NHS
North East London

UEC Improvement Strategy and Plan: BHR Places

Draft Plan to Committees in Common of ICB Sub Committee and Health and Wellbeing Board

Kirsty Boettcher

Introduction

This pack sets out the BHR Places UEC Improvement plan.

This is a plan in development and is supported by a detailed action plan also in development which is clear on leads, deliverables, outcomes and timelines.

A risk and issues log is being worked on which will sit alongside the plan and it should also be noted that a number of the schemes will only be able to move forward with funding.

Historically the BHR UEC Transformation Programme Board was responsible for the work relating purely to UEC flow, and was supported by sub-groups. Adhoc updates were received from other programmes, with accountability for these sitting at their respective Transformation Boards.

It is proposed that under new governance arrangements, the BHR Places UEC Improvement Board is asked to "hold the ring" on this System Improvement Plan containing all actions that have an impact on the UEC system across the BHR places and hold respective programmes accountable for the delivery of their actions. Its membership will reflect the system and include BHRUT, NELFT, Havering, Barking and Dagenham and Redbridge Councils, Barts Health (Whipps Cross), Primary Care, the VCSE, LAS and NHS NEL as well as a wider set of system contributors

The plan for this requires work-up through the new governance arrangements including clarity for responsibilities on the UEC Improvement Plan to be confirmed and this is outlined in the conclusions on the last page of this slide.

Contents:

Overview of Barking and Dagenham, Havering, Redbridge Places

- **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
- **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)
- **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
- **Avoidable admissions**
    - Avoidable admissions at Queens appear 3 times higher than other sites. There are practice outliers in B&D and Havering.
- **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

System Overview

There is widespread recognition that the system has a role to play in bringing partners together, supporting collaboration and taking other 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 will need to include reporting from the Collaboratives on the work that support the plan.

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 reduce duplication and fragmentation and to respond to the needs we have in our system.

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 effective discharge, ensuring reducing avoidable admissions across partners
- Work to improve primary care capacity
- Work with LAS to increase appropriate conveyance avoidance in turn reducing ambulance delays and admission
- Responses to the findings of the CQC in response both to their inspections of UTCs and BHRUT front doors.
- Support to and assurance of, PELC's improvement plan including an independent governance review of PELC
- Significant system work on reducing long waits for those in mental health crisis in our emergency departments
- Work to improve patient flow through each of the hospital sites

System Overview: governance

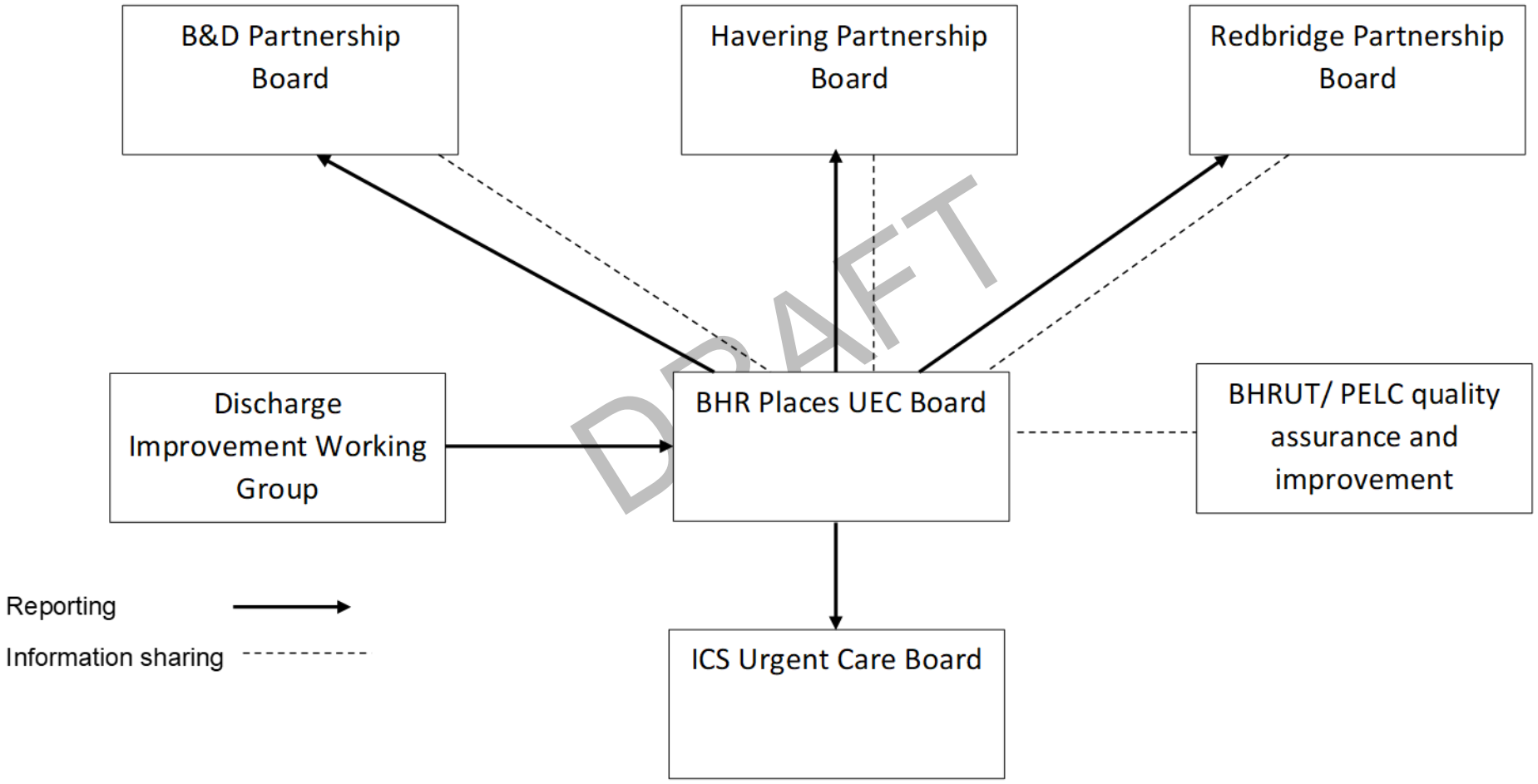
We have increasingly robust system governance designed to enable us to work together to improve the urgent and emergency care pathway including a North East London UEC System Board chaired by the NHS NEL Chief Medical Officer which holds to account the BHR Places UEC Improvement Board for delivery against this Improvement Plan.

The BHR UEC Places Improvement Board is a system level and strategic Board which will oversee 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 will be a number of sub-groups which deliver on the wide range of workstream activity required. There are group 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 on implementing integrated neighbourhood teams
- Primary Care development of same day capacity to deliver continuity of care

The aim is to retain a focus on structures which are working well, ensuring that they recognise their relationship with the Places Improvement Board and their role in delivering the UEC Improvement Plan. Next step: Primary care, Planned Care and the Collaboratives will need to report into this structure. The arrangements need to be worked through and agreed over the coming weeks.

System Overview: governance structure



System overview: Data

We have seen 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. We can 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
- 7 and 21 day LOS
- Patients not meeting criteria to reside – by Trust/ partners
- Activity levels in our GP Access Hubs, in Queen's and KGH's EDs and in the four UTCs across this area
- Elective waits

(next stage will add the activity trends for these key metrics)

System Overview: Insight (next stage to be added)

We will add an overview on citizen's experience of our UEC system in BHR which will help to highlight where we need to improve

- Qualitative data from HealthWatch – GPs, LAS, UEC
  - What are local people telling us about what they are seeing – from a primary care (how easy is it to access a GP), UEC (what is their experience of the system) and LAS (most recent work commissioned by LAS) perspective
- Insight reports
- Place level feedback

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 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 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 will 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

UEC Improvement Plan: Workstreams

The six workstreams have been selected to cluster a range of actions across partners and sectors. They are:

- Keeping People well at home
- Reducing avoidable admissions and same day access for urgent care
- Improving in-hospital flow and discharge
- Ensuring focus on children and young people
- Supporting mental health needs
- Communicating and engaging

There are also two infrastructure workstreams which are being led across north east London as they cannot be facilitated for BHR Places alone. Again, they will need to be considered through the lens of immediate actions, medium term responses and more systemic work to address capacity and sustainability issues in the longer term:

- Ensuring a sustainable workforce
- Supporting 999 and 111 services

In the following slides, we set out our plan for improvement across these workstreams.

Context: BHRUT is one of the busiest A&Es in the country
Within BHR there are significant areas of deprivation - There is a growing population
Age demographics – there is a high proportion of residents aged over 65 – in Havering this is expected to increase by 13% by 2032.
Avoidable admissions at Queens appear 3 times higher than other sites.
Recent CQC inspections has seen areas of urgent care within the system require improvement
ICB restructure, ICS implementation

LOGIC MODEL

Vision: To have a more integrated and more preventative urgent care system across the B and D, Havering and Redbridge Places where citizens are supported to stay well at home where possible and have good quality care when needed, with all services rated at least Good.

Inputs for All Logic Models

- NEL UEC BOARD
- BHR UEC IMPROVEMENT BOARD
- PELC CQC ASSURANCE BOARD
- BHRUT CQC ASSURANCE
- COLLABORATIVES
- DIGITAL
- DATA INSIGHT
- PROGRAMME TEAMS
- DELIVERY TEAMS
- BUDGET PER PROGRAMME

Activities

KEEPING PEOPLE WELL

ADMISSIONS AVOIDANCE / SAME DAY ACCESS

HOSPITAL FLOWS

DISCHARGE

CYP FOCUS

MENTAL HEALTH SUPPORT

ENABLERS

Outputs

- Increase Preferred place of death for EOL Avoidable admissions reduction
- Increase in same day access
- Reduction in ambulance conveyances/ ED attendances/ admissions
- Improve Vaccination rates
- Reduction in attendance and admissions for falls
- Reduction in LOS
- Decrease delay discharge
- Improved Ambulance hand over

Outcomes

Increase of healthy life expectancy

Increase in satisfaction of urgent and emergency care

Increase staff satisfaction

Increase in staff retention

Urgent care providers to be rated at least Good

Improvement Plan: Keeping People Well at Home

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.

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, will enable care that would often currently be delivered in a hospital to be delivered closer to people's homes.

Improvement Plan: Keeping People Well at Home

- **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

<u>Contributes to Metrics:</u>

- 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

Improvement Plan: Keeping People Well at Home

Now and over the winter

- Develop community catheter service
  - Reduce ambulance conveyances and admissions for frail elders
- Maintain delivery on 2 hour target for UCR
  - Link with LAS and increase number of people kept at home
- Monitoring utilisation of UCR cars and PRU
  - Review utilisation of new car and work with LAS and BH to maximise utilisation
- Review of HALO provision and update service specification
  - Monitor impact of reducing conveyance and increased use of ACPs
- Extend REACH equitably across BHR (subject to funding)
  - To deliver enhanced response to keep people at home, avoiding admission
- Mobilise falls service for all of BHR
  - To reduce pressure on EDs: falls is highest risk factor for ED attendances and admissions for frail older people

Improvement Plan: Keeping People Well at Home

Now and over the winter

- Deliver consistent enhanced health offer into care homes
  - To reduce risk of people becoming unwell and requiring urgent assistance
- Facilitate easy access to vaccinations and screening
  - To protect people from infection and to identify need early
- Ensure network of social prescribers, community connectors and local area co-ordinators work well together
  - To provide early intervention and prevention, to reduce social isolation and to reduce impact on clinical and care services
- Roll out Minor Ailments Service across north east London
  - To respond to the acute shock of the cost of living crisis and reduce unnecessary demand on primary care
- ARI hubs (subject to evaluation of 2022/23 winter)

Improvement Plan: Keeping People Well at Home

Medium term

- Evaluate and review impact of REACH, PRU, Community Response
  - To compare the different models currently in place across north east London with a view to a north east London wide implementation of the most effective, sustainable and affordable model
- Develop and respond to Demand and capacity Plan across community care services to define a consistent community 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)

Improvement Plan: Keeping People Well at Home

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 capacity 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

Improvement Plan: Avoidable admissions/same day urgent access

- **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 historical 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.

Improvement Plan: Avoidable admissions/same day urgent access

Now and over winter

- Safeguard primary care capacity currently delivered through the five GP Access Hubs (over 100,000 appointments per year) beyond the first six months of the year (subject to funding)
    - To reduce risk of further pressure on UTCs and EDs over the winter months
- Deliver PELC CQC and wider improvement actions, including plan to meet 98% 4 hour target
    - To ensure demand and capacity in UTC over winter are understood and acted on
    - To increase community confidence
- Collaborative working on front door model between PELC/ BHRUT
    - To improve flow and patient experience
- BHRUT deliver CQC actions and operating plan targets for 4 hours and ambulance turnaround times
- Work proactively with people on the elective waiting lists (Planned Care lead)
    - To reduce risk of admissions for these targeted individuals

Improvement Plan: Avoidable admissions/same day urgent access

Now and over winter

- Implement virtual wards for both frailty and ARI
  - Increase capacity for patients to be managed safely in the community and avoid admission
- Review 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
- Deliver consistent speciality advice to GPs, confirming and promoting contacts and pathways
  - To support GPs to offer advice and support in the community
- Improve management of High Intensity users
  - Reduce attendances and improve patient experience
- Extend and evaluate pilot of social workers in acute frailty units
  - To increase early identification of people's needs – evaluation to test effectiveness and affordability of model
- Pilot integrated case manager at KGH ED to support discharge
  - To ensure timeliness of discharge with multi-disciplinary approach avoid admissions

Improvement Plan: Avoidable admissions/same day urgent access

Medium term

- Review Urgent Treatment Centres: what is our model in outer London, have we got sufficient capacity and how do we build for the future (confirm lead in NEL)
    - To build sustainability for the future as demand changes over time
- Conclude deep dive on virtual wards and act on findings (Community Collaborative)
    - To ensure join up of urgent and emergency provision, community beds and care capacity to avoid admissions and to enable discharge

Improvement Plan: Avoidable admissions/same day urgent access

Longer term

- Implement Fuller incorporating same day urgent access model across primary care, UTCs etc.
    - To have a coherent and consistent model in place
- Implement virtual ward deep dive findings
    - To follow through and ensure connectivity between all parts of our system through a community based care model

Improvement Plan: Improving hospital flow

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.

The NHS will continue to make effective use of 'system control centres' (SCCs). These pioneering centres use data to respond to emerging challenges and bring together experts from across the system to make better, real-time decisions. They will 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.

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

For us locally, we are focusing on the following actions over the winter, in the medium term and over the longer term too.

Improvement Plan: Improving hospital flow

Now and over winter (needs to be updated with BHRUT plan)

- Implement CQC actions must dos and should dos - BHRUT
  - To build confidence and respond to all findings and recommendations to achieve better outcomes
- Implement and staff fully operational SDEC model on both Queen's and KGH hospital sites
  - To meet national requirements and to enable better flows
- Deliver fit for purpose discharge lounges in both Queen's and KGH
  - To facilitate discharges earlier in the day, with a focus of leaving before 11am

Improvement Plan: Improving hospital flow

Medium term (needs to be updated with BHRUT plan)

- Evaluate impact of Operation Snowball
  - To ensure it is effective, sustainable and promotes patient wellbeing
- Reconfiguration of ED and UTC spaces given relocation of renal unit and Rom Valley Gardens development
  - Opportunity to improve UEC hospital flow

Improvement Plan: Improving hospital flow

Longer term (needs to be updated with BHRUT plan)

Improvement Plan: Discharge

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. 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

<u>Contributes to Metrics:</u>

- Reducing number of patients in beds not meeting criteria to reside
- Reduce 7 and 21 day LOS in beds

Improvement Plan: Discharge

Now and over the winter

- Review Integrated Discharge Hub operations, including Trusted Assessor models
  - To 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
- Develop and implement Discharge to Assess home for more patients
  - Avoid patients losing independence and moving into long term care
- Review and simplify Rehab pathways
  - To ensure efficient use of provision for all, with the correct capacity and in preparation for additional community rehab availability
- Implement Welfare checks pilot in Redbridge
  - Reduce risk of readmission

Improvement Plan: Discharge

Medium term

- Review Intensive Rehabilitation Service (IRS) Capacity
  - To have a fully functioning rehab pathway across a range of provisions to meet a range of needs and to enable timely discharge
- 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

Improvement Plan: Discharge

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

Improvement Plan: Supporting mental health needs

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 MH Needs in ED
- Numbers of people with no criteria to reside in MH Beds

Improvement Plan: Supporting mental health needs

Now and over the winter

- Improve crisis support and diversion, including building capacity and focusing existing work on diversion working with LAS, Met Police, Primary care and local authorities
    - To reduce numbers of people attending ED in acute mental health need/crisis
    - To enhance partnership working in this space
    - Increase LAS use of MH ACP
- Improve Processes and support into ED and Mental health streaming pilot in Queen's UTC
    - To support people already in ED to receive timely care and support
- Improve quality and timeliness of data and escalation routes
    - To support real time progress updates for all clinicians and ensure effective joint working
- Increase bed capacity through ensuring access to Winter Surge Beds, delivering of new 12 bed ward and a renewed focus on discharge
    - 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
- Review of MH patients n KGH ED for learning and pathway improvements
- Introduction of Crisis cafes across the BHR Places

Improvement Plan: Supporting mental health needs

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
- 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

Improvement plan: focus on babies, children and young people

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, as well as excellent support for parents and the broad front line workforce working with children and young people daily.

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.

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

Improvement plan: focus on babies, children and young people

These actions are taken from the north east London discussion about a focus on babies, children and young people. We need to work through any specific actions and emphases for this Improvement Plan

- 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
- 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

Improvement plan: focus on babies, children and young people

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

Improvement plan: communication and engagement

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 keen to develop 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. Specific actions include:

- Consider feasibility of developing a directory of services for a range of stakeholders; develop electronic model, roll out and training plan
- Ensure Healthwatch insights and information is 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
- Evaluation community champion models of health communication
- Develop models for co-design of solutions across the scope of this Improvement Plan

Improvement plan: Data and digital

NEL wide enabler

Placeholder: 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.

Areas such as ease of access to all partners to the Universal Care Plan for 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.

There is work underway across north east London which will support delivery across this Plan.

Detail to be added

Improvement Plan: Building a sustainable workforce

NEL wide enabler

Placeholder: Ensuring a sustainable workforce

NEL work on a Workforce Strategy is underway and ensuring the right capacity at the right time is critical to the successful delivery of this ambitious Plan.

Detail to be added

Improvement Plan: Enhancing 999 and 111 services

<u>NEL wide enabler</u>

Place holder: supporting 999 and 111 services

- Areas being developed locally include:
  - Additional clinical specialists in LAS
  - Sustainability of Emergency Operations Centre
  - Consideration of Emergency Care Assistants
  - More work on diversions

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