1 discharge within 24 hours or referral and p2 within 48 hours of referral. P2 capacity gap mitigations are being worked up and improvements in referral processes to support timely allocation are underway.	Yes - System-wide demand and capacity modelling completed, showing capacity gap of 29 after mitigations are delivered. Aligning and integrating the system discharge hub and SCC will provide greater opportunity for real time monitoring and escalation of issues related to discharge.	Community Care Partnership

High impact intervention	Progress against metrics	Further opportunity	Governance
Virtual wards: Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.	▪ Virtual ward capacity increased from 155 to 199 as per plan by September 2024, with occupancy exceeding 80% on average ▪ Further increase to 252 virtual ward beds by March 2025	Yes – Utilisation is good on average but variable through the year Impact of further 20-50 patients being supported through VW programme, either step up or down	Community Care Partnership
Urgent Community Response: Increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission.	▪ 92% of UCR referrals supported within 2 hours against metric of 80%. 3,925 patients supported M1-6 2425	Yes – linked to frailty and VW step up model above *Impact already counted above*	Community Care Partnership
Single point of access: Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.	▪ Clinical Assessment Service in place, taking calls from key access points – GP's, EMAS, LA's etc. ▪ DOS updated with all relevant pathways ▪ 'call before convey' in place, highest EMAS usage rate in Midlands M1-6 24/25	Yes – merger of triage points expected by March 2026 *Impact already counted above*	Community Care Partnership
Acute Respiratory Infection Hubs: Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.	▪ ARI hub evaluation from 2324 saw little impact on ED from ARI hubs. ▪ 10,025 same day appts planned for 'acute clinics' in the community for winter 2425, including respiratory illness across all ages	To be evaluated from 2425 cycle	Same day access steering group

Other key local high impact actions being implemented through 24/25:

- Vaccination
  - Increasing our vaccination rates for Covid, flu & RSV via dedicated clinics, focused support for visiting housebound and care home residents via roving healthcare unit.
  - Increasing our immunisation rates for measles and pertussis via ongoing hyper-local offer and communications plans
- Same Day Access To Care
  - 99% of LLR GP practices offering a minimum of 75 clinical contacts per ‘000 population.
  - Supporting ED streaming to UTCs at Oadby and Merlyn Vaz - 4,543 patients supported to more local healthcare pathways for the period April to August 2024.
  - CYP Respiratory support via the 48hr Wheeze Follow Up Pathway, which is profiled to save 1,485 Childrens ED attends from September 2024 to March 2025.
- Implementation of the Proactive care programme for our vulnerable patient cohort
  - 4,592 patients enrolled onto the programme for the period April to August 2024, with care plans in place to support admission avoidance via SPOC’s
- Mental Health support
  - Whole system focus on signposting to the 25 Mental Health Cafés across LLR, with over 1000 patients supported each month in 24/25.
  - 10 hyper-local schemes in place with VCS to support early intervention and asset-based community support to reduce ED presentation and utilise appropriate local provision.
  - Maximising use of Joy app to support people’s knowledge of local services and support
  - Maximise use of NHS 111 option 2, directing patients to local central access point for Mental Health Services.

Despite the impact of each of these schemes, demand is still outstripping capacity in the majority of our health and care services. Given the clinical risks faced in every part of the system, the winter plan has been further strengthened. The majority of schemes below are to either increase the impact of the ten high impact interventions listed above or to supplement capacity in areas we know that demand continues to increase.

Additional Winter capacity with existing funding identified

Focus (High impact interventions or national UEC recovery plan)	Scheme	Additionality	Impact	Outcome
Maximising UTC/UCC capacity	M/Vaz 7/7 Oadby 7/7 Enderby 5/7 Oakham 7/7	11,008 appts Dec 1st to Mar 31st	Reduction in failure demand from 111 to ED by 3870 appts	ED to plan
Maximising capacity	PC Validation of NHS111 calls 5/7	800 hrs of staffing Dec 1st to Mar 31st for 6,800 contacts/month	Re- direction of NHS111 calls with a PC disposition who choose ED	ED to plan
Same Day Emergency Care	Direct access to SDEC	Variable according to demand	Increase in no of patients straight to SDEC	Decrease POA's
Maximising capacity	MH consultant cover	Variable according to demand	Reduce waiting time in ED	ED to plan
Acute Respiratory Infection Hubs	CYP respiratory support	Hub model in areas of high footfall Sep - Mar	1,485 saved ED attends	ED to plan
Frailty PTCDA expansion PDSA	System Frailty Service	Q4 2 x WTE ACP & 2 x WTE GPwSI	Q4 39-65 additional visits	Reduced conveyances to Acute care
Virtual Wards	Virtual Wards	Increase VW beds from 199 to 252 in year	Reducing ED attends and Non-Elective Admissions	Improved Acute Discharge flow
Maximising capacity	Additional Stroke Therapy support	2 x WTE Therapists for 5m	Reduction in LoS Improved	Reduction in LoS LGH Wd 3 and increase in

				Discharge flow	ESDS activity
Maximising capacity	Additional Bariatric Bedded Capacity	Funded from the Discharge Grant	Additional 4 beds to March 2025	Improved Discharge flow	Reduced MOFD delays in UHL / LPT

Additional funding requests for consideration

Focus (High impact interventions or national UEC recovery plan)	Scheme	Additionality	Impact	Outcome
Maximising UTC capacity	Oadby UTC capacity	3870 appts Jan 2nd to Mar 31st	Reduction in failure demand from NHS111 to ED	ED to plan
Maximising capacity	Xray @ Loughborough 5.30-8pm	Quantification to be confirmed as a part of the PDSA review	Increase in capacity in MIaMI	ED to plan
Maximising capacity	LRI MIaMI extension to 02:00 daily	13 patients / day	Increase in capacity in MIaMI	Increased capacity in ED
Maximising capacity	GP capacity at front door / ED	Seeing pts x 20 mins = 2,040 appts Streaming patients at 6 per hour – 4,080 pts	Decrease type 3 and 4 attends to ED	ED to plan

Maximising flow	GP support for EMAS stack management	2 x GPs 12/7 to 31/03/2025	Improve C3-C5 flow to LLR CAS and wider pathways	Improve C3/C4 waiting times
Maximising flow	Frailty SDEC	Geriatric Consultant and 2 x ACPs	Improving SDEC and reducing admissions	Improve flow from ED
Maximising discharge	Weekend discharge pilot	Senior clinical decision makers in Medicine across weekends	Improve discharge flow across 7 days	Improved Acute Discharge flow
Inpatient flow and length of stay (acute)	Transport cohorting	Discharge lounge at each of LRI and LGH	Reducing waiting times for patient transport	Improved Acute Discharge flow
Inpatient flow and length of stay (acute)	Additional Community Hospital Beds	Additional 19 CoHo beds @ L'boro 12/2024-03/2025	Improved Discharge flow	Improved flow out of ED
Inpatient flow and length of stay (acute)	Patient Transport	2 x crews for 12hrs/day Mon & Tues weekly	Improved Discharge flow	Reduced re-beds, reduced late transfers
Intermediate care demand and capacity	Preston Lodge	TBC	Improved Discharge flow	Improved patient experience and outcome

Each action has a management lead and a clinical accountable lead to ensure actions are not just delivered from an 'input' perspective but that the impact is evidenced and embedded.

Preston Lodge – scoping is underway to identify opportunities to open a part of the unit from January 2025. However, funding for capital expenditure requires clarification as is pre-committed to another project, and for revenue no additional funding has been identified.

Part Three: The escalation plan

During peak demand, it is likely that the system will have to make tactical decisions to ensure patient safety. To enable this proactively, a set of system triggers for escalation have been

developed and work is ongoing to agree this. These are expected to be agreed by Clinical Executive in October.

The revised LLR Surge and Escalation Plan sets out how the health and care system will manage surges in the Operational Pressure Escalation Levels (OPEL). The plan articulates actions to be undertaken by all system providers to mitigate and de-escalate from extreme operational pressure.

The **LLR Winter Director (LLRUEC System Director)** assumes oversight of delivery, with escalations to Chief Operating Officers as required as part of normal responsibilities.

The **System Coordination Centre** (and provider operational teams) works across seven days a week, supporting operational decision making across the system. This will include oversight of non-elective pathways, elective cancellations, maternity, neonatal and mental health escalations.

The daily system operating rhythm remains in place across seven days a week, with all partners joining the **system flow call** daily at 09.30 and 1400 as needed.

The **Regional Operational Call** takes place at 1000 daily, seven days a week.

When on OPEL 4, **mental health tactical calls** are also scheduled at 1200.

Handover to **out of hours tactical and strategic on-call** occurs at 1700 daily, Mon-Fri for ICB colleagues and at 1700, seven days a week, for each provider.

Standard Operating Procedures are in place for ambulance handovers, long bed waits etc as per usual protocols.

In the event of a critical incident, the plan has identified key system partners to co-locate and support with strategic decision making and incident response. The LLR Surge and Escalation plan sets out routes of escalation from operational / tactical to strategic responders who are led by the Winter Director. Emergency Preparedness, Resilience and Recovery remains the responsibility of each Accountable Emergency Officer.

Part Four: The communications plan

The System Winter Communications Plan will be iterative throughout Winter, using feedback from the LLR Winter Workshop and a cadence of regular meetings with health and care partners to inform the variety of targeted messaging per month. Following feedback from September's Health Overview & Scrutiny Committee meetings, nuanced communications to specific patient groups in a variety of messaging media will be developed for cascade by system partners. Winter Director meeting with ICB Comms lead 16/10/24 to revise.
The communication strategy for Winter includes:

- **Supporting people to get the right care, first time**.
    - Informing people about the services available and encouraging them to use them in the right way – staff, stakeholders, patients and the public.
        - When to use ED and 999
        - Urgent care options for physical and mental health, including NHS 111.
        - Pharmacy

            - (Sexual health services)
- **Supporting people to look after their own health and wellbeing and prevent illness, so they are less likely to need health and care services.**
    - Self-care and winter wellness
    - Keeping warm
    - Cost of living support
    - Mental health support
    - Encouraging vaccination uptake in eligible/priority groups
    - NHS App
    - Managing long term conditions
    - Winter safety, e.g. flooding, falls prevention
- **Maintaining public confidence in care:**
    - Promoting good news and case studies
    - Robust stakeholder engagement
    - Effective media handling
- **Helping to protect the health and wellbeing of system colleagues** through internal communication of support offers and advice.
- **Engendering increased collaboration and support for each other among system colleagues** by sharing information, partnership working and new initiatives from across the system

Conclusion

This plan represents the actions this system knows will make a difference this winter; however, given the model laid out, it is clear that we will need to strengthen the plan further, together as a health and care system. Some of our metrics are improving as is our joint working as a single team. Despite this, this winter is likely to be exceptionally tough and we need to be actively aware of and managing the risks as they arise across the system.

The implementation of the Plan will also require wider partner engagement such as Healthwatch and our regulatory partners such as the CQC. Wider engagement will commence in October, along with a plan to communicate with our staff and population using lessons learnt from previous winters and the COVID response.

The impact of the cost-of-living crisis and fuel / food poverty are also impacting on illness and the ability of our citizens to stay physically and mentally well. The agility and ability to react therefore, at every level of the ICS, will be significant and the system will be reliant on partnership working at a scale seen only through the pandemic.

Appendix One – Winter Scenarios

Updated by UHL 15/10/2024

	Level One	Level Two	Level Three
Predicted Bed demand	1,850	1,929	2,008
Patients waiting a bed in ED, CDU, GPAU & RF/BB @ 8am	120	120	120
TOTAL DEMAND	1,970	2,049	2,128
TOTAL CAPACITY	1,699	1,671	1,643
Unmitigated Bed gap	-271	-378	-485
Mitigations	+120	+113	+96
Residual bed gap	**-151**	**-265**	**-389**
Assumptions	▪ 0% growth for NEL ▪ 28 beds closed for IPC ▪ Emergency demand as per model ▪ 92% elective occupancy ▪ 92% emergency occupancy	▪ 5% growth for NEL ▪ 56 beds closed for IPC ▪ Emergency demand as per model ▪ 92% elective occupancy ▪ 92% emergency occupancy	▪ 10% growth for NEL ▪ 84 beds closed for IPC ▪ Emergency demand as per model ▪ 92% elective occupancy ▪ 92% emergency occupancy