APPENDIX 2

NHS
North East London

UEC Improvement Strategy and Plan: BHR Places

Version 7.0

June 2023

Overview of Barking and Dagenham, Havering, Redbridge Places

- **Within BHR there are significant areas of deprivation** - based on the 2021 census, out of all London local authorities, Barking and Dagenham has the highest number of households experiencing a dimension of deprivation (the four dimensions of deprivation are employment, education, housing and health and disability). The cost of living crisis is having a disproportionate impact on those from lower income households across north east London.

- **There is a growing population** – in total across BHR over the last five years alone the population has grown by 1.3% (19,618 people). Redbridge is the 11th largest borough in London with the 8th largest increase in population across all boroughs. Havering's children's population grew by 20% between the 2011 and 2021 census (highest in London, second highest in England) and is projected to grow by 15,000 by 2032. B&D's house building programme will result in at least another 50,000 residents over the next 20 years

- **Age demographics** – there is a high proportion of residents aged over 65 – in Havering this is expected to increase by 13% by 2032.
    - **Barking & Dagenham has a relatively young population** compared to the rest of London with 17.7% of residents aged 9 or under

- **Primary care – average GPs per 100k of the population is below the north east London (48.2 per 100k) and England (76 per 100k) averages in each of the three Places**
    - Redbridge 37
    - Havering 39
    - Barking and Dagenham 39

Overview of Barking and Dagenham, Havering, Redbridge Places (cont.)

- **BHRUT is one of the busiest A&Es in the country** - based on ED attendances (all types) in November 2022 – BHRUT was the 12th busiest in the country and the 4th busiest in London
- **Avoidable admissions** at Queens appear 3 times higher than other sites. There are practice outliers in B&D and Havering from which avoidable admissions are particularly high
- **The winter of 2022/2023** was exceptionally busy with high demand on ED and primary areas of need driven largely by frailty (older people) and respiratory (all ages)
- **Responses to people with mental health needs** can be variable, resulting in long waits in ED for appropriate assessment and support

System Overview

There is widespread recognition that the system has a role to play in bringing partners together, supporting collaboration and ensuring action as required. This improvement strategy sets out how we will work together as a system to ensure UEC services are resilient and delivering well for our local populations. This includes reporting from the Place Partnerships and Collaboratives on the work that supports the plan and ensuring a focus on addressing need and reducing demand as well as on responding to those requiring an urgent response.

We know that individual organisations are undertaking a range of actions, all of which are contributing to improvements, and it is through this Plan that we bring together all these actions to ensure we are co-ordinated, cohesive and having maximum impact. Acting in a system way we aim to understand their interdependencies, reduce duplication and fragmentation and to respond to the needs we have in our system. As noted above, this marks a change from previous approaches to urgent and emergency care locally.

The various elements that we are bringing together here include:

- Work at place (Borough) level to tackle drivers of ED attendance and admissions and ensure an effective response, whether prevention, diversion to alternative community provision or admission with timely discharge
- Work to sustain and increase primary care capacity and capability
- Work with LAS to increase appropriate conveyance avoidance in turn reducing ambulance delays and admission
- Responses to the findings of the CQC from their inspections of UTCs and BHRUT front doors improving experience and outcomes
- Support to and assurance of, PELC's improvement plan including an independent governance review of PELC
- System work on reducing long waits for those in mental health crisis in our emergency department
- Work to improve patient flow through each of the hospital sites
- Mobilisation and growth in capacity of Virtual Wards for both frailty and respiratory
- Communications assets and engagement with local people

System Overview: governance

We have increasingly robust system governance designed to enable us to work together to improve the urgent and emergency care pathway including a North East London UEC System Board chaired by the NHS NEL Chief Medical Officer which holds to account the BHR Places UEC Improvement Board for delivery against this Improvement Plan. There is a single programme approach, with a senior programme lead for north east London working to deliver a single, co-ordinated plan.

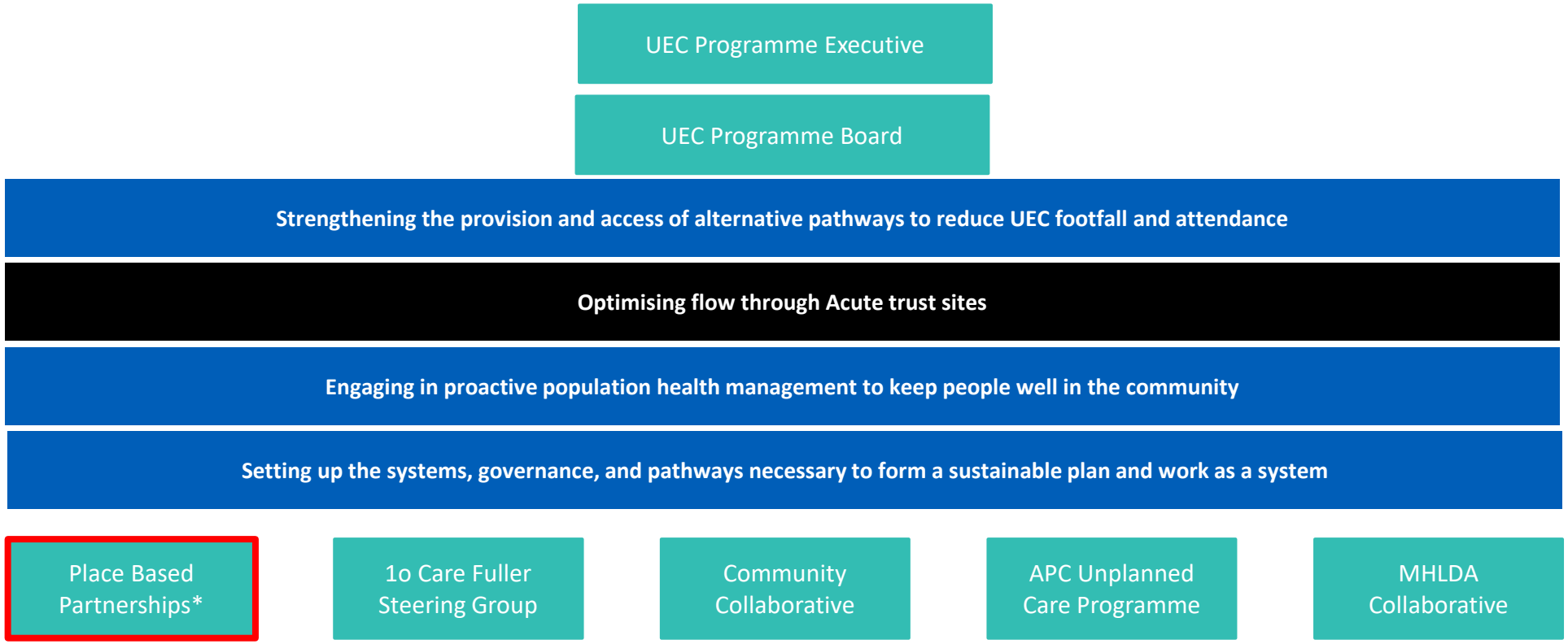
The BHR UEC Places Improvement Board (the Board) is a system level and strategic Board which oversees the Improvement Plan. The Board is clinically chaired and led, enabled by system leaders with responsibility for a range of deliverables. Reporting to the Board are a number of sub-groups which deliver on the wide range of workstream activity required. There are groups in place (as set out below) but others may be deemed necessary by the Improvement Board:

- Discharge Improvement Working Group
- PELC CQC Assurance Group
- BHRUT UEC Improvement Programme
- NELFT UEC Programme
- Place Partnership work including dedicated work on implementing integrated neighbourhood teams and delivering virtual wards
- NEL Primary Care development of same day capacity to deliver continuity of care

Whilst this is complex, it is important that the interdependencies are held at an appropriate level, here across the BHRUT footprint and for the BHR Places with contributions from across north east London and from individual Place Partnerships.

Proposed north east London UEC programme governance

- We want to align and connect all of the improvement work that is already underway and led by our Place Based Partnerships, individual providers and Provider Collaboratives
- All reporting of our improvement work to the UEC Programme Board is aligned to our five strategic system goals. Delivery of individual improvement projects is overseen by Place Based Partnerships, Provider Collaboratives and NEL programmes
- No additional meetings aligned to the strategic system goals will be introduced without agreement of the UEC Programme Board



* includes BHR improvement plan

System Overview: Demand

We recognise significant pressures on urgent and emergency care services across north east London, with the greatest pressure on services for residents in Barking & Dagenham, Havering and Redbridge using Queen's and King George Hospitals. We are beginning to better understand the nature of our demand which we can see is driven largely by three cohorts: older people with frailty, people of all ages with respiratory issues and people with mental health needs in crisis.

It is important that we recognise the context of need in which this demand sits. For frailty, the demographics of the local population, the levels of deprivation compounded by the cost of living crisis and the capacity in primary care can be seen as contributory factors to high demand from frail older people. For respiratory, we see high levels of air pollution, again linked to deprivation and housing development, with significant levels of smoking in parts of the population, poor asthma management and the reality of variable primary care capacity. And for mental health, again deprivation is an important context as are the wider pressures on mental health access and responses in the community.

During winter 2022/2023, demand on crisis and ED services was exceptionally high affecting performance but equally demonstrating the importance of working at a system level to keep people well at home and to avoid hospital attendances and admissions wherever possible. A cluster of factors, including population level concerns about Strep A for very young children, a resurgence in flu and Covid and variable access to same day primary care across the locality led to significant use of emergency provision. However, it is noteworthy that we are seeing exceptionally high levels of demand during the summer months too, with the hot weather, air pollution and pollen count leading to unprecedented demand on the front door of ED – all again underlining the need for a system approach which builds effectiveness of approach and efficiency of delivery together.

System Overview: Data

We recognise significant pressures on urgent and emergency care services across north east London, with the greatest pressure on services for residents in Barking & Dagenham, Havering and Redbridge using Queen's and King George Hospitals.

Some supporting data is provided in the next slides and has been used to identify areas requiring specific focus as then followed up in the Improvement Plan. We will use this data to track progress as we initiate the range of improvements, additions and changes set out in the Improvement Plan. Where intended impacts are not seen in our data we will review and reflect on next steps including further changes and improvements.

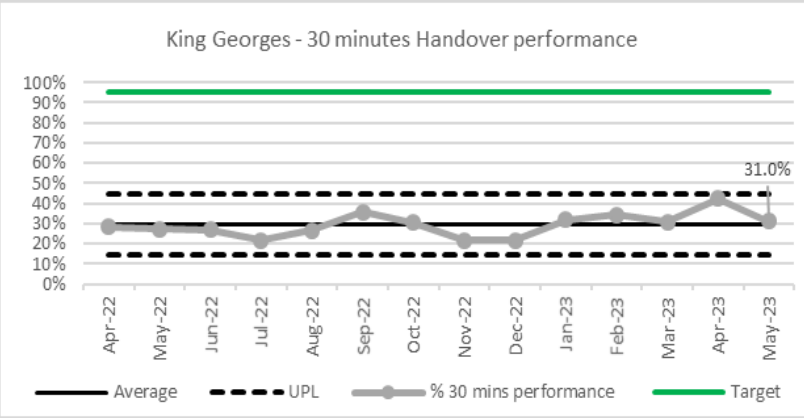
We see these pressures reflected in:

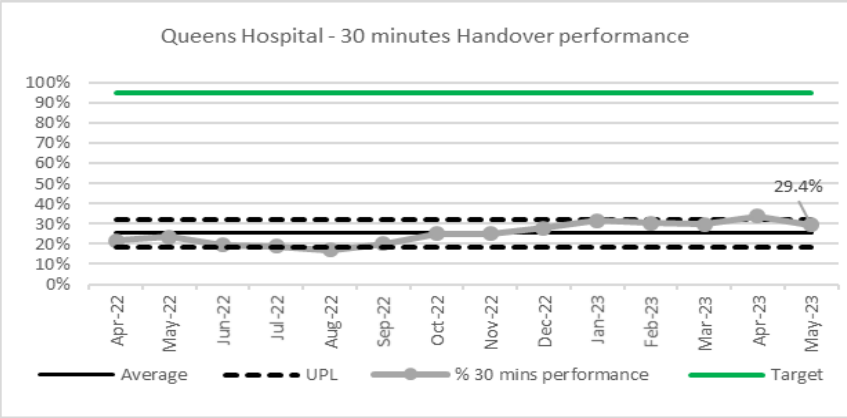
- Ambulance handover times against targets
- UTC – 15 min stream and 4 hour wait
- ED waits – 4 hour wait
- Bed occupancy
- 14 and 21 day Length of Stay
- Patients not meeting criteria to reside
- Activity levels in our GP Access Hubs, in Queen's and KGH's EDs and in the four UTCs across this area
- Elective waits

Ambulance Handovers

Data source – Ambulance monthly published data

30 minute handovers



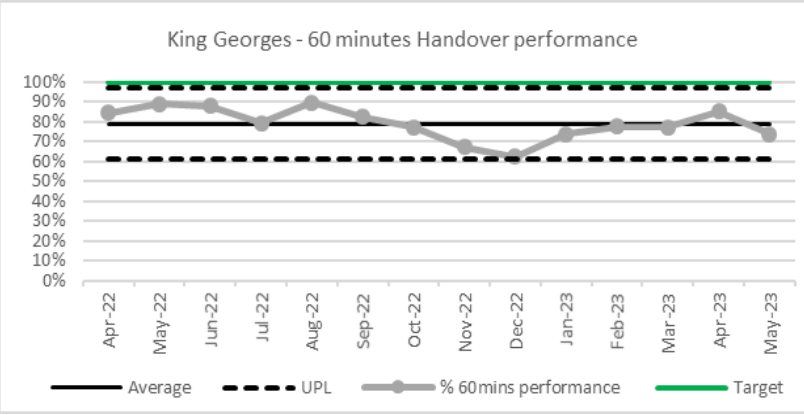


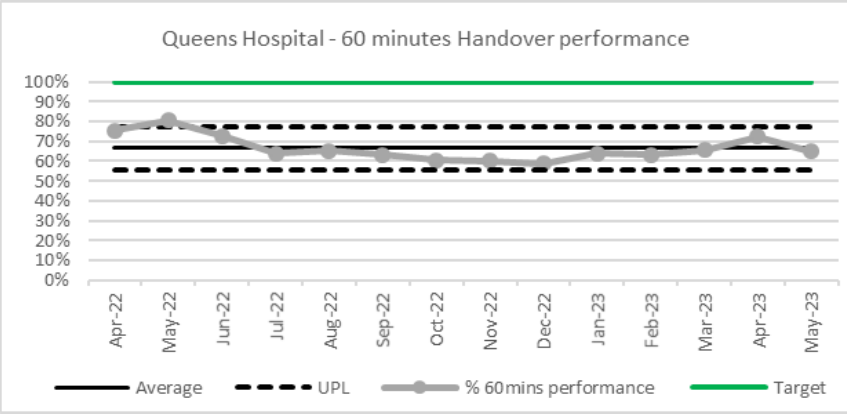
The charts on the left shows the 30 minute handover performance.

On an average,

- 29% of the handovers were within 30 minutes each month at KGH site in 2022-23.
- 25% of the handovers were within 30 minutes in Queen's hospital site.

60 minute handovers





The charts on the left shows the 60 minute handover performance

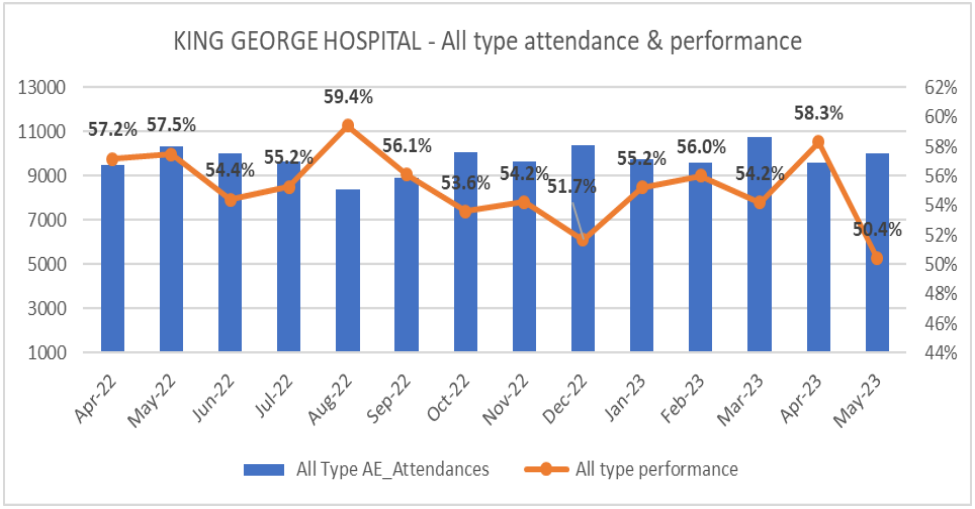
On an average

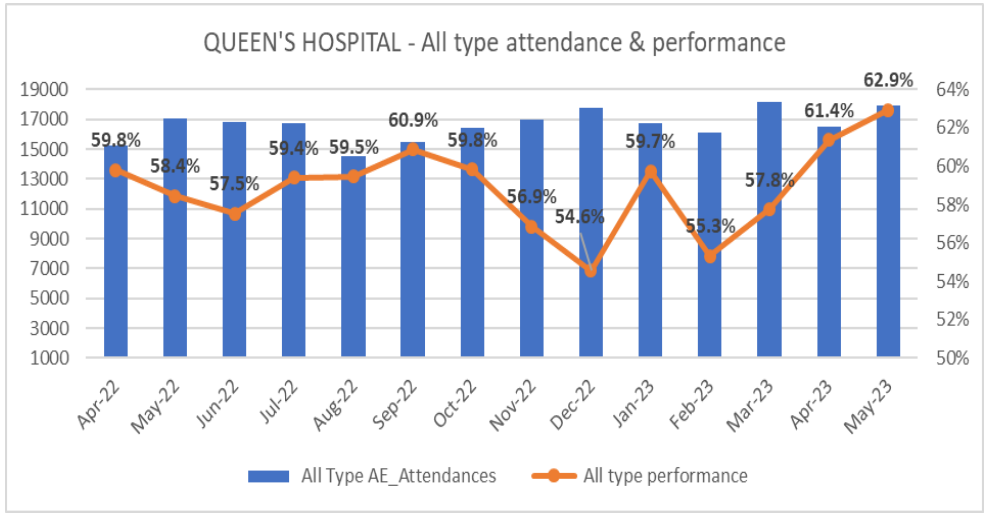
- 79% of the handovers were within 60 minutes at KGH site in 2022-23.
- 66% of the handovers were within 60 minutes in Queens.

A&E attendances & 4 hour performance – All Types and Type 1

Data source – Ambulance monthly published data

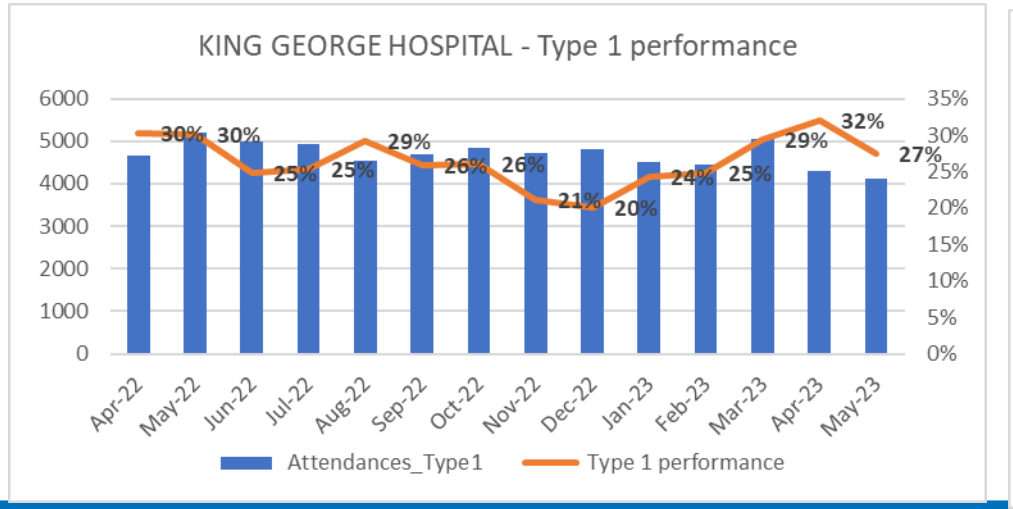
All Type attendances

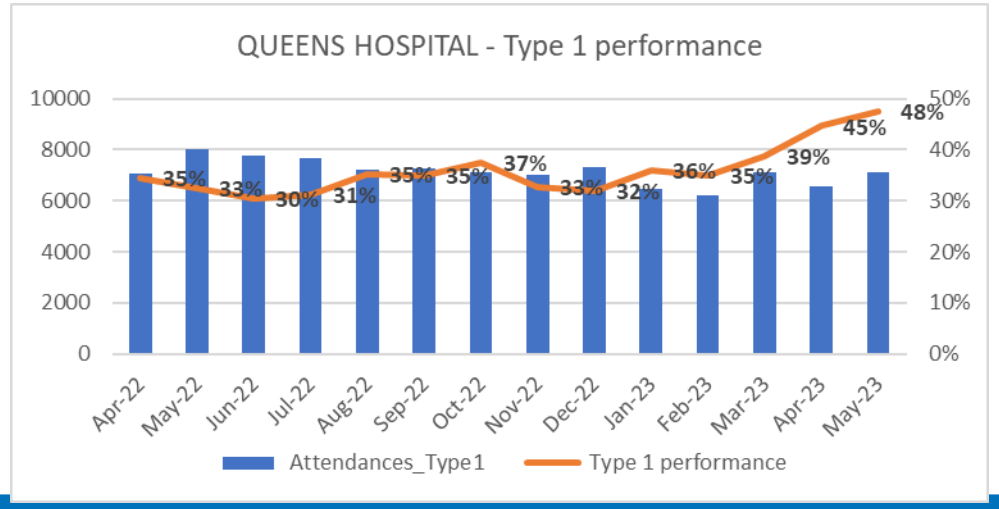




The charts on the left shows the trend of all type attendances and 4 hour performance at BHRUT sites.

Type 1 attendances

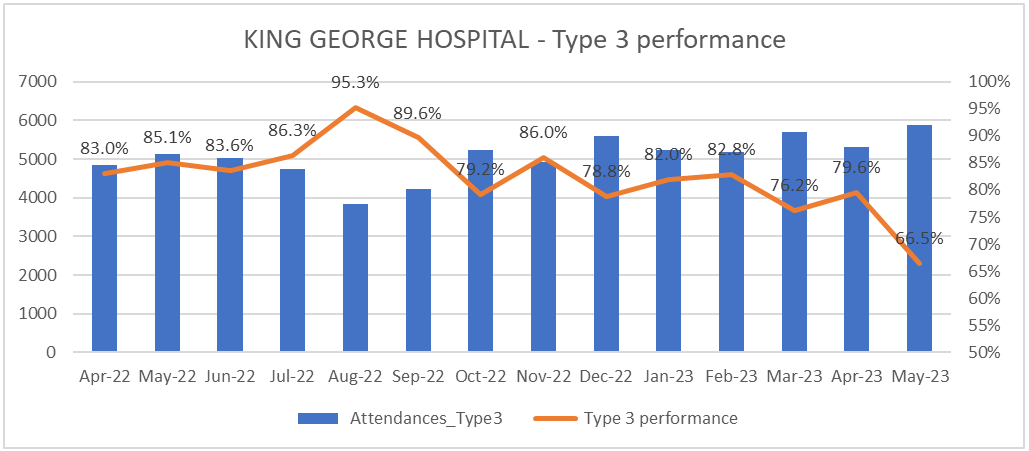


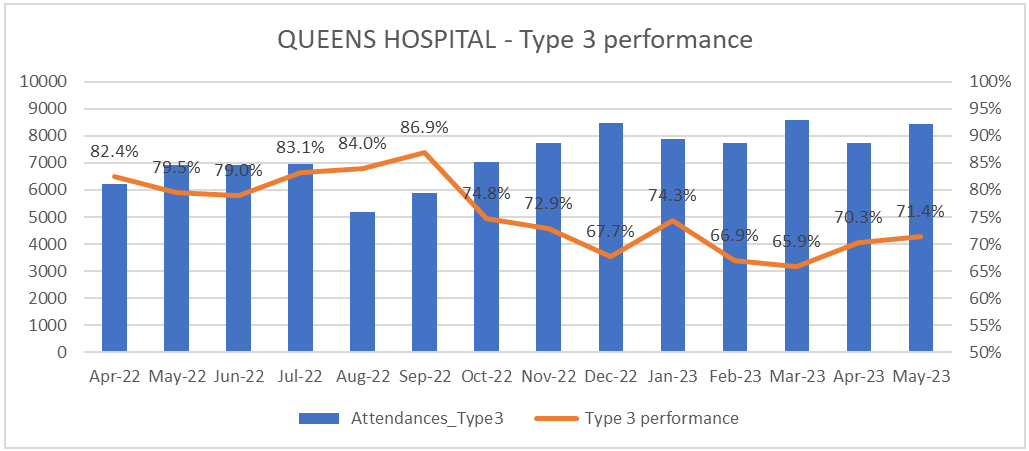


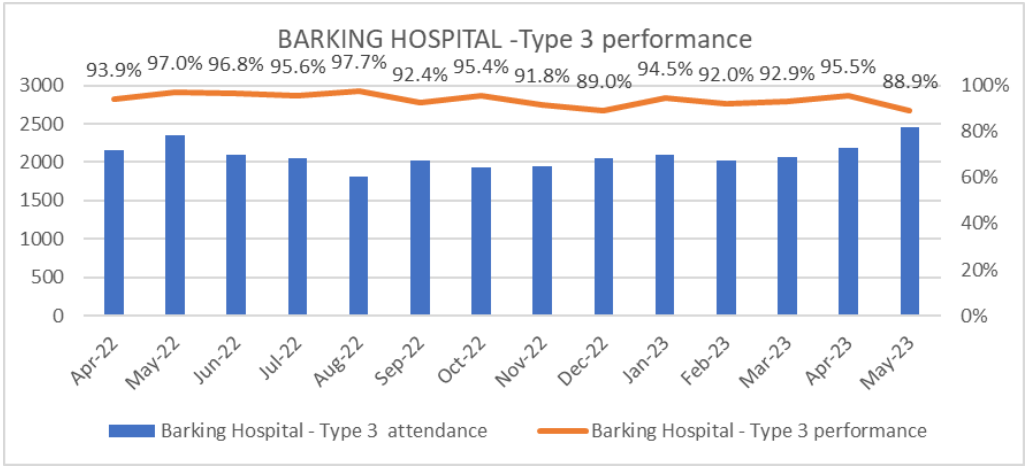
The charts on the left shows the trend of Type 1 attendances and 4 hour performance at BHRUT sites.

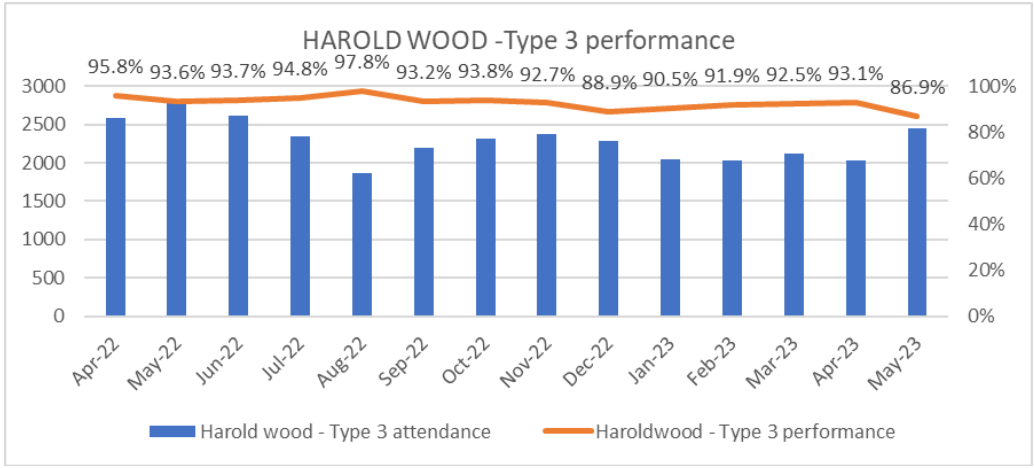
A&E attendances & 4 hour Performance – Type 3/UTC attendances

Data source – Ambulance monthly published data







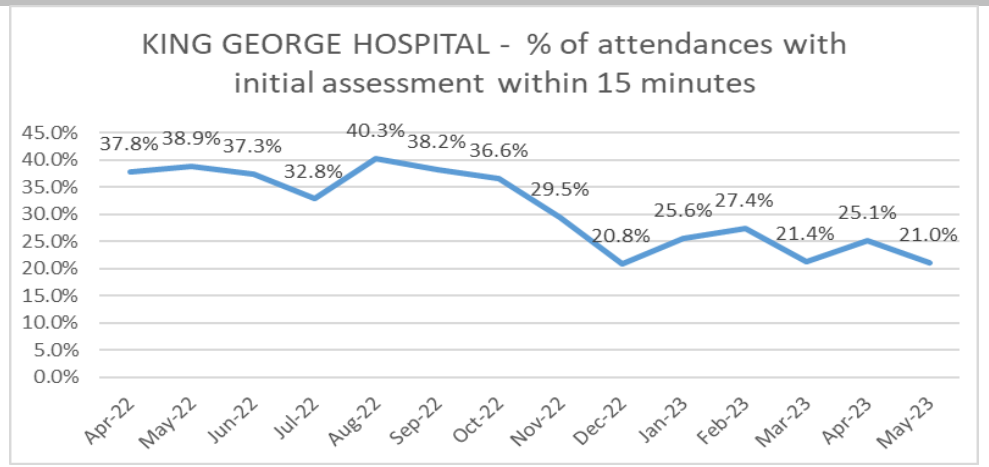


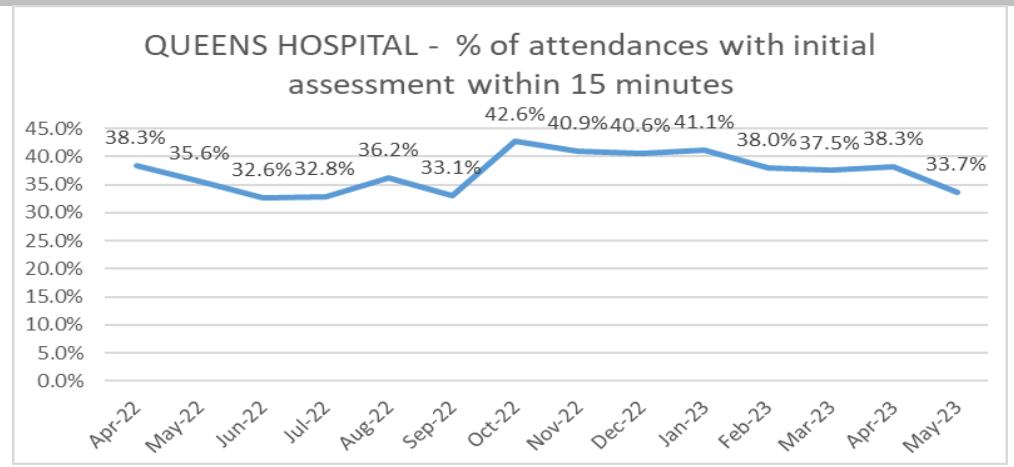
The charts on the left shows the trend of Type 3/ UTC attendances and their 4 hour performance.

ED and UTC streaming– 15 minutes

ED- Time to Initial assessment within 15 minutes

Data source – ECDS data

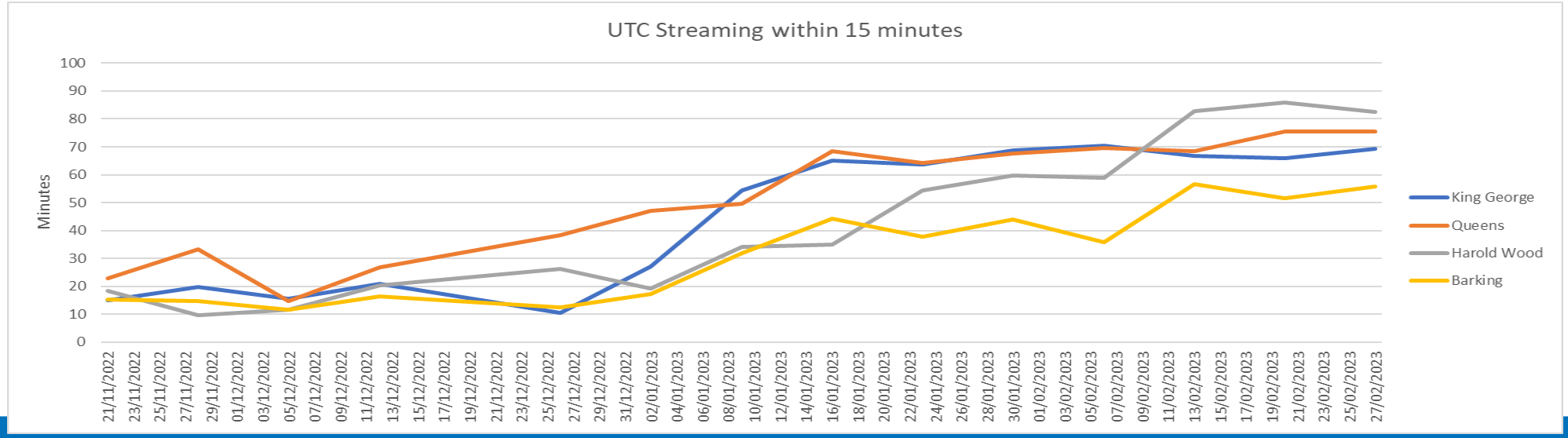




The charts on the left shows the time to initial assessment in ED within 15 minutes of arrival. This data is to be treated with caution due to data quality issues.

UTC Streaming- Time to Initial assessment within 15 minutes

Data source – PELC data



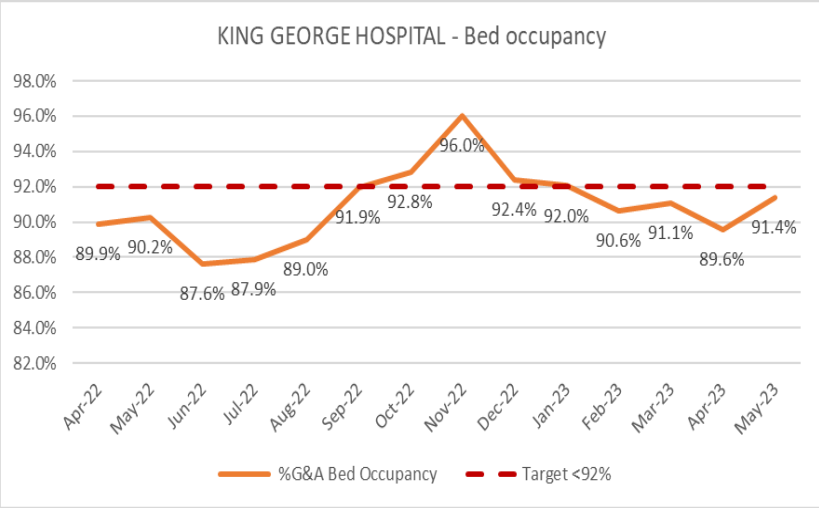
The charts on the left shows the time to initial assessment in UTC within 15 minutes of arrival.

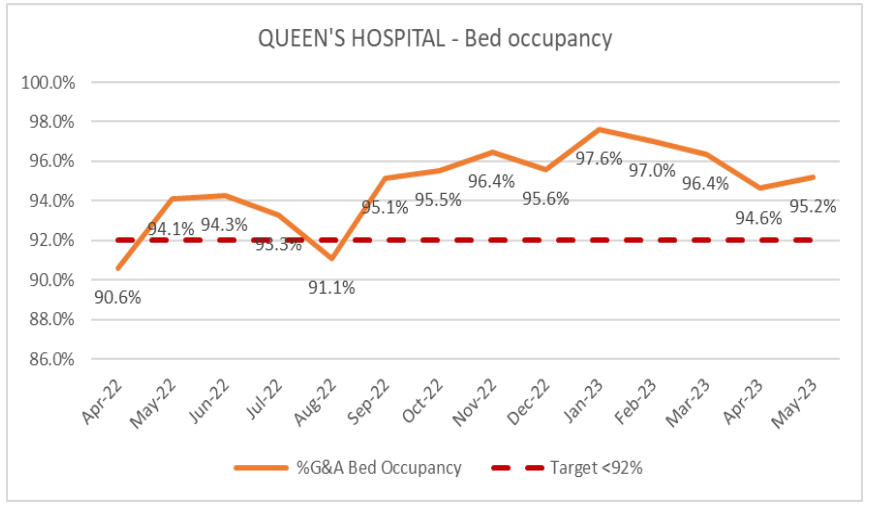
Data shows improvement in UTC streaming.

Bed Occupancy and Long stay patients occupying beds

Data source – UEC Daily Sitrep

Bed Occupancy

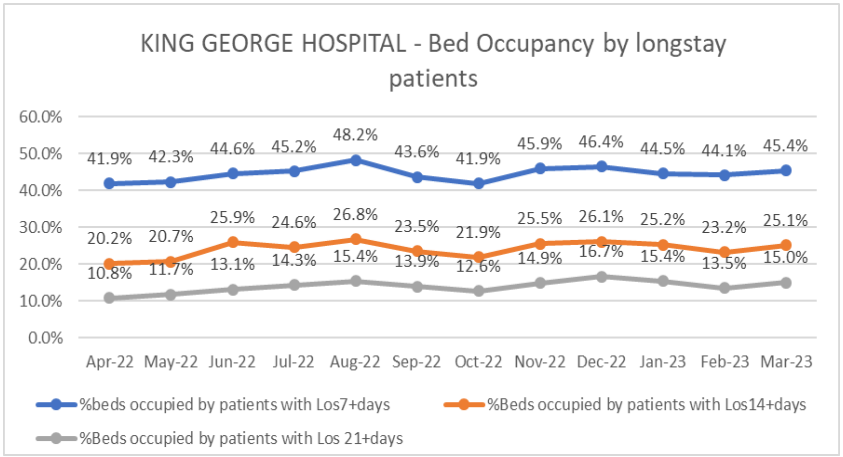


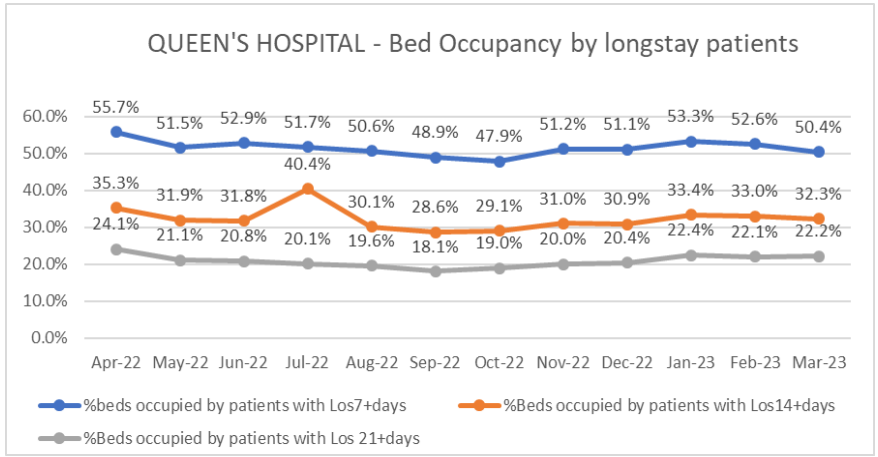


The charts on the left shows the G&A bed occupancy at BHRUT sites.

Significant Bed pressure in Queens.

Long Stay patients – LoS over 7 days, LoS over 14 days, Los over 21 days



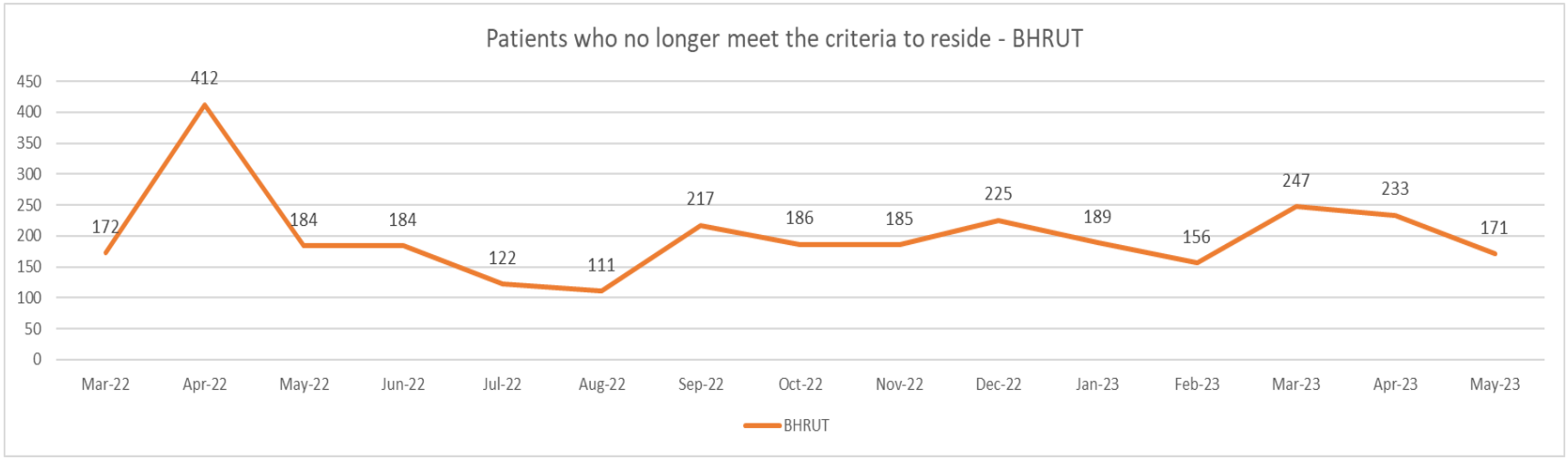


The charts on the left shows % of beds occupied by patients with length of stay over 7 days, 14+days and 21+ days.

Patients no longer meeting criteria to reside (CTR) and reasons for delays

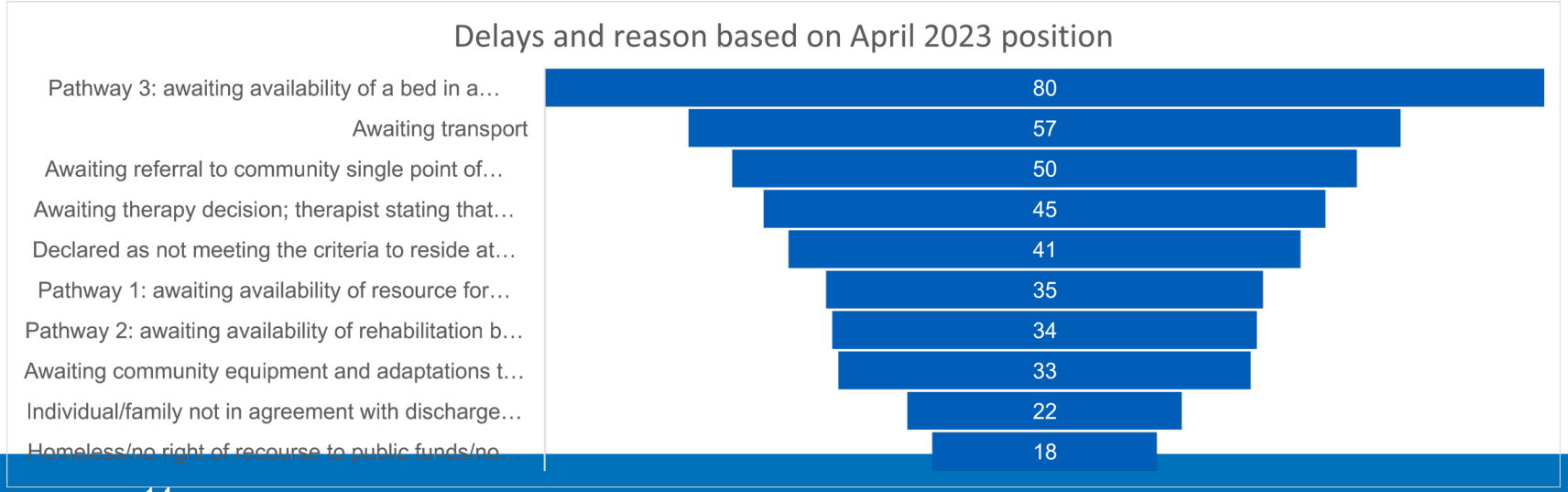
Data source – weekly discharge sitrep

Patients no longer meeting the criteria to reside(CTR)



The chart on the left shows the number of patients at the end of each month at BHRUT who no longer meet the criteria to reside but still continue to occupy the beds.

Reasons for delays with Los 7+ days

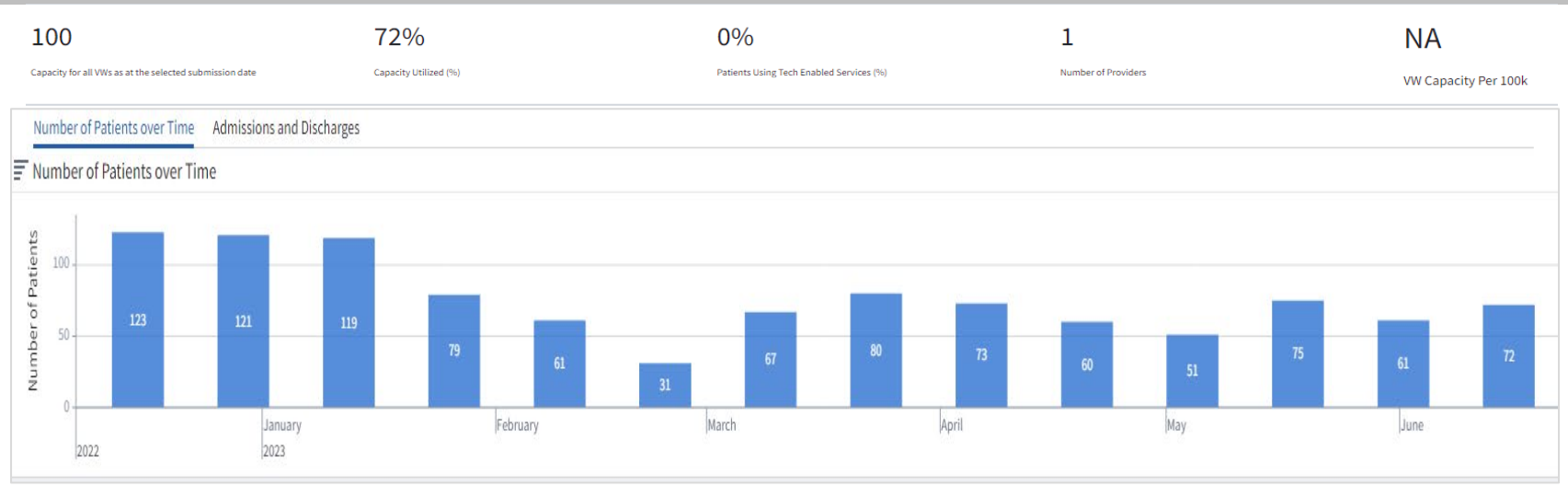


The chart on the left shows the reasons for delay in April for those staying over 7+ days

Virtual wards (VW) and Urgent Community Response (UCR- 2 hour standard)

Virtual wards

Data source – Virtual ward dashboard in NHS Foundry

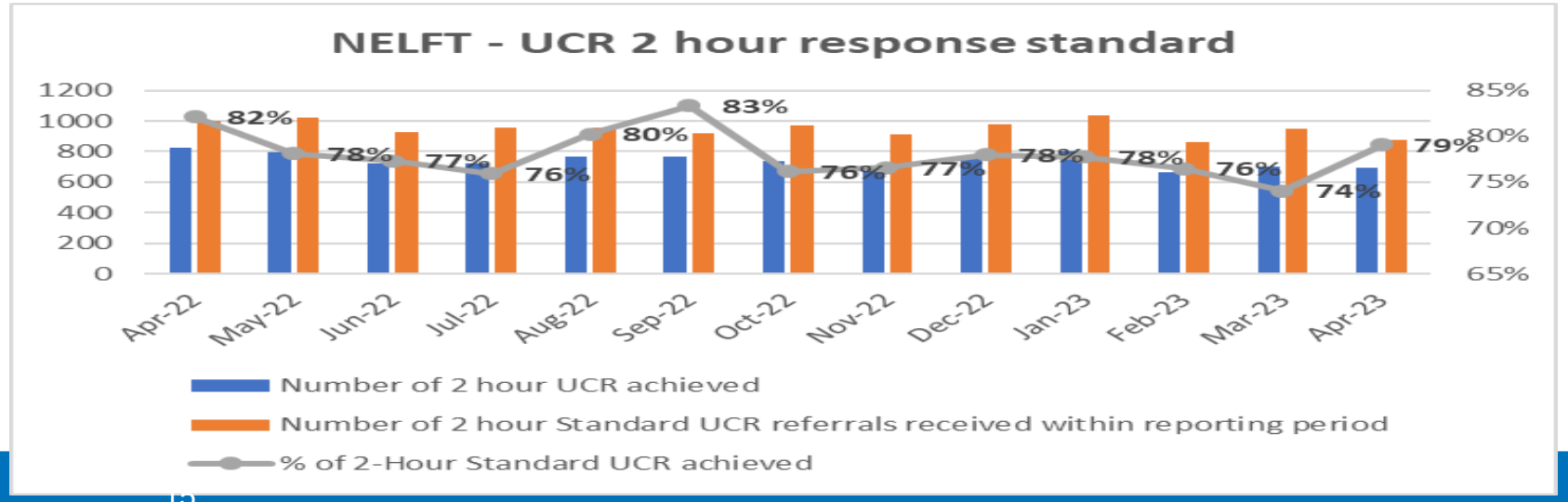


The numbers on the left shows the total VW beds by NELFT and the capacity.

There were 100 beds in the virtual ward and the virtual ward capacity based on 16th June submission was reported as 72%.

Urgent Community response (UCR)- 2 hour standard

Data source – UCR Data published data



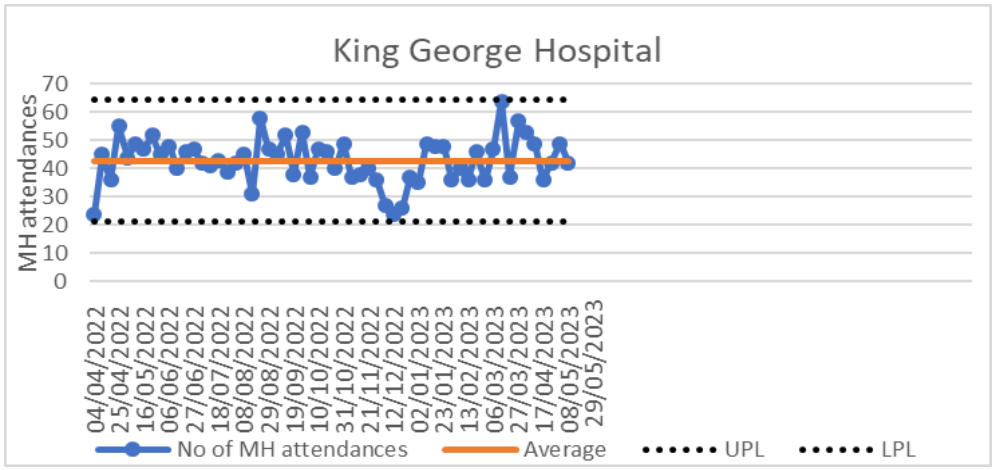
On an average 957 referrals in scope of two hour standard were received by NELFT in 22-23.

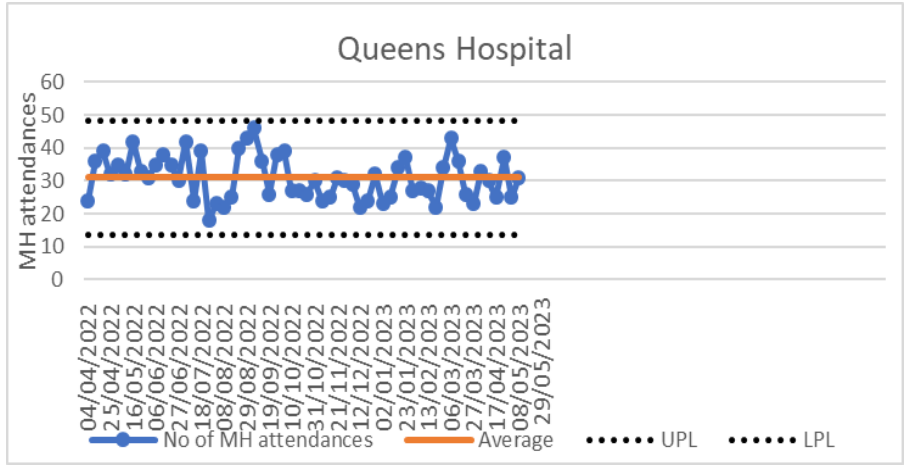
NELFT has been achieving the 70% standard rather has been exceeding consistently.

Mental Health attendances in ED

Data source – ECDS

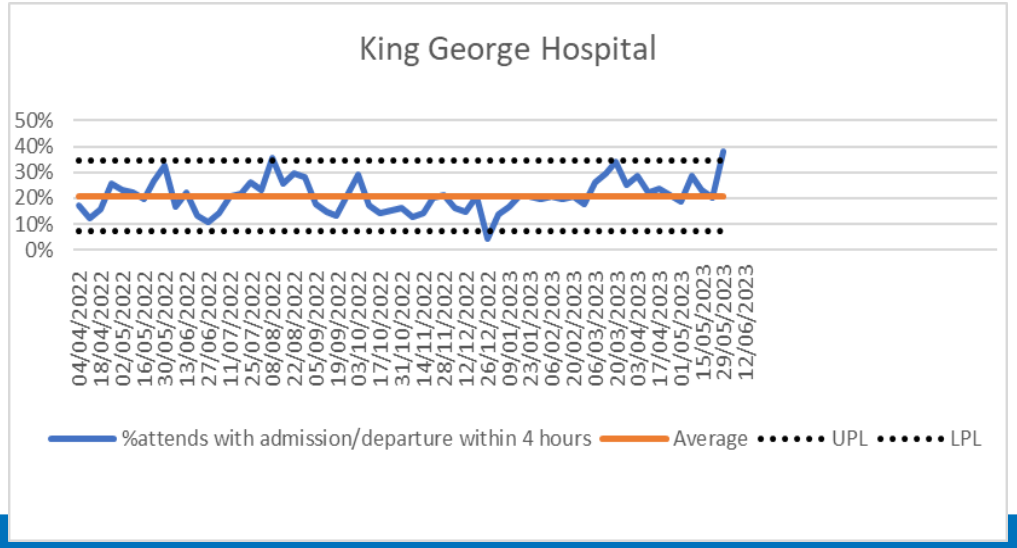
Mental health attendances in ED

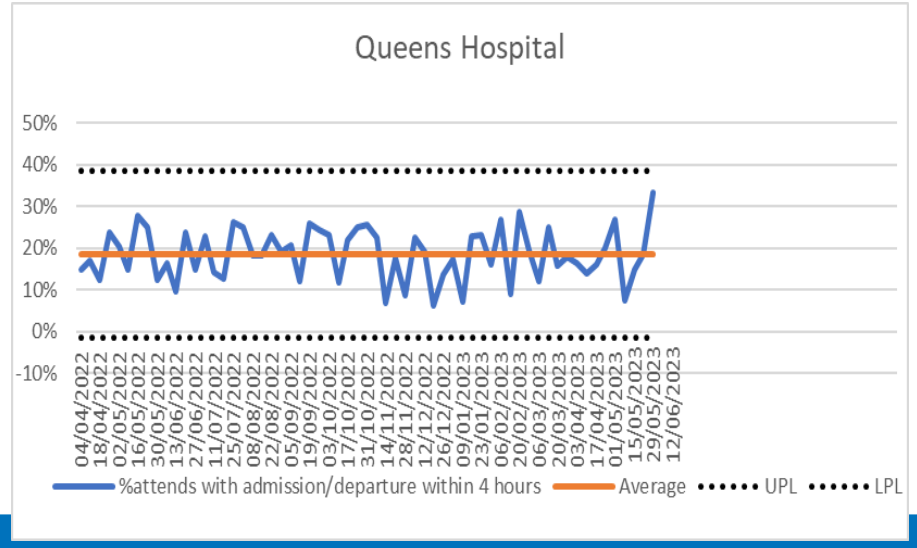




The charts on the left shows the number of attendances related to Mental Health.

Mental Health attendances – 4 hour waits





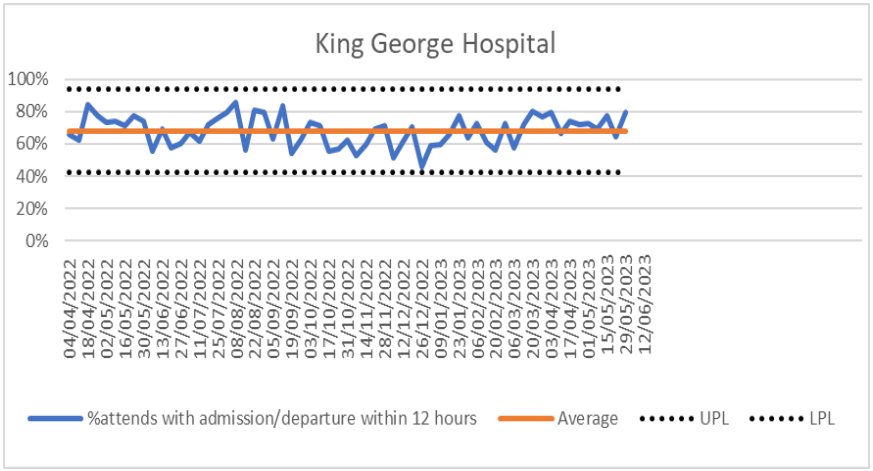
The charts on the left shows the % of attendances that waited less than 4 hours from arrival to departure.

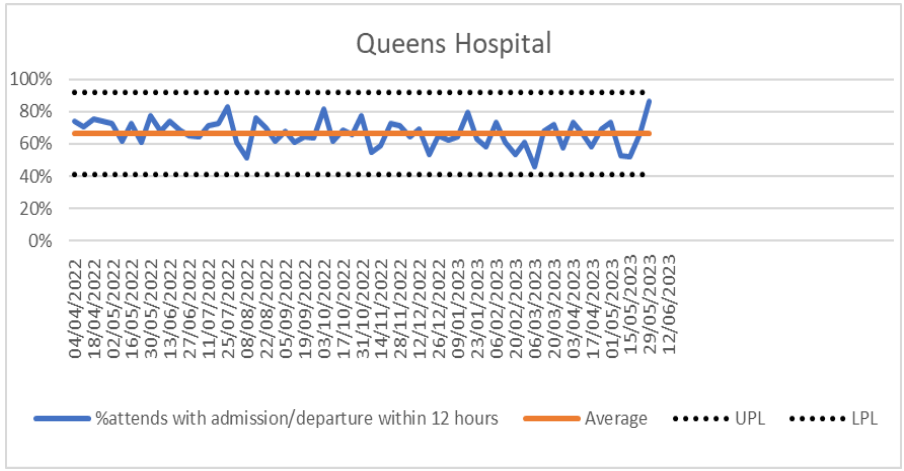
Improvement reported in both King Georges and Queens Site.

Mental Health attendances 12 hour waits and referrals to Crisis teams

Mental Health – 12 hour waits

Data source – ECDS



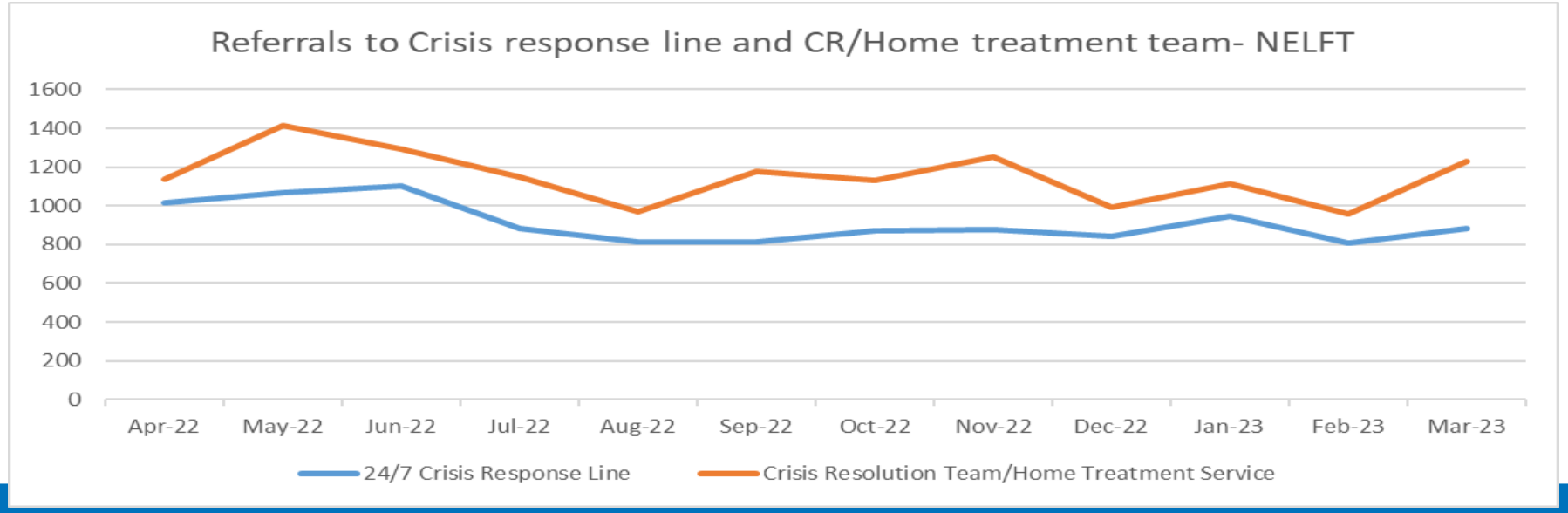


The charts on the left shows the % of attendances that waited less than 12 hours from arrival to departure from A&E.

Improvement reported in both King Georges and Queens Site.

Mental Health – Referrals to 24/7 Crisis team and Crisis resolution/Home treatment team

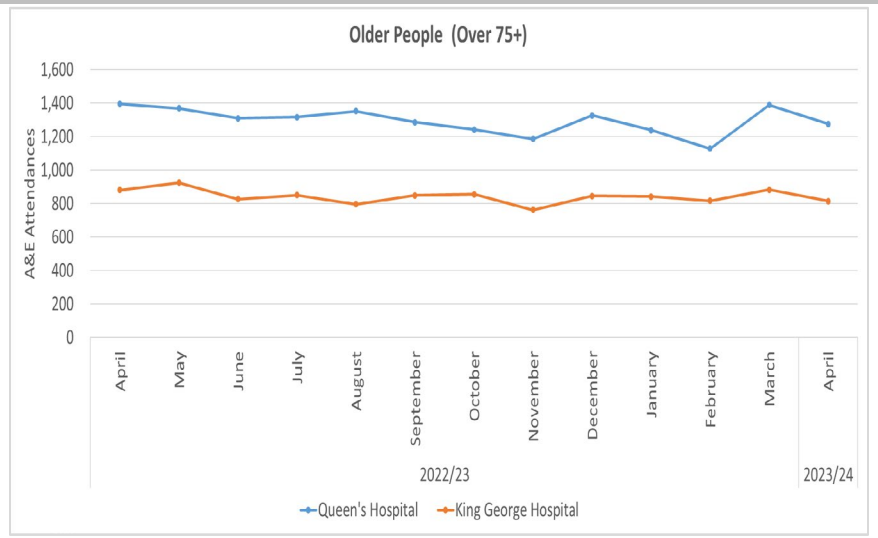
Data source – UEC MH Dashboard Tableau Server (England.NHS.UK)

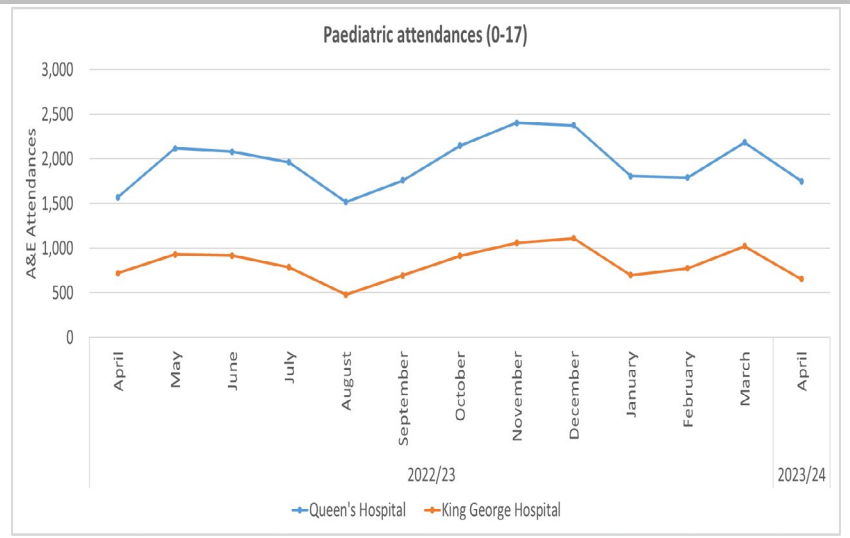


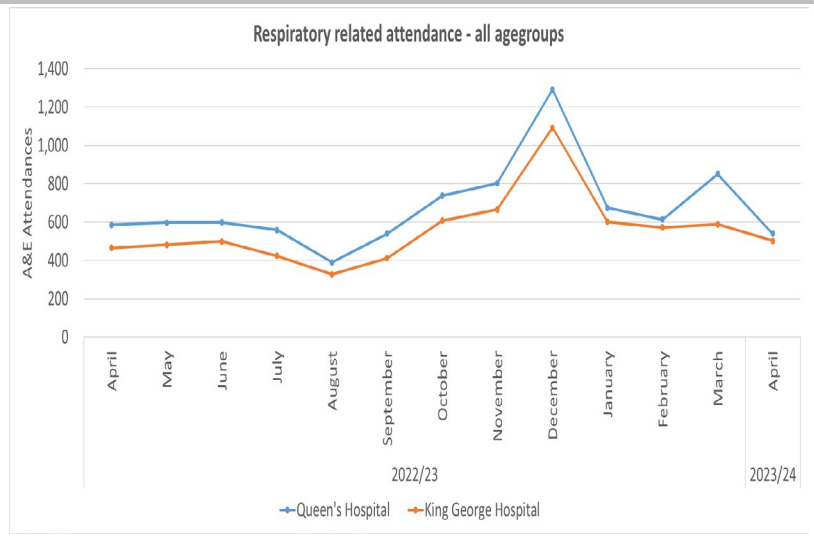
The charts on the left referrals to NELFT Services 24/7 Crisis team and Crisis resolution/ home treatment team.

Attendances – 75+ age group , Children (0-17)and people with respiratory conditions (all ages)

Data source – ECDS







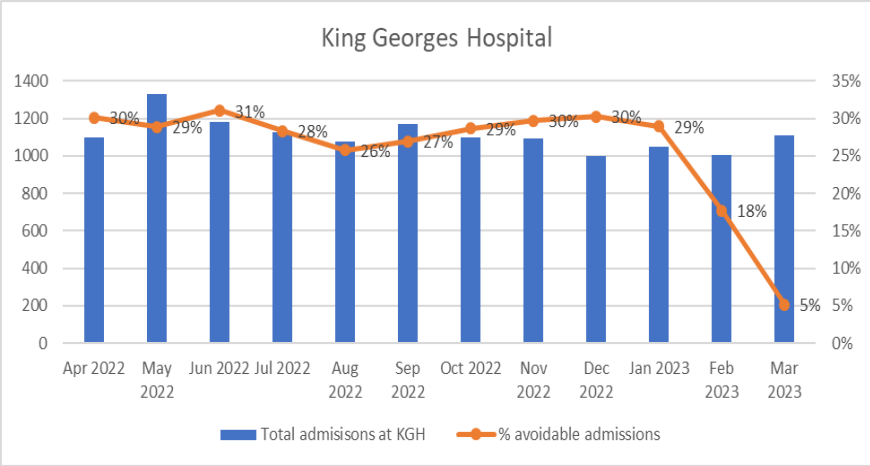
The charts on the above shows the A&E attendances for Over 75 age group, Children(0-17 age group) and those with respiratory related conditions.

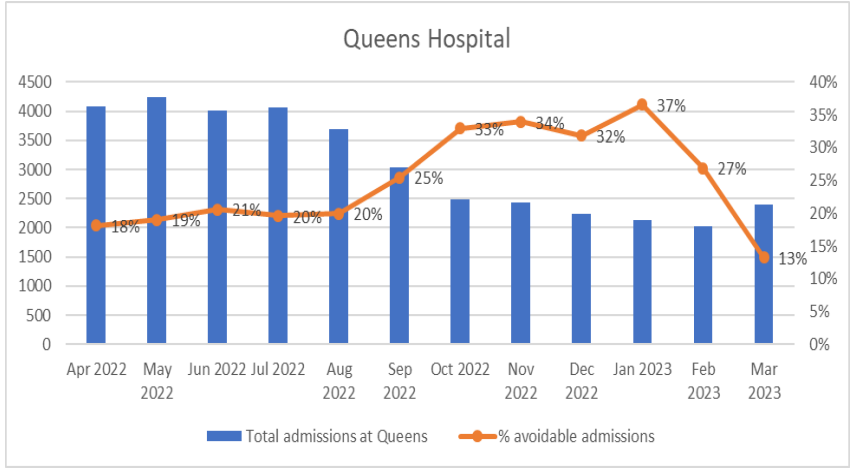
Older people (75+)- Data for 2022-23 shows that on an average there were over 2139 attendances per month across BHRUT sites.
Children (0-17) – Data for 2022-23 shows that on an average there were over 2600 attendances per month.
Respiratory related attendances- Data for 2022-23 shows that on an average there were circa 1248 attendances per month.

Avoidable admissions

Data source – SUS Data

Avoidable admissions as a % of total admissions





The charts on the left shows the avoidable admissions as a % of total admissions.

Reduction in avoidable admissions at both King Georges and KGH sites and this could be attributed to the various initiatives and transformation schemes.

The below table provide information on what has been considered as avoidable admission

Four indicators of avoidable admissions

In people of all ages:	In children and young people (0-18)
Emergency admissions for conditions not usually requiring hospital treatment (NHSOF: 2.3.i) Acute conditions such as ear/nose/throat infections, kidney/urinary tract infections and angina, among others, - *? Potential for management in primary care or outside of hospital*	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHSOF: 2.3.ii) Indicator measures how many young people (0-18) who have asthma, diabetes or epilepsy are admitted to hospital in an emergency. conditions are included in national indicator as they account for around 94% of admissions for children with LTC's conditions.
Unplanned hospitalisations for chronic ambulatory care sensitive conditions (NHSOF: 3a) Includes admissions for specific long-term conditions, which should not normally require hospitalisation, e.g. diabetes, epilepsy and high blood pressure. - *Assertion that optimum management can be achieved in the community (NHSOF)*	Emergency admissions for children with lower respiratory tract infections (NHSOF: 3.2) Indicator measures the number of emergency admissions to hospital of children (0-18 years) with selected types of lower respiratory tract infections (bronchiolitis, bronchopneumonia and pneumonia). ? Potential for avoidance of admission by some management in primary care or outside of hospital

* An ***Avoidable admission*** is one where there was scope for earlier, or different, action to prevent an individual's health deteriorating to the extent where hospital care is required.
It is NOT identifying any admission to be inappropriate. It is intended to identify only those where, if optimal primary and community care system were in place and proactive self-care supported, the exacerbation or infection may not have occurred.

Same day Urgent access

Data source

Published data is at ICB level does not provide break down at Place/Sub-system level, this is work in progress and important to the approach being adopted.

Electives- PTL size

Data source – National waiting list MDS data

PTL Size - 1st week of the Month

Year								2022					2023
Month	May	June	July	August	September	October	November	December	January	February	March	April	May
Provider Grouped	1	5	3	7	4	2	6	4	1	5	5	2	7
BHRUT	4,866	4,915	4,901	4,814	4,780	4,433	4,023	3,651	3,562	3,438	3,449	3,446	3,284

The chart on the left shows the trend of PTL size at the first week of the month in BHRUT.

Based on the data available there are 3284 patients on the list.

System Overview: Resident insight

Whilst quantitative data and analysis on performance is fundamental, to our Plan and areas of focus, we are also driven to improve by the experience of local people who need access to urgent and emergency care. Our overarching purpose as an ICS is to work with and for the people of north east London to improve their health and wellbeing and their insights are therefore critical to our improvement approach.

We have commissioned our 8 HealthWatches across north east London to work with local people to gain their insights into a range of areas, most relevantly here primary care access and urgent and emergency care. The HealthWatches have also been commissioned by the LAS to focus on their activity and its interaction with other parts of the urgent and emergency care system. This rich set of insights provides a backdrop to the work that we are doing to improve their experience and outcomes and sits in an accessible Community Insights System which we can use to test improvements and feedback. We also know from wider engagement through Place Partnerships, Scrutiny Committees, Health and Wellbeing Boards and JHOSCs for example that access is the single most frequently highlighted issue, often to same day primary care.

Working with local people is a clear part of our approach as many of the solutions to the challenges we face can be co-designed and co-produced, based on a shared understanding of the issues. We are currently engaging in the Big Conversation across north east London which continues to generate insights into what will work best from a resident perspective and where they see their priorities lying.

UEC improvement plan: Making a difference – outcomes

The Improvement Plan pulls together a number of contributing plans in order to demonstrate how we as a system are working strategically and operationally to improve our performance against key critical metrics, set out on the next slide. These metrics show how we as a system will achieve the following overarching outcomes, which have already been agreed across north east London:

1. Helping people stay well, independent and healthy, preventing them needing acute levels of care as far as possible;
2. Ensuring that we are planning for and delivering the capacity we need for those who do need it;
3. Ensuring that people can access the right care at the right time, and which prevents them from becoming more unwell whilst they are waiting;
4. When a resident has been admitted to hospital, ensuring that we have the right plans and support in place that they can move to a less acute setting and regain their independence as quickly as possible.

The contributing actions are fully meshed into a detailed project level action Plan, sitting behind this more strategic Improvement Plan. The more detailed plans include the UEC Improvement Plan for BHRUT, which incorporates the responses to the CQC findings and recommendations; PELC CQC Action Plan; NELFT's UEC Action Plan focusing on 4 workstreams.; (further contributing plans to be identified e.g. Primary Care, Mental Health, other Collaborative Plans). Together these Plans form the Improvement Plan.
The Improvement Plan sets out how we as a system will work to deliver improvements through a number of workstreams, each of which will in effect operate across three phases: issues to be addressed by winter; medium term issues which require a system response; longer term issues. Action on all three need to happen in parallel to avoid a single focus on the immediate and crisis actions, rather than the longer term and more preventative actions.

UEC improvement plan: Making a difference

The Improvement Plan sets out how we as a system will work to deliver improvements across urgent and emergency care measured through the following metrics, some of which are still in development and all of which are being monitored at regional and national level as well:

- People able to access same day urgent care through primary care (including pharmacy)
- Reduction in percentage of people with avoidable admissions
    - Emergency admissions for conditions not usually requiring hospital treatment (NHSOF: 2.3.i); Unplanned hospitalisations for chronic ambulatory care sensitive conditions (NHSOF: 3a); Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHSOF: 2.3.ii); Emergency admissions for children with lower respiratory tract infections (NHSOF: 3.2)
- Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25 and monitoring of time spent in A&E, including 12 hour waits from time of arrival
- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.
- Ambulance handovers 85% within 30 minutes
- Discharge of those patients who do not meet the criteria to reside
- Improvement in experience of local people in staying well and accessing urgent and emergency care

BHR Places UEC Improvement Plan: Workstreams

From analysing the data, reflecting on the insights of local people and responding to the recent Care Quality Commission (CQC) inspections carried out in this area of activity, we have identified six workstreams which we believe will have the most impact and in a timely way on the local resident experience, the activity and performance and the high level outcomes we have agreed for this Plan. They span a range of actions across a range of partners and sectors, are often interdependent and require active work to deliver maximum impact. Each is being considered from an immediate, medium and long term perspective. They are:

- Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions
- Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home
- Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible
- Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem
- Ensuring focus on children and young people – to reflect the local demography and respond sustainably to need
- Communicating and engaging – to engage with local populations to change behaviour and embed understanding

Three infrastructure workstreams are being led across north east London and support this work:

- Building effective data and digital resources
- Growing a sustainable workforce
- Supporting 999 and 111

As set out in the Introduction, the plan is structured to identify the workstreams which will have most impact on the performance of our system and the experience of our residents with the workstreams broken down into clusters of actions which need to be taken in the immediate, medium and longer term. The Plan is structured with more focus on the actions for the immediate horizon, to affect the performance and delivery of urgent and emergency care over winter, with the medium and long term issues set out at a high level and being worked up in more detail.

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Outcome 1: Our residents will be supported to stay well at home and in their communities during winter and for the longer term, increasing healthy life years.

A key area of focus is keeping people well at home. We know that good, joined up community services (delivered by a range of partners across health, social care and the voluntary and community sector) can support people to stay well for longer, receiving care closer to home and staying living well with a range of conditions and importantly we know that wherever possible people want to be at home, whether that for them is living independently in the community or in a care setting such as residential care. Community health services, including therapy services, help keep people well at home and in community settings close to home, and support people to live independently. When community services are delivered in combination with personalised care, they can reduce pressures on hospitals and emergency services by supporting people at home and in the community, as well as provide them with greater choice and control, leading to improved experience and outcomes.

Falls are the number one single reason why older people are taken to the emergency department, and around 30% of people 65 and over will fall at some point.

Care outside hospital is of particular importance for older people living with frailty, who are much more likely than younger people to be admitted to hospital, and likely to have a longer stay when they are admitted. Through better joint working and sharing of information between services we can help improve care for people who fall or are living with frailty.

Continued focus on mental health crisis prevention and a joined-up community response will ensure people are accessing the best service for their needs in a timely way, reducing avoidable admissions to hospital. Making use of new technology and better collaboration, including between ambulance services and community care, enables care that would often currently be delivered in a hospital to be delivered closer to people's homes.

For us, this workstream is fundamental to addressing need and reducing demand on our UEC system. It focuses on those cohorts most likely to attend ED or to be admitted in a crisis. This helps enable a more efficient system with better hospital flow and outcomes for local people.

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Outcome 1: Our residents will be supported to stay well at home and in their communities during winter and for the longer term, increasing healthy life years.

Objectives include:

- Improve quality of life and ageing well
- Increase support for carers and community support
- reduce the demand for unplanned care
- Increase take up of vaccinations and other health protection measures
- Support the sustainability of community-based care including care providers
- Build community resilience
- Improve support for MH crisis in the community

Contributes to Metrics:

- Preferred place of death for EOL
- Avoidable admissions
- Reduction on ambulance conveyances/ ED attendances/ admissions – including breakdown from care homes
- Vaccination rates
- Reduction in attendance and admissions for falls

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Deliver consistent enhanced health offer into care homes

Rationale: High number of care homes for older people across BHR including residential and nursing provision with variation in in blue light conveyancing, primary care and nursing cover and ability to keep people well in their home

Aims:

- To reduce level of blue light conveyancing by reducing risk of people becoming unwell and requiring urgent assistance
- To target those care homes with highest rates of blue light conveyances through skills development and quality improvement
- To support care homes to deliver a reablement approach to keep older people as active and well as possible

Milestones:

- Data analysis and engagement with care homes with high ED usage completed by end July 2023
- Programme of work in each targeted Care home in place by end August 2023, to include work with residents and families tested by data analysis every month

Target:

- All care homes to achieve best in class (residential, nursing, residential with dementia, nursing with dementia) by end September 2023

Facilitate easy access to vaccinations and screening

Rationale: Frailty and respiratory are the key drivers for ED attendance and admission and are those conditions for which vaccinations offer greatest benefit

Aims:

- To protect people from infection and to identify need early
- To target cohorts most at risk of ED attendance or admission

Milestones:

- Resourcing plan for flu and covid top up vaccinations in place by x

Target:

- Xx % of all older people and vulnerable cohorts to be vaccinated by October 2023

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Mobilise falls service for all of BHR

Rationale: falls is highest risk factor for ED attendances and admissions for frail older people, with use of falls service reducing risk

Aims:

- To reduce pressure on EDs by reducing falls in key cohorts through preventative action
- To expand falls services so that it is accessible to all older people across and has capacity to respond in a timely and proactive way to individuals requiring a service

Milestones:

- Model agreed and being implemented by end July 2023
- KPIs and capacity agreed by end July 2023
- Recruitment underway and complete by end September 2023

Target:

- Xx% of older people at risk of falls to be seen by a falls service

Ensure network of social prescribers, community connectors and local area co-ordinators work well together

Rationale: social isolation has a significant impact on physical health and increases attendance at ED

Aims:

- To provide early intervention and prevention, to reduce social isolation and to reduce impact on clinical and care services
- To reduce fragmentation and create a coherent network of early intervention

Milestones:

- Community of practice established in each Place by end September 2023
- Clear referral and introduction pathways in place by end October 2023

Target:

- Xxx% of vulnerable people able to access early intervention in the community without direct referral to clinical or care services

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Roll out Minor Ailments Service across north east London

Rationale: the cost of living crisis is driving people to attend primary care when their needs could be met elsewhere with the right support, this is particularly acute in our most deprived Places including B&D and Havering

Aims:

- To respond to the acute shock of the cost of living crisis and reduce unnecessary demand on primary care by targeting those households least able to afford over the counter solutions for common ailments
- To support primary care to keep people well by focusing activity on pharmacies and building awareness of wider community pharmacy offer

Milestones:

- Funding agreed by end July 2023 with plan for implementation
- Rollout during August – September 2023

Target:

- Coverage and promotion across north east London

Develop community catheter service

Rationale: alongside falls, catheter issues are a key driver of ambulance conveyances and admissions for frail elders

Aims:

- to reduce conveyancing and pressure on ED attendance
- To build skills in community provision

Milestones:

- to reduce conveyancing and pressure on ED attendance
- To build skills in community provision

Target:

- x

Workstream 1: Keeping People well at home – to address need in the local population and seek to prevent the exacerbation of conditions

Medium term

- **Develop and respond to NEL Wide Demand and capacity Plan across social care services to build market resilience, develop skills and grow relationships with the social care sector**
  - To ensure the robustness of the social care market across north east London, with a particular focus on Outer boroughs
- **Develop and respond to Demand and capacity Plan across community services to ensure consistent community services offer**
  - To ensure all residents have access to a consistent core community services offer
- **Review availability of Community equipment needed for winter**
  - To ensure people have timely access to community equipment whether living at home or in hospital
- **Support people waiting for elective interventions** (planned care)

Longer term

- **Implement Continuity of Care workstream in each Place – Fuller**
  - To reduce pressure for people with long term conditions and keep people well at home
- **Grow capability in primary care**
  - To build the right capacity to meet needs
- **To ensure joined up provision across primary care**
  - To join up capacity and resources across GPs, nursing, pharmacy, ARRS, etc.
- **Supporting people waiting for elective interventions**

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Outcome 2: Our residents will be supported in crisis to avoid attendance at ED and to prevent an attendance becoming an admittance to hospital or long-term bed-based care.

Objectives include:

- Reduce demand at the front door of ED and waiting times
- Reduce the growth in demand for institutional care in the longer term
- Increase quality of life and wellbeing during crisis
- Increase support carers and community support

Analysis has been undertaken to understand what is the variation in avoidable admissions across NEL and if there are opportunities to reduce this variation with the aim of *Keeping people well at* home. Analysis was done to understand this variation and to explore what may be driving these and looks at heterogeneity in social demographic factors and underlying health status and also proximity to an acute site. We also look at trends in admission rates by place using nationally published data from the NHS outcomes framework.

Our analysis shows there is considerable variation in the volume of avoidable admissions by site with this type of admission being nearly three times as common at Queen's Hospital than it is at the Royal London. This variation in volume plays out when we create age-standardised rates by GP practice and further when we view rates by GP practice in funnel plots to differentiate what may be random variation from what is non-random. In this analysis, we see noticeable clustering of these rates by place with, in particular, Tower Hamlets showing many practices as having low outlying rates. In contrast Barking & Dagenham and Havering in particular have a higher number of practices where rates are high outliers.

The analysis of proximity to an acute hospital site shows that this is not a factor in accounting for high rates, there is instead a weak inverse relationship between travel time and avoidable admission rates. There has been significant progress in building SDEC capability at KGH which is now operational and also focused collaborative work across BHRUT and PELC to improve the front door experience and flow which we believe are already having a positive impact for residents and the workforce.

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Safeguard and sustain primary care capacity currently delivered through the five GP Access Hubs (over 100,000 appointments per year)

Rationale: access demands met in primary care are better co-ordinated with wider care plans, ensure EDs focus on those in crisis and who are most unwell and improve resident experience as well as being more cost effective overall

Aims:

- to reduce risk of further pressure on UTCs and EDs over the winter months
- To build sustainable capacity through Primary Care Networks to prepare for Fuller

Milestones:

- Model agreed by end June 2023
- Contracting and sub-contracting in place by September 2023

Target:

- To ensure x % additional primary care capacity from September 2023 as compared with March 2023

Improve primary care capability

Rationale: responding to more complex presentations in primary care will reduce demand at the front door of ED, build continuity of care and ensure a more robust response to long term conditions, which have been under-resourced in primary care in outer NEL

- **Aims:**
- To strengthen primary care capability in outer NEL
- To make outer NEL a more attractive place to work improving recruitment and retention

Milestones:

- To strengthen primary care capability in outer NEL
- To make outer NEL a more attractive place to work improving recruitment and retention

Target:

- Continuity of care targets
- Complexity of cases

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Deliver a targeted improvement offer to primary care

Rationale: a small number of practices are associated with higher rates of avoidable admissions and targeted improvement work with those practices will improve rates of avoidable admissions

Aims:

- To reduce rate of avoidable admissions to QH and KGH
- To build sustainable capacity through Primary Care Networks to prepare for Fuller

Milestones:

- Improvement offer in place Summer 2023 2023
- Changes implemented in response to improvement offer by September 2023

Target:

- To bring avoidable admissions for QH and KGH in line with the rest of north east London

Increase the number of patients, requiring IV, who are safely managed in the community

Rationale: increasing IV antibiotics administration in the community will improve patient experience and reduce demand for hospital based services

- **Aims:**
- To strengthen primary care capability in outer NEL
- To make outer NEL a more attractive place to work improving recruitment and retention

Milestones:

- To agree community model and plan by end August 2023
- To implement new model by Autumn 2023

Target:

- To bring avoidable admissions for QH and KGH in line with the rest of north east London
- To reduce demand on the front door

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Extend REACH equitably across BHR

Rationale: supporting people to stay at home reduces demand at the front door and improves their outcomes and experience

Aims:

- To respond to people in their own homes and reduce activity at the front door of ED

Milestones:

- Fully staffed model in place from end July 2023
- Evaluation of model after 6 months of full operation

Target:

- Contributes to 76% target by depressing demand at the front door

Review Urgent Treatment Centre model

Rationale: to understand the efficacy of our current model and to build capacity and capability for the future

Aims:

- To build sustainability for the future as demand changes over time

Milestones:

- Lead appointed June 2023
- Intensive review work underway to complete review with proposals by end July 2023
- Agreement on next steps by September 2023 with any quick wins in place by start November 2023

Target:

- UTC performance to reach 98% target consistently throughout review and remodelling period

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Deliver PELC CQC and wider improvement actions, including plan to meet 98% 4 hour target

Rationale: As the front door to BHRUT, PELC is a vital partner and contributor to overall performance and experience across the hospital footprint

Aims:

- To ensure demand and capacity in UTC over winter are understood and acted on
- To increase community confidence in use of UTC

Milestones:

- Respond to all CQC recommendations and findings as part of a quality improvement approach within agreed timeframes
- Ensure demand and capacity in UTC over winter are understood and acted on
- Increase community confidence in use of UTC

Target:

- Performance to shift to 98% 4 hour waits by xx date to contribute to overall 76% target for the sites

Collaborative working on front door model between PELC/ BHRUT

Rationale: To improve flow and patient experience

Aims:

- To streamline activity and flow at the front door of ED improving resident experience and outcomes

Milestones:

- As above
- SDEC fully operational at KGH site by mid July 2023, building to full capacity by end August 2023
- Paediatrics pathway road testing from mid-June 2023, roll out from mid July if successful

Target:

- 76% 4 hour waits by xxx date

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Better understand demand and connect capacity across the system

Rationale: better use of alternative care pathways and visibility on their capacity will reduce demand at the front door

Aims:

- To integrate the models of community capacity better into wider system working on UEC

Milestones/Areas of activity

- Work proactively with people on the elective waiting lists (Planned Care lead)
- Monitor utilisation of UCR cars and PRU, maintaining delivery on 2 hour target, reviewing utilisation of new capacity
- Review HALO provision and update service specification
- Monitor impact of reducing conveyance and increased use of ACPs
- Extend and evaluate pilot of social workers in acute frailty units to increase early identification of people's need
- Deliver consistent speciality advice to GPs, confirming and promoting contacts and pathways
- Monitor people using ED frequently

Respond to high intensity users of ED

Rationale: better co-ordination and support of high intensity users will reduce levels of activity and reduce demand at the front door

Aims:

- To develop and implement a service to proactively manage the cohort of patients frequently attending the Emergency Department.

Milestones/Areas of activity

- Agree model by end July 2023
- Agree funding by end August 2023
- Monitor people using ED frequently

Targets:

- Number of reduced emergency admissions to hospital and reduction in A&E attendances

Workstream 2: Reducing avoidable admissions – to increase same day access and to care for people in the right place and where possible at home

Medium term

- Review and deliver Better Care Fund schemes with evaluation and impact
    - To ensure we are using funding appropriately to reduce admissions and support people to be discharged well
- Respond to review of UTCs in full
- Develop community led models of virtual ward to sit alongside acute led models
    - To ensure join up of urgent and emergency provision, community beds and care capacity to avoid admissions and to enable discharge
- Deliver Long Term Conditions LES
    - To build Fuller capacity for continuity of care across primary care

Longer term

- Implement Fuller incorporating same day urgent access model across primary care, UTCs etc.
    - To have a coherent and consistent model in place

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Outcome 4: When a resident has been admitted to hospital, ensuring that we have the right plans and support in place that they can move to a less acute setting and regain their independence as quickly as possible.

We know from local from people who use urgent and emergency care, and the national UEC recovery plan how important it is to have a smooth experience in hospital, and not to experience too many unnecessary delays, especially where it is not clear why.

The national plans sets out how the NHS will use existing capacity as effectively as possible by standardising processes so that patients get the right care at the right time, including when moving between organisations. There will be a focus on reducing variation in care when patients arrive at A&E, ensuring greater consistency in direct referrals to specialist care, and access to same day emergency care (SDEC) so people avoid unnecessary overnight stays. There will also be a more standardised approach to the first 72 hours in hospital so that people are assessed, get any required scans, and start their treatment as soon as possible.

Locally, we are focusing on work across our UTC and BHRUT, with a focus on improving flow, responding better to need and reducing waits. We are building SDEC capacity and capability now with immediate benefits for local people and the system overall. We are focusing on pathways to ensure those who are most ill are seen as soon as possible freeing up other frontline staff to respond to incoming demand.

We are also continuing to build and make effective use of our system control centre (SCC) using data to respond to emerging challenges and bring together experts from across the system to make better, real-time decisions. They will help us to ensure the highest quality of care possible for the population in every area by balancing the clinical risk within and across acute, community, mental health, primary care, and social care services. For us locally, we are focusing on the following actions over the winter, in the medium term and over the longer term too.

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Outcome 4: When a resident has been admitted to hospital, ensuring that we have the right plans and support in place that they can move to a less acute setting and regain their independence as quickly as possible.

We have worked to improve our discharge processes both through the hospital sites using initiatives such as Operation Snowball and through the Integrated Discharge Hub with partners across the system. As well as a north east London focus on discharge we have a BHR Discharge Working Group which responds both strategically and operationally to issues as they arise. With partners across north east London we have embarked on a Care Market Review to understand better the capacity we have across need cohorts in social care, to identify gaps and to build the appropriate capacity in light of demand for the future. This is a large scale piece of work, hosted by a partner local authority, with full support across north east London, including Continuing Health Care, which we believe will assist not only to effect timely discharge but to keep people well at home too.

Objectives include:

- Improve quality of life and ageing well
- Improve speed and quality of discharge
- reduce admissions to long term care
- Improve hospital bed utilisation

Contributes to Metrics:

- Reducing number of patients in beds not meeting criteria to reside
- Reduce 14 and 21 day LOS in beds

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

BHRUT deliver CQC actions and operating plan targets for ambulance turnaround times

Rationale: Ambulance handover times are consistently longer than the rest of London due to the level of pressure being experienced in ED with consequences for ambulance call responsiveness and access to emergency care in BHRUT

Aims:

- To achieve parity with London on ambulance handovers
- To improve the experience for residents of blue light conveyancing

Milestones:

- Improved access to CADO within the department and processes to enable earlier patient handover (releasing crews) by September 2023
- Enable earlier clinical review including working with LAS to improve crew pin off by September 2023

Target:

- Contributes to 30 minute handover targets

Implement virtual wards for both frailty and ARI (recognition that this will have impact across workstreams)

Rationale: supporting people in the community with frailty and respiratory (the key drivers of need and demand into Queen's and KGH) will reduce length of stay, improve reablement potential and free up hospital capacity sooner

Aims:

- Increase capacity for patients to be managed safely in the community and avoid admission as well as being discharged sooner
- To co-ordinate activity across secondary, primary, community and social care

Milestones:

- Frailty virtual ward to open in July, increasing capacity to 45 over first year – focus on referrals from KGH and QH before community step- up referrals possible
- Respiratory virtual ward to open in September, 15 beds in first year – focus on referrals from KGH and QH before community step-up referrals possible
- Paediatrics virtual ward to open by October 2023

Target:

- 100% capacity

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Deliver PELC CQC and wider improvement actions, including plan to meet 98% 4 hour target

Rationale: As the front door to BHRUT, PELC is a vital partner and contributor to overall performance and experience across the hospital footprint

Aims:

- To ensure demand and capacity in UTC over winter are understood and acted on
- To increase community confidence in use of UTC

Milestones:

- Respond to all CQC recommendations and findings as part of a quality improvement approach within agreed timeframes
- Revised Paediatrics pathway road testing from mid-June 2023, roll out from mid July if successful
- Streaming move – pilot in place from mid-July 2023
- Minor/moderate injuries pathway – new model in place by mid-September 2023

Target:

- Performance to shift to 98% 4 hour waits by March 2024 to contribute to overall 76% target for the sites

Establish and grow SDEC capacity at KGH and QH

Rationale: To improve flow and patient experience

Aims:

- To streamline activity and flow at the front door of ED improving resident experience and outcomes

Milestones:

- SDEC fully operational 24/7 at KGH site by mid July 2023, building to full capacity by end August 2023
- Expanded capacity on QH site operational 24/7

Target:

- Contributes to 76% 4 hour waits

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Implement Welfare Checks pilot in Redbridge

Rationale: post-discharge readmissions are distressing and disorienting for older people and families and may be avoided by ensuring earlier identification of deterioration in the community

Aims:

- To reduce risk of readmission

Milestones

- Engagement with PCNs by end June 2023
- Training in place for co-ordinators by end July 2023
- Start of pilot July 2023 – pilot completes end October 2023 with evaluation and possibility to extend/expand

Targets:

- Reduction in rate of readmissions for over 75s in Redbridge

Increase reablement capacity across the BHR Places

Rationale: enabling people to regain their pre-hospital admission mobility and independence reduces dependence on care services and improves quality of life and wellbeing

Aims:

- To increase reablement activity and effectiveness

Milestones:

- Funding secured through BCF submissions for BHR Places end June 2023
- Recruitment of additional workforce and induction to processes

Target:

- Reduction in rate of readmissions and in care services over time

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Improve discharge lounge

Rationale: enabling discharges to take place earlier in the day both improves the experience for patients and their carers and makes best use of capacity in the hospital

Aims:

- To enable discharge earlier in the day from wards and to improve hospital flow

Milestones:

- New expanded criteria for discharge lounges in place from September 2023
- Improved environment in discharge lounges by September 2023

Targets:

- Increase in number of early day discharges and overall flow

Review and increase Intensive Rehabilitation Support in the community

Rationale: ensuring appropriate capacity to maximise discharge from hospital and support rehab in the community enabling people to regain their pre-hospital admission mobility and independence reduces dependence on care services and improves quality of life and wellbeing

Aims:

- To increase individuals' mobility, activity and independence

Milestones:

- Capacity and funding requirements agreed by end July 2023
- Plan for meeting capacity and funding requirements in place to enable implementation from Autumn 2023
- Improved pathway processes in place by Autumn 2023 to improve take up and usage

Target:

- Reduction in rate of readmissions and in care services over time

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Review Integrated Discharge Hub operations, including Trusted Assessor models

Rationale: Improved co-ordination of discharges will assist hospital flow and improve the patient experience

Aims:

- **T**o build equity across north east London and to reduce the numbers of people with no criteria to reside continuing to stay in hospital
- To ensure models and pathways meet the needs of all patients including those with a complex history of homelessness

Milestones:

- Review of model and new specification completed by end August 2023
- Change champions identified by end August 2023
- Improved processes in place by Autumn 2023

Targets:

- Contributes to reduction in numbers of people with no criteria to reside and improve patient experience

Develop and implement discharge to assess home for more patients

Rationale: supporting people to regain independence and to stay at home reduces reliance on long term care and improves wellbeing and quality of life

Aims:

- To increase individuals' mobility, activity and independence

Milestones:

- Review current pathways by July 2023
- Review best practice models and financials by end August 2023
- Agree improvement priorities and implement by Autumn 2023

Target:

- Reduction in long term care placements

Workstream 3: Improving in-hospital flow and discharge – to reduce length of stay and get people active and independent as early as possible

Medium term

- **Develop and respond to Demand and Capacity Plan for care across north east London**
  - To ensure we have an overview of need and gaps in care provision to plan better for the future
  - To ensure we have the right provision, in the right area, at the right capacity
  - To include reablement, intermediate care as well as care homes
- **Evaluate impact of Operation Snowball**
  - To ensure it is effective, sustainable and promotes patient wellbeing
- **Reconfigure ED and UTC spaces given relocation of renal unit and Rom Valley Gardens development to St George's 2024**
  - To improve UEC hospital flow

Longer term

- **Build community Stroke and Neuro rehab, implementing business case**
  - To enhance community rehab for people with complex needs to enable timely discharge and support in the community

Workstream 4: Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem

Outcome 3: Ensuring that people can access the right care at the right time, and which prevents them from becoming more unwell whilst they are waiting

It is critically important to us that our urgent and emergency pathways and responses work well for people who are experiencing poor mental health and are entering a period of crisis as well as for those with a physical health need. We know that people attending ED in mental health crisis may also have physical health issues which may also need a response but it is critical that we reduce the incidences of people with mental health needs in ED waiting for mental health support and a mental health bed.

Our local plans reflect the range of work underway in the area to reduce ED attendances, to support people to stay well, to move people to appropriate provision at the earliest opportunity and to ensure that where delays do occur, people continue to be supported by people who can best respond to their needs.

We are ensuring a focus across each of our workstreams in effect for people with mental health needs, with specific targets to reduce lengths of stay in EDs for people with mental health needs. For us locally, we are focusing on the following actions over the winter, in the medium term and over the longer term too.

Outcome metrics:

- Length of stay for people with mental health needs in ED
- Numbers of people with no criteria to reside in MH beds

Workstream 4: Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem

Improve crisis support and diversion, including building capacity and focusing existing work on diversion working across acute and secondary care with LAS, Met Police, Primary care and local authorities

Rationale: People with mental health needs nearing crisis need specialist support in a timely and effective way, ideally in a community setting

Aims:

- To reduce numbers of people attending ED in acute mental health need/crisis
- To enhance partnership working in this space
- To increase use by LAS of alternative care provision for MH

Milestones:

- Mental health partnership forums operational in each Place Partnership
- Information about alternative community options for local people and agencies
- Introduction of Crisis cafes across the BHR Places

Target:

- Reduction in numbers attending mental health in crisis

Improve processes at the front door to support people already in ED to receive timely care and support

Rationale: people with mental health needs in crisis need to be treated in a timely way to avoid further escalation of crisis and impact on other people using acute services

Aims:

- To ensure people with mental health needs get the right care at the right time
- To reduce impact for wider workforce of supporting people in mental health crisis without the specialist skills
- To improve quality and timeliness of data and escalation routes to support real time progress updates for all clinicians and ensure effective joint working

Milestones:

- New pathway in place
- Additional support

Target:

- Reduction of waiting times in ED for people in mental health crisis needing specialist support

Workstream 4: Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem

Increase bed capacity through ensuring access to Winter Surge Beds, delivering of new 12 bed ward and a renewed focus on discharge

Rationale: wherever possible we want to support people who need an in-patient stay to be local, connected to their family, friends and community

Aims:

- To ensure we have additional capacity and are improving flows, supporting people to receive the right care in the right place at the right time
- To ensure we have an appropriate balance of in-patient and community based offers

Milestones:

- Opening of additional capacity by September 2023
- Discharge flow improvements from October 2023

Target:

- Reduced length of waits
- Reduced occupancy on wards to improve flow

Increase clinical Decision Unit capacity

Rationale: focal point for clinical decision making can support the pathway to work effectively

Aims:

- **to** improve flow from A&E into MH setting, and reduce length of stay in ED for people in mental health crisis

Milestones:

- Currently 20 beds at Goodmayes Hospital, with consideration being given to further expansion by end August 2023

Targets:

- Maintain reduction in length of stay on CDU (Average LOS from Aug-Jan was 45 days, average LOS for Feb was 8 days).

Workstream 4: Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem

Improve flow in our MH UEC pathway

Rationale: flow through mental health interventions is important to enable patient recovery and support better outcomes, whilst making best use of resources

Aims:

- To develop partnership working by carrying out an audit across partners for 30 people who waited over 12hrs in each A&E in North East London
- To share back some of the findings of the Psychiatric Liaison Service review which has just got underway
- To provide some high-level teaching on theory of flow management
- To facilitate some site-specific theory-of-change work, and begin planning some tests of change for the next quarter

Milestones:

- Whole system UEC event focused on mental health mid-July 2023
- Key recommendations to be used across the partnership from September 2023

Targets:

- Reduction in waits in ED to meet 76% target

Workstream 4: Supporting mental health needs – to ensure the needs of people with mental ill-health receive parity of esteem

Medium term

- **Evaluate approach to crisis support and diversion, including with partners**
  - To reduce numbers of people attending ED in acute mental health need/crisis
  - To enhance partnership working in this space
- **Evaluate UTC MH streaming pilot and enhanced staffing to support in ED**
  - To support people already in ED to receive timely care and support
- **Embed CDU and reduce ED ALOS**
  - To support real time progress updates for all clinicians and ensure effective joint working

Longer term

- **Respond to findings of MH Demand and Capacity Plan across NEL for BHR, ensuring implementation to meet known gaps and capacity challenges**
  - To ensure equity and build capacity locally to reduce urgent and emergency pressures for individuals in crisis

Workstream 5: Ensuring focus on children and young people – to reflect the local demography and respond sustainably to need

Outcome 3: Ensuring that people can access the right care at the right time, and which prevents them from becoming more unwell whilst they are waiting

Babies, children and young people and their families need and use urgent and emergency care, and yet may not receive the focus required to ensure we as a system can meet their needs. As babies and children's health can deteriorate rapidly it is important that parents, carers and a wide range of practitioners and clinicians have confidence in our systems for early identification and follow through, with excellent support for parents and the broad front line workforce working with children and young people.

Children and young people's urgent and emergency care services have also faced unprecedented levels of demand, with CYP attendances peaking at 40% above pre-pandemic levels in December 2022, and as high as 60% above pre-pandemic levels for children aged 2-10. This has been particularly true for the BHRUT footprint, where demand over winter 2022/2023 and over early summer 2023 have been unprecedented.

The national plan set out specific interventions to improve urgent and emergency care for children and young people. It highlighted the need to ensure that services reflect the needs of different groups of people, including all age groups. It is crucial that implementation plans meet the specific needs of children and young people, parents/carers, and families. The most common conditions and symptoms experienced by children and young people presenting at ED are: • Fever • Respiratory: bronchiolitis; croup; asthma • Gastroenteritis • Abdominal pain

Many of these attendances could be managed effectively in primary care or community settings. Meta-analytic evidence suggests key reasons for parents attending emergency departments non-urgently include: parental worry, perceived advantages of paediatric ED, convenience and access, anticipated difficulty in accessing primary care, and the need for reassurance. Scaling up initiatives that provide additional support to children and families, improve flow, manage demand, and divert low-acuity CYP presentations to more appropriate care settings will be crucial to support children, their parents/carers, reduce pressure on ED, and increase capacity and operational resilience in urgent and emergency care. This is a core area of focus going forward to ensure sufficient capacity for paediatric responses and to improve the experience of babies, children, young people and their families.

Workstream 5: Ensuring focus on children and young people – to reflect the local demography and respond sustainably to need

Through our BCYP Programme across north east London, we have identified the following actions for urgent and emergency care. We have agreed a way of working to ensure focus on the specific needs of babies, children and young people. We recognise this as a key area of focus for this Improvement Plan – and whilst we have agreed to integrate responses for children and young people as appropriate (for example the changes to the paediatric pathways at the front door) we know that there needs to be a distinct focus for babies, children and young people in the same way as for people with mental health needs. Our main areas of focus are:

- Expand support and paediatric advice through NHS.UK, NHS111, and NHS111 online to support decision making and management of minor illness including information for Pharmacists and use of the 'What to do if your child is unwell' information for parents and carers

- Increase access to paediatric expertise through further roll out of NHS111 Paediatric Clinical Assessment Service

- Embed Family Support Workers across selected A&E sites to provide support to children with non-urgent issues, as well as outreach and additional support in community settings – consider the development of a BHR Social Care Liaison Officer (SCLO) role

- Ensure direct access to urgent mental health support through NHS 111 'option 2', to be universally available by April 2024

Workstream 5: Ensuring focus on children and young people – to reflect the local demography and respond sustainably to need

- Expand access to care in the community, including roll out of paediatric acute respiratory infections (ARI) hubs for children ahead of next winter
- Improve acute pathways through consistent adoption of paediatric Same Day Emergency Care
- EOL pathways for CYP – Haven House and Richard House: we will build on the excellent step down from BHRUT in place
- Implement locally the national roll-out of a standardised paediatric early warning system (PEWS) in inpatient settings in 2023/24 to improve identification and management of deterioration in children
- Develop streamlined pathways for mental health patients who need to remain in acute settings until their care can be transferred, with particular reference to better working with children and young people's mental health services 10. Better support for discharge through clear pathways and escalations including OOA
- Ensure access to 24/7 liaison mental health teams (or other age-appropriate equivalent for children and young people) that are resourced to be able to meet urgent and emergency mental health needs in both A&E and on the wards
- Provide consistent and repeated early parent education – to be developed at Place

This is an area for immediate development given the young populations across north east London and the need to build capability and capacity appropriately through work with Place.

Workstream 6: Communicating and engaging – to engage with local populations to change behaviour and embed understanding

Contributes to all outcomes but particularly Outcome 3: Ensuring that people can access the right care at the rig
from becoming more unwell whilst they are waiting

Working with local people and communities is critical to improving our urgent and emergency care response. We have a number of opportunities for local voice to be heard through the Healthwatch Community Insights System, through regular PPG meetings, through dedicated co-design work in specific areas, through population level communications and engagement plans and through feedback on specific services.

We are developing our mechanisms for people to contribute to this Plan and the many actions which will be in place to deliver against our top level outcomes. Whilst this is a north east London approach we are engaging locally and through the BHR Places Improvement Board and through our Place Partnerships with local people to support behaviour change.

We have evaluated our winter communications campaign and have been able to understand where we have had most impact on resident behaviours. While the focus will remain on helping people access the right NHS help at the right time, it can also support comms around wider drivers of ill health and NHS attendance in line with advice from partners and this wider Improvement Plan. It will also sit alongside other campaigns like immunisations to make every contact count and build the resilience of local communities to respond to needs arising within their communities.

The next slides set out our approach in more detail but we are keen to explore information and advice, ensure Healthwatch insights and information are used as core data in decision making, continue to implement all year round system resilience campaign, ensuring it reaches out to communities through other communication

Workstream 6: Communicating and engaging – to engage with local populations to change behaviour and embed understanding

Deliver a holistic communications and engagement campaign with outreach to communities we most need to target and engage

Rationale: the behaviours of our local populations drive need and demand and working alongside residents will help to shape those behaviours.

Aims:

- To build on the work at a place level to support holistic outreach through local hubs, events and community champions, working with our partners and sharing assets and collateral
- To operate in the digital and non-digital space
- To ensure accessible communication and engagement including community languages and disability friendly communications
- To increase the voices of local people in our messaging and materials and devote time to sourcing and curating them and work closely with Healthwatch and utilise the community insight system to develop content.

Milestones:

- Funding in place by end June 2023
- Campaign messages and approach agreed by end July 2023
- Move to develop hyper localisation of messaging and targeting based on new data sources, by end September 2023
- Commission other forms of digital marketing outside of social media and website adverts in place by end September

Targets:

- Fully operational campaign visible and active throughout the year

Workstream 6: Communicating and engaging – to engage with local populations to change behaviour and embed understanding

We will call our campaign **'Finding the right support'** and deliver messages in separate strands (sometimes overlapping) and will actively engage with local populations as it is developed. Our core strands are as set out below:

GPs and GP access

- The importance of registration.
- Helping people understand the different roles in GP practices and what receptionists do.
- Different ways to access your GP including online consultation forms.
- The NHS app.
- Convenient OOH appointments.
- Fuller Review transformation
- Pump prime before winter

Pharmacy

- Pharmacists are experts in medicines who can help you with NHS prescriptions as well as support for minor health concerns.
- Pharmacists can also help get you emergency medicine.
- Many pharmacies are open until late and at weekends. You do not need an appointment.
- Fuller Review expansion of prescriptions
- Pump prime before winter

Minor conditions and child health

- Minor condition focused content directing people to pharmacy
- Parent focused content directing people to pharmacy
- Long term condition management via GP
- Deploy during winter and other peaks

Mental health

- Available support including talking therapies
- Pump prime before winter
- Crisis lines and urgent support
- Deploy during winter and other peaks
- Support ELFT/NELFT campaigns

Urgent help

- Out of hours urgent GP appointments.
- NHS 111
- A&E for emergencies only
- Hierarchy of help – 'route' to help from self-care to A&E
- Deploy during winter and other peaks
- New OOH GP provision across NEL yet to be agreed

NEL wide enabler: Building effective data and digital resources

Improving our data and digital functionality across operational and strategic functions will enable us to operate more efficiently across our system and to understand better the impact of our actions on our intended outcomes both in real time and over time.

A London UEC IUC Digital transformation Programme has been developed for 2023/24. The vision for this programme is for a UEC IUC service that utilises digital technology, to streamline the patient journey and clinical interactions as much as possible. Key aspect of the programme include call before you convey, digital front door triage, direct booking and digital transfers of care. Much of this work is already underway, in particular direct booking from 111 into primary care, UTC's and ED's and work will continue to improve efficiency and functionality.

A UEC system dashboard has been developed across NEL, reporting on key metrics including 111, ambulance and ED performance. Work continues to develop the dashboard, to ensure key data is reported so that the system has clear oversight on activity.

Access to the Universal Care Plan is now available to all key stakeholders across north east London, including ED's ,UTC's and Primary Care. A Universal Care Plan dashboard is being rolled out to all stakeholders. In addition shared care models need to be agreed at pace to ensure we can move forward in more integrated ways. This will involve working with Information Governance to ensure we are building resilience and a focus on integration throughout our work.

Digital systems used within the unplanned care pathway have also been reviewed or are being reviewed, including UTC's and Urgent Care Response/Community referral processes. The aim of the reviews is to standardise digital processes where possible, using the IT systems used.

Discussions underway around the digital interface between UEC and Urgent Care Response services, across NEL ahead of winter.

All ICB's have been mandated to have procured and implemented a System Control Centre (SCC) by 1st November 2023. The SCC will improve situation awareness, holistic and real time management of capacity and co-ordinated action across north east London and mutual aid. Next steps for NEL include agreeing resource, procure a tech solution, recruitment and training.

There is an established UEC Digital Enabler Group within north east London to support with the delivery of key digital objectives relating to unplanned care.

NEL wide enabler: Growing a sustainable workforce

We are working with system partners to co-design a NEL-wide People and Workforce Strategy to implement a 'one workforce' model across health and social care providers, to ensure that we have the right capacity at the right time which is critical to the successful delivery of this ambitious Plan. From engagement with providers across the system, we have identified the following high level strategic priorities set out below:

Parity	Portability	Planning	Partnership	Purpose	Population	Productivity
• How we can achieve better equity in pay and benefits between health and social care . • We would also seek to promote seamless joint working and retention by ensuring comparable attractiveness of the offer for health and social care roles. • Address current disparities in high cost allowance between inner and outer London boroughs	• How we can use digital systems interoperability and solutions such as e-passports, remote supervision and digital up-skilling and other interventions to support 'one workforce' • To develop and enable effective joint teams and seamless working and deployment across health and social care employers.	• How we will strengthen our capability for pro-active, joined up, system-wide operational and strategic workforce planning • Develop a 'one workforce' perspective across both health and social care at system, place and neighbourhood levels.	• To address inequities in the system and ensure access to employment opportunities for young people, older people and under-representative groups in NEL. • Understand recognition of generational differences in perceptions of work and employee motivation, informing the design of health and social care careers and roles that would be attractive to our future workforce	• How we will strengthen collaboration between schools and higher education institutions and health and social care providers, to develop and train a continuous supply pipeline of talent to be channelled into innovative flexible careers • Delivery through apprenticeships, and redesigned roles, skills and entry requirements.	• How we will strengthen collaboration between schools and higher education institutions and health and social care providers, to develop and train a continuous supply pipeline of talent • To be channelled into innovative flexible careers through apprenticeships, and redesigned roles, skills and entry requirements.	• How we will put in place interventions to support, develop and ensure the health and mental well-being and resilience of all our system health and social care workforce, • Including primary care, the voluntary and independent care sectors, so as to enable and retain a productive, motivated and sustainable 'one workforce'.

NEL wide Enabler: Enhancing 999 and 111 services

London Ambulance Service provides both 999 and 111 services across the NEL footprint, both elements of which are challenged in terms of achieving contractual and national expectations in terms of performance. The following is a list of areas being developed across London Region, the NEL System footprint, and some BHRUT specific initiatives:

- 999
    - Evaluation of Pilot in NWL of 45 minute rapid release/handover of patients from LAS to EDs – likely pilot for 2 weeks in NEL within the next 2-3 months
    - Roll-out of Cat 2 Response pilot (completed in NCL) across London
    - Extension of the REACH model to include BHRUT
    - Dedicated evaluation of LAS and ED behaviours during patient handover/ambulance offload at both BHRUT EDs to identify areas for improvement
    - Enhancing the senior clinician cadre withing the LAS Emergency Operations Centre (The 'NEL Cell' trial was successful during recent periods of Industrial Action)
    - PAN NEL review of the LAS 'STEPS' to be more collaborative
- 111
    - National review of 111 service model expected in Q2 23/24
    - Remodelling of current 111 service in NEL & SEL including:
        - Review and update of Dx Codes
        - Recruitment of more senior clinicians for the CAS
    - Consideration of moving 111 from UEC to Primary Care to ensure linked in with both Fuller and Primary Care Recovery Plan

Improvement Plan: Conclusion

As set out throughout the presentation, this is a Plan under development. It is ambitious in its aims and in its system wide approach which recognises the contributions of Place, Providers, Collaboratives and Programme in improving outcomes in outer north east London. We are asking the Board today to comment on the Plan and on the next steps in its development which are summarised below:

- Finalise the metrics, data and reporting requirements throughout the governance
- Work through the governance arrangements, including the groups reporting into the BHR Places UEC Improvement Board, the role of Place Partnerships, Collaboratives and the oversight through the UEC System Board
- Work with colleagues across Providers, Primary Care, Planned Care and other relevant areas to provide detail on the north east London wide work which will support the delivery of this Plan with a clear focus on data and information governance as an enabling priority
- Develop a risks and issues log which will provide an at a glance picture of progress
- Agree the logic model, with clarity on input, activities, outputs and outcomes including a clear summary on the core outputs and outcomes to ensure focus and understanding
- Work with local people to co-design solutions for the challenges identified