BHR Integrated Care Partnership
Better care, better lives, together for all

NHS
North East London
Clinical Commissioning Group

BHR Transformation Board 21/22 Key Progress and Achievements to Date

Meeting name: London Borough of Havering (LBH) Overview and Scrutiny Committee (OSC)
Presenter: Tracy Rubery – Director of Transformation (NEL CCG)/ Hanh Xuan-Tang – Deputy Director of Recovery and Planning
Date: 14th March 2022

Background

The NHS services covering the London Boroughs of Barking and Dagenham, Havering and Redbridge (BHR) System have seen declining financial performance since at least 2012 and possibly even earlier. These financial challenges are linked closely to negative changes in the outcomes for our population. The drivers of the challenges are related to a historic and chronic under-investment in Out of Hospital Support for patients with a lack of focus on prevention and early intervention. This has driven a significant increase in Non-Elective Admissions particularly for Older People and those with one or more Long Term Conditions.

In 2018/19 the NHS partners in BHR agreed London's first integrated Financial Recovery Plan (FRP) and in the first year of operation saw a significant improvement both in system finances and the start of changes and improvements in outcomes for our population.

Due to the Covid Pandemic, the changes in national contracting arrangements and the positive impacts of accelerated integration of our system Partners, the original FRP has been reviewed and has resulted in the development of the Integrated Sustainability Plan (ISP). The ISP resets the previous FRP and expands the scope to include redressing historic under-investment in Out of Hospital services. The aim of the ISP is to reduce secondary care activity by Transforming Health and Care services and delivering care differently, closer to home, improving outcomes and investing in prevention.

Background Continued

The BHR System Transformation Boards are a key part of the system architecture which will deliver the transformation required to support the assumptions set out in the ISP. Transformation Boards are responsible for the development of care models for their particular care group within the overall strategic framework set by the Integrated Care Partnership Board (ICPB). They are made up of all partners across health, care and voluntary sector in BHR and have strong clinical representation. They will continue to develop plans through co-production with residents, patients and their families.

There are currently eight Transformation Boards in BHR comprising:

1. Cancer
2. Children and Young People (CYP)
3. Learning Disabilities (LD) and Autism (North East London System wide Board)
4. Long Term Conditions (LTC)
5. Mental Health (NELFT/North East London System wide Board)
6. Planned Care
7. Older People/ Frailty
8. Urgent and Emergency Care (UEC)

This pack provides an update on the current progress of each of the BHR system Transformation Boards so far.

Aims and Objectives of the BHR Transformation Boards

The role of the Transformation Boards is to develop and deliver service transformation to improve the outcomes of our population, tackling inequalities and in turn, deliver efficiencies and savings by reducing the burden on the Acute Hospitals and shifting care closer to home. Some of the key aims and objective of the ISP include:

Integrated and Collaborative working across system partners to:

- Increase Prevention services
- Improve Early Detection and Early Intervention
- Promote Self-Care and Self-Management
- Bringing Care Closer to Home by increasing investment into Community and Primary Care based services and therefore avoid patients attending Hospital when they don't need to and allowing patients to be discharged as soon as clinically and medically possible with the appropriate support in the Community.
- Support our population to start well, live well and age well
- Tackle inequalities

BHR 2020/21 Transformation Board Progress

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

OLDER PEOPLE

- The expansion of the **NELFT Community Treatment Team (CTT)** went live in August 2021 with 10 of the 11 additional posts recruited. The CTT supports the delivery of the National 2 Hour Community Crisis Response Standard. Based on latest 2021 data, the service is forecast to provide a reduction in emergency admissions of 2,112, providing the BHR System with savings of £4m.
- The new **Single Point of Access (SPA) Discharge** team, hosted by NELFT launched in October 21, , building on the enhanced Hospital Discharge Service (HDS) that was developed during 2020 in response to the Covid pandemic. The service supports patients who require health and/or social care support to be discharged into their own home, or an appropriate community setting, as soon as they are medically fit. The service is expected to support c9 patients to be discharged each day, with at least 3,442 reductions in acute bed days per year.
- The **Acute Frailty Service** continues to support c250 patients a month with at least c80% avoiding an admission. Based on April to August data, the services are forecast to deliver 382 less emergency admissions, saving the BHR system £1.8m. The Queen's Frailty Unit which was launched in May 2021 and alongside the King George Frailty Unit will continue to focus on seeing more elderly frail patients to help increase the speed at which they are discharged from ED and being managed in the community or their own homes and therefore avoiding an admission.

PLANNED CARE

- The **Musculoskeleta**l (**MSK) Single Point of Access (SPA)** went fully operational in April 2021, following a delay due to Covid, and the **MSK Exercise on Referral (EoR)** went live in late November 21. The EoR service provides patients with chronic pain with an alternative treatment to clinical intervention. Between April to August, the SPA has reduced 1,106 unnecessary Outpatient appointments and is expected to deliver a reduction of 2,444 unnecessary outpatient attendances in 21/22. With the procurement of the new e-referral system, the reductions are expected to increase next year. provide patients with chronic pain an alternative treatment to clinical intervention.
- A **uro-gynae pathway,** to help reduce inappropriate referrals to the Gynaecology department and aid the long term aim of reducing GP referral volumes through targeted education, has been developed and launched in September 21. The pathway is expected to reduce the number of referrals to BHRUT gynaecology department by 20% in 6 months post-launch.
- The **Community Minor Surgery** service has been finalised and is ready to go-live. The service is due to be launched in April-22 following the NHS England guidance that all enhanced GP services should be paused in Quarter 4 of 21/22 to allow resources to focus on the Covid Vaccination Booster programme.. The service aims to undertake over 2,000 additional minor surgery procedures each year in a Primary Care setting, and therefore reduce the burden on Acute services and support the clearance of the current Elective backlog post Covid. The service will also reduce waiting time for patients.

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

URGENT AND EMERGENCY CARE

- A **Same Day Emergency Care (SDEC)** unit was successfully launched on Wednesday 28 July 2021. The service has 10 patient spaces and is located in the Majors A&E facility within Queen's Hospital. The service is currently seeing 6,720 patients a month, of which, the unit estimates 510 p/m (7.5%) are an avoided admission.
- The **Hospital Ambulance Liaison Officer (HALO)** service, at both the KGH & Queens sites, went live in November-2021. The service will operate from 10am to 10pm, to help redirect crews to utilise alternative care pathways instead of the acute based services. This will aid with ambulance crews awareness and utilisation of alternatives services, and therefore, contribute to improved patient care by transferring patients to the most appropriate setting and ensuring that more patients are treated at the right place, at the right time, first time.
- A business case for a **Duty Doctor** Pilot went live in January 2022. The pilot service aims to have a dedicated doctor, based in primary care, who will provide a dedicated call-in service which can be accessed by ambulance crews and community health care professionals when they need to seek advice from a GP about a patient's condition. The expectation is that the advice and guidance provided by the service will help prevent the patient being automatically conveyed or sent to A&E when this could have been avoided.
- A winter business case covering the following schemes: additional community rehab beds, additional intensive rehab service staff, additional care home rehab beds, increased PELC capacity, a Therapy Assessment at RAFTing pilot, additional 30 bed unit at Queen's and a weekend discharge nursing home pilot has been taken through the Urgent & Emergency Care Transformation Board and governance processes and many of the services are now live. All elements support the hospital with discharging patients to release bed capacity during the winter months, or provide additional capacity at the front door or within the hospital.

CHILDREN AND YOUNG PEOPLE (CYP)

- The **Paediatric Assessment Unit (PAU)** has been successfully implemented at the KGH site following the implementation at the Queen's site last year. The service supports children attending ED to be appropriately assessed and monitored with the aim of reducing unnecessary emergency admissions.
- The integrated **Paediatric Hospital at Home** pathway is currently at the final stages of approval. The service will support the PAU service through integrating the pathways between secondary care (from PAU), to care in community and home settings. The expectation is that 1,396 admissions will be avoided each year.
- A collaboration between the CYP Transformation Board and BHR Workforce academy has resulted in the successful delivery of a workforce workshop in September-21. The workshop identified short and long term solutions to address the shortage in the workforce affecting children across BHR, enabling further development of initiatives which were previously constrained by workforce capacity.

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

LONG TERM CONDITIONS

- An **Atrial Fibrillation (AF) Case Finding** pilot in Havering has been approved and recently went live in November 2021. The pilot utilises a specialised algorithm developed by Pfizer, and approved by the MHRA, to detect patients with high risk of AF related stroke. Patients are then admitted to a Rapid Access pathway for diagnosis and treatment, resulting in a reduced risk of imminent strokes. The pilot is expected to prevent 18 strokes between December 2021 and March 22.

- The **Urine Albumin to Creatinine Ratio (ACR) Testing from Home/ACR Diabetes** initiative is a 'post Covid catch-up plan' which is expected to be implemented in Quarter 4 21/22. Due to the Covid pandemic, and the reduction in face to face contacts with GPs/Nurses, Diabetic patients were not receiving the full 8 care processes required to detect any risks or issues with their condition that could result in complications associated with Diabetes. This initiative provides the ability to deliver a 'catch-up' plan at scale prior to returning to BAU levels and annual check-ups going forward.

CANCER

- A '**C the Signs'** digital tool was rolled out across BHR in Quarter 1. The tool helps to identify patients at risk of cancer; which cancer or cancers a patient is at risk of and identifies the most appropriate next steps. There are currently 358 users, helping to improve early detection, referral and diagnosis rates and therefore improving the outcomes for the residents of BHR.

- The **Rapid Diagnostic Centre (RDC)** is now fully live and receiving referrals from B&D. Work is ongoing to roll out the RDC across Havering and Redbridge. The RDC is a single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer, but do not "fit" into the Pan-London 2ww tumour specific pathways. The service provides personalised, accurate and rapid diagnosis of patients' symptoms by integrating existing diagnostic provision and utilising networked clinical expertise and information locally. This supports improvements in the Faster Diagnosis Standards (FDS) which is currently at pre-Covid levels.

- The **Lung screening project (The SUMMIT study)** delivered by UCLH and GRAIL has to date delivered a service to over 13,000 participants. The aim of the project is to develop and evaluate a new blood test for detecting multiple types of cancer early including lung cancer amongst at-risk residents and contribute to the examination of the feasibility of a large-scale lung screening programme in England. Participants were invited via their GP practice to attend a lung health check, offered a blood test and a low-dose CT scan of lungs. If signs for concern were seen in first scan, these were followed up, either immediately or twice annually depending on severity. The screening project will run until July 22 but has already impacted patients through early lung cancer detection & patients successfully treated.

BHR Transformation Board 21/22 Scheme Overview (January-21)

Red schemes – denotes progress to next stage of process from previous month

Blue Schemes – New schemes added in since previous reporting month

Concept Schemes

Evidence Based Interventions (EBI) Wave 2

Electrocardiogram (ECG) LIS

Autism Spectrum Disorder (ASD)Attention Deficit Hyperactivity Disorder (ADHD) Service

LTC Diabetes – out of hospital management

Ageing Well - Community catheter clinics

Winter - Ambulatory BHR Nurse-led Catheter Clinic

Marie Curie - Night Sitting Service

Domicillary Care Pilot

Business Case

Musculoskeletal (MSK) e-Referral Tool

Albumin to Creatinine ratio (ACR)Testing from Home/ACR Diabetes

Ageing Well - Urgent Care 2-hour response (UCR)

Winter schemes x10

Weekend Nursing Home Discharges Service

Mobilisation

Hospital Discharge Service

Duty Doctor

Community Minor Surgery

Simple Wound Care

Diabetes Assisted Discharge

Tier 3 Weight Mgt

Local Non Invasive Ventilation (NIV)Service

Stroke Rehab- Service Review

Ageing Well - Out Of Hours (OOH) - End of life rapid response team

Ageing Well - Hospice End of Life Service (RRT 24hr helpline and Nurse)

Ageing Well - Hospice End of Life Service (Care Home End Of Life (EOL) Nurse Specialist)

Ageing Well - Community Falls Care Home Service

Expansion of Community Falls Service

Alternative Care Pathway (ACP) Pharmacist in the Community Treatment Team (CTT)

Community Complex Dementia - Havering

Point of Care Testing (POCT)

LIPIDS Management

Live Schemes

Queens Frailty Hub Service (AFS)

Falls Programme Line - Strength & Balance Service

Local Area Coordination - Havering

Local Area Coordination - Redbridge

Reduce attendances for High Intensity Users (HIU)

Develop Same Day Emergency Care (SDEC) Pathways

Advice & Guidance (A&G)

Consultant 2 Consultant (C2C) referral reduction - Triage/Rapid Access Service (RAS)

Musculoskeletal (MSK)New Model of Care:

Musculoskeletal- (MSK) New Model Of Care-EOR

Musculoskeletal (MSK) New Model Of Care-Primary Care MSK Team

Musculoskeletal (MSK) New Model Of Care-Rheumatology Hub

Patient Initiated Follow Up (PIFU)

Urology-gynae pathway

Children Asthma Local Incentive Scheme (LIS)

Long Term Condition (LTC) LIS - Atrial Fibrillation

Long Term Condition (LTC) LIS - Diabetes Injectables

LTC LIS Group 2 (COPD/Asthma)

Diabetes 8 Care Processes

v Chronic Kidney Disease (CKD) Pilot

Pilot HALO (Hospital Ambulance Liaison Officer)

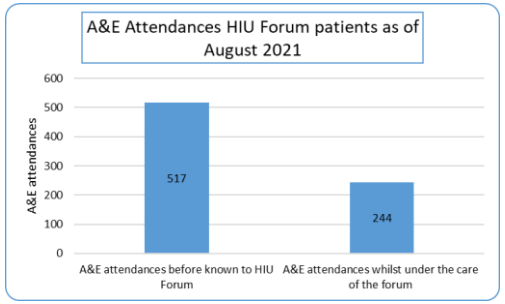
Atrial Fibrillation (AF) Case Finding-Havering

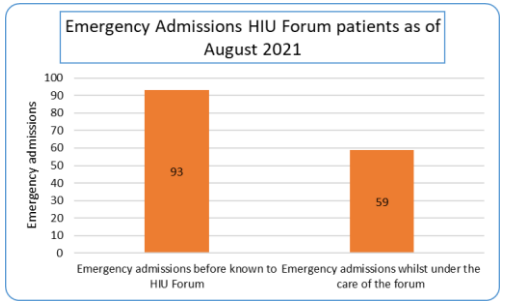
Complex Wound care Programme/Dressings and Lymphedema

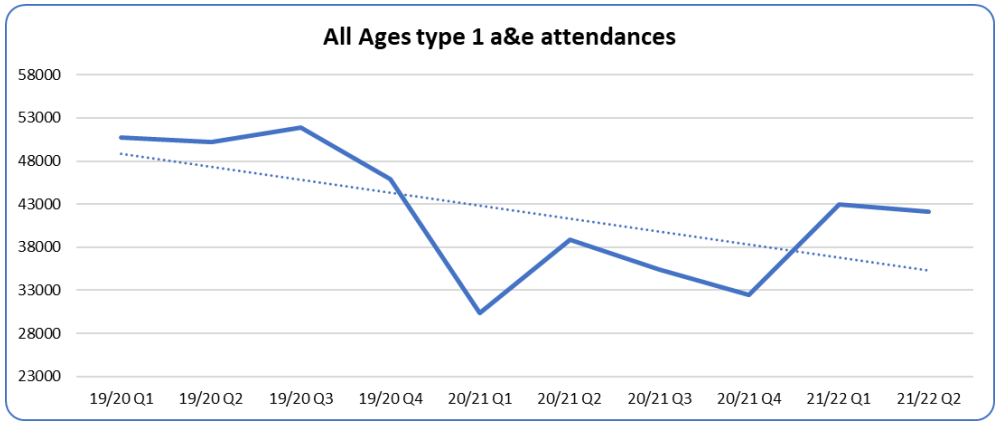
Ageing Well - Discharge to assess pilot

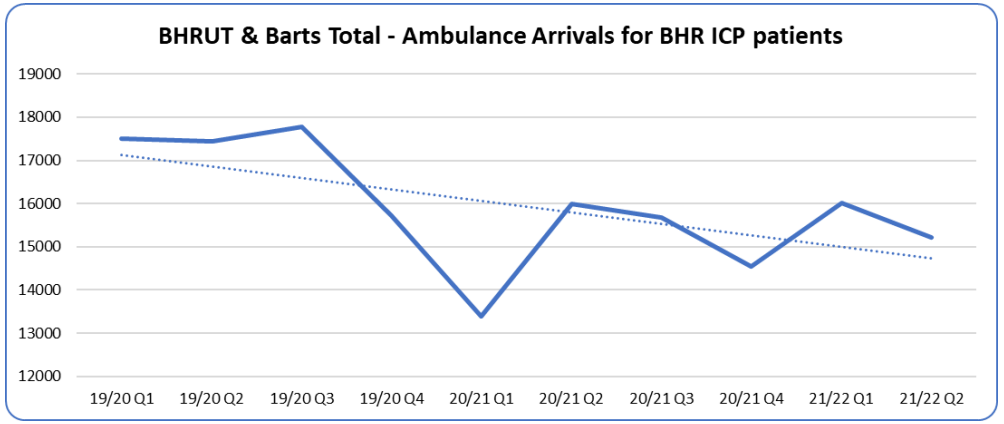
Impact of Transformation

Urgent & Emergency Care Transformation Board Impact Achievements









High Intensity User Forum & Open Dialogue service

The High Intensity User Forum is a multi-disciplinary team, consisting of London Ambulance Service, BHRUT, NELFT, Police, Social Care, patient GPs and others who provide direct care for the patients. They devise care plans and support options for patients who are identified as 'complex high intensity users' to prevent them from utilising urgent and emergency care services when not required, and directing them to more appropriate services to support the needs of the patient.

In 21/22 (as of August 2021), the service has delivered a reduction in emergency admissions of 37% (34 less admissions) and a reduction in A&E attendances by 53% (273 less attendances).

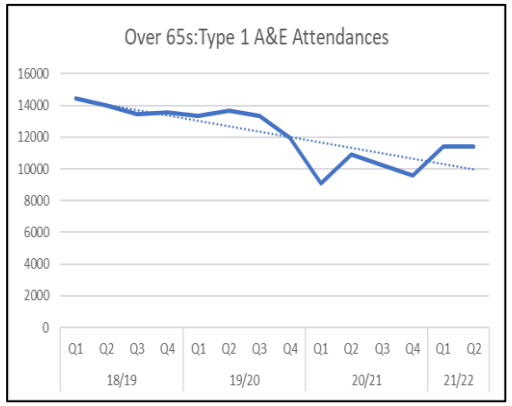
Alternative Care Pathways (ACPs)/Hospital Ambulance Liaison Officer Pilot (HALO)

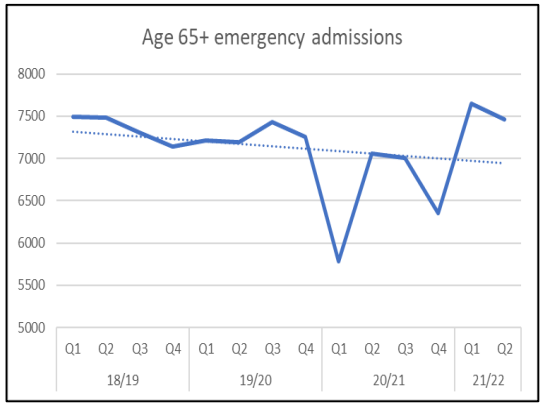
Type 1 A&E Attendances, relating to BHR patients of all ages at BHRUT, continue to show an overall downward trend with a 16% reduction (15,895 less) in A&E attendances in Q1 & Q2 FOT 21/22 when compared to Q1 & Q2 2019/20. Whilst some of the reduction is due to the Covid pandemic, especially in April and May, a significant contributor to this shift has been the successful implementation of 4 UTCs across BHR and the ongoing work to increase utilisation of alternative care pathways so that the emergency department is not the first port of call for patients when clinically safe to utilise alternative services..

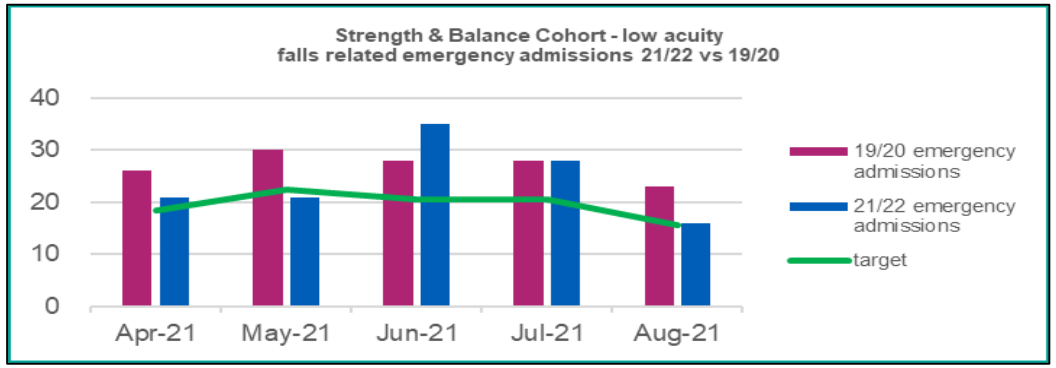
A significant amount of work has been undertaken to ensure alternative care pathways are increasingly available, such as CTT, Urgent Treatment Centre's (UTCs), Crisis Centres and Frailty Units. As a result, ambulance crews are now able to take an increasing number of patients to these alternative services. The impact of this can be seen in the reduction of ambulance arrivals, when comparing Q1 & Q2 FOT 2021/22 with Q1 & Q2 2019/20, which shows a 11% reduction (3,699 less conveyances.).

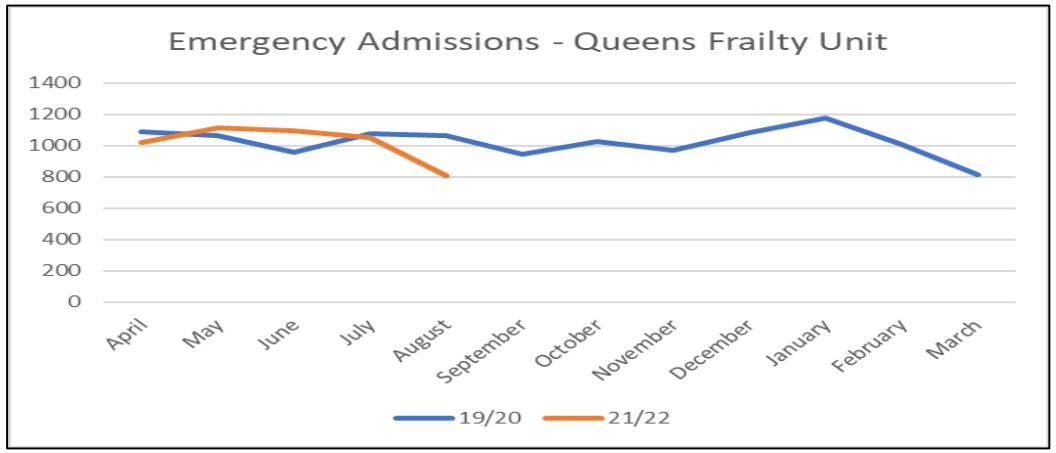
To enhance the usage of ACPs further and to support with winter, LAS has recruited paramedics (HALO) who will review ambulance arrivals, 7 days a week throughout winter and guide/educate their colleagues around the alternatives available. Through doing this, it is forecast to prevent 1,820 A&E attendances throughout winter.

Older People Transformation Board Impact Achievements





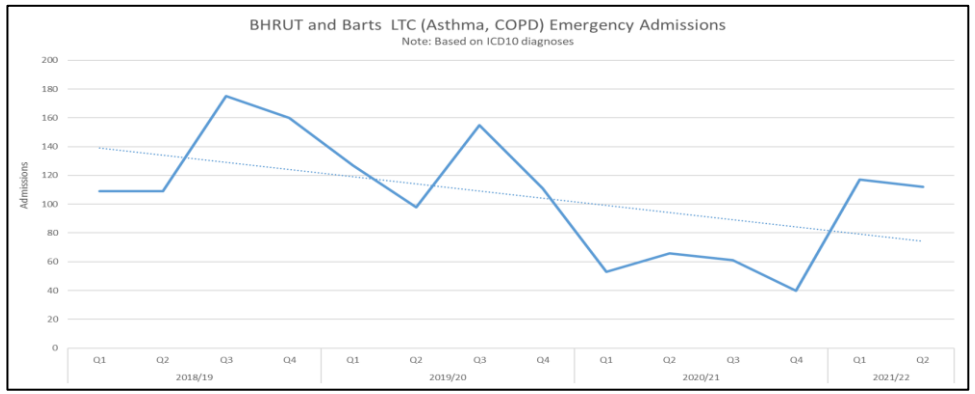


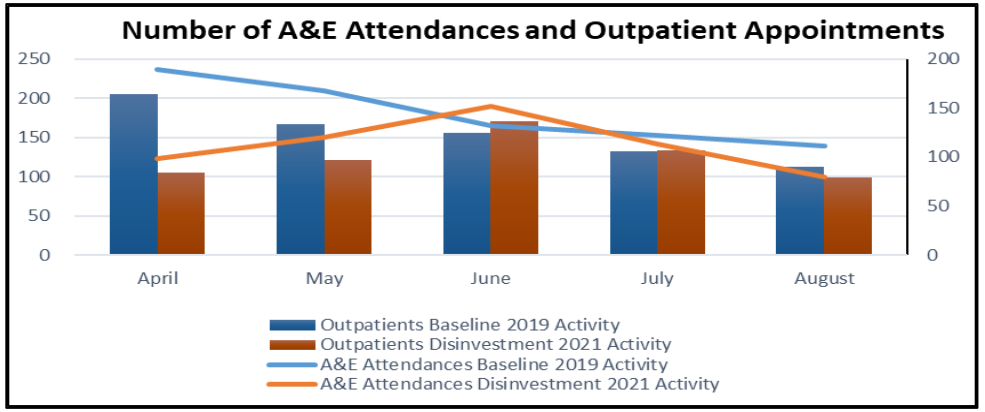


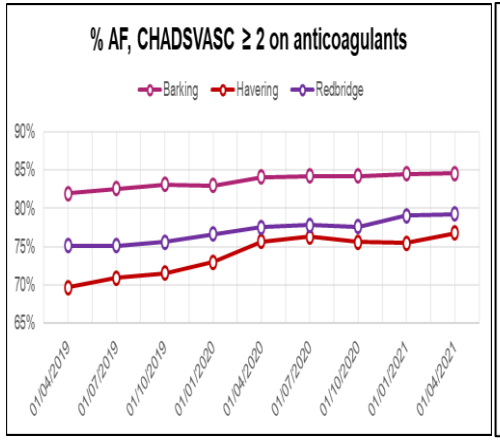
Key Notes

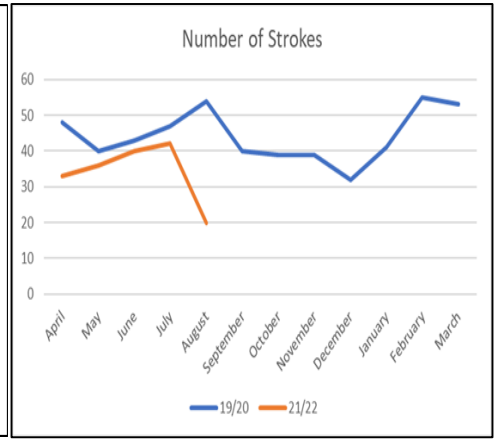
- Due to the impact of Covid, the 20/21 position have been skewed and therefore, the 21/22 position have been compared to the 19/20 pre-Covid levels.
- The Year To Date (YTD) (Q2) level of A&E attendances, for patients aged 65+, is currently 15% (4,167 attendances) lower than the comparable period in 19/20.
- However, the spike in the level of over 65+ admissions in recent months indicates that older patients presenting to Hospital are more complex and with a higher acuity of their condition, in part driven by Covid.
- The Queen's Frailty Unit, which was launched in May 2021 , incorporating the previous 'ED Front Door' and 'Home is Best' services, is starting to impact on the admission rates through a more dedicated and integrated Frailty service aimed at assessing and supporting patients to be cared for in an appropriate setting where an admission is not required. In August 2021, there were 24% (258) less admissions than in August 19.
- The Falls Strength and Balance service was impacted during Covid due to social distancing measures and the move to virtual sessions. However, despite a spike in June 2021, the 21/22 position shows a 10% reduction in falls equating to 14 less falls by August 2021 compared to the same period in 19/20.
- As the Strength and Balance classes resume face to face sessions, it is expected that the number of falls will decrease further in future months.

Long Term Conditions Transformation Board Impact Achievements









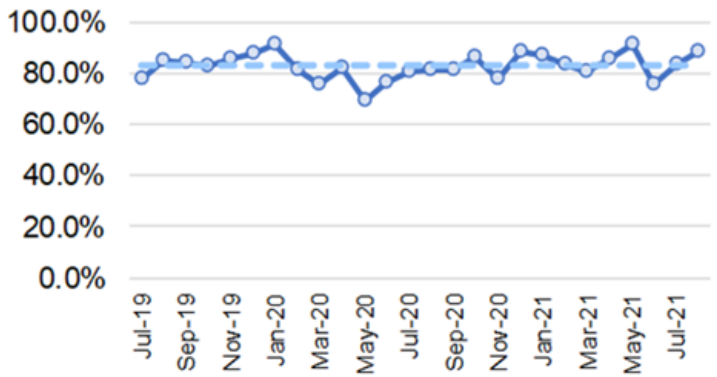
Key Notes

- The LTC Asthma and COPD LIS was implemented prior to Covid, with the purpose of shifting routine spirometry tests, for diagnosis of COPD/asthma, from an Acute setting into Primary Care, and to support patients through the development of care plans to better manage their condition and reduce presentations to Secondary Care.
- Since April 2021, there have been 159 less respiratory related A&E admissions compared to the same period in 19/20.
- COPD and asthma related admissions remain on a downward trajectory, and despite a post-Covid surge in admissions in June 21, at Quarter 2, admission remain below the 19/20 position.
- The shift in setting for the delivery of routine Spirometry testing, has resulted in 77% less spirometry activity (reduction of 610 tests between April to August 2021) taking place in secondary care. As the Tests are performed in an Outpatient setting, this has resulted in the freeing up of 610 outpatient appointments at BHRUT.
- Since the implementation of the Atrial Fibrillation LIS in 19/20, 93 out of 116 GP practices have had their AF registers reviewed for high-risk patients (CHADVASc >2) who are not on anticoagulation treatment. This review of 769 patients has led to over 200 patients being anticoagulated.
- Due to early detection and intervention, this has contributed to 27% (61) less strokes in 21/22 (to August 21), compared to the same period in 19/20.

Planned Care Transformation Board Impact Achievements

6. Responded within 48Hrs All Specialties (Top 18)

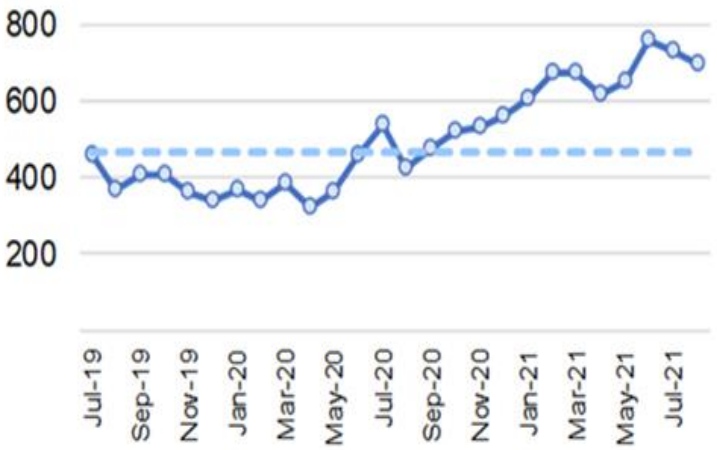
Barking, Havering And Redbridge University Hospitals NHS Trust



Month	Value
Mar-21	80.9%
Apr-21	85.4%
May-21	91.3%
Jun-21	75.6%
Jul-21	83.1%
Aug-21	**88.1%**
Median	82.8%

2. eRS Requests All Specialties (Top 18)

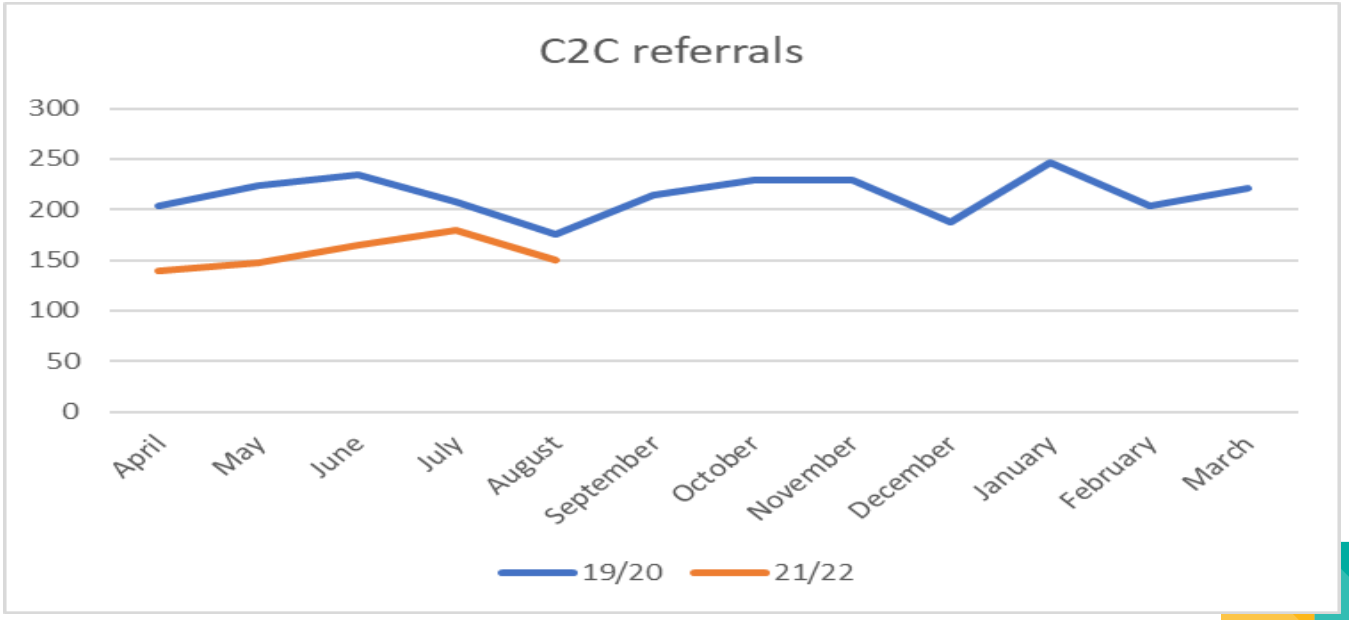
Barking, Havering And Redbridge University Hospitals NHS Trust



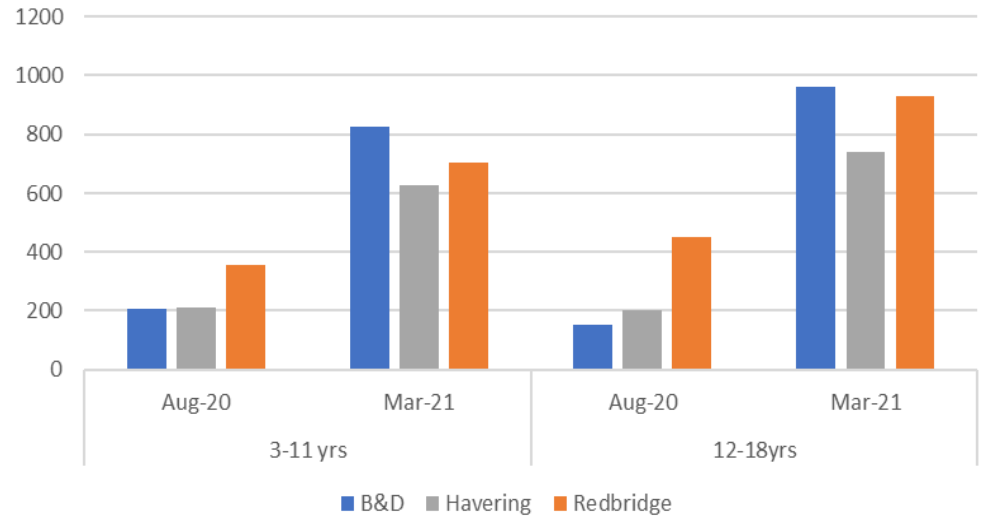
Month	Value
Mar-21	675
Apr-21	618
May-21	652
Jun-21	759
Jul-21	729
Aug-21	**696**
Median	466

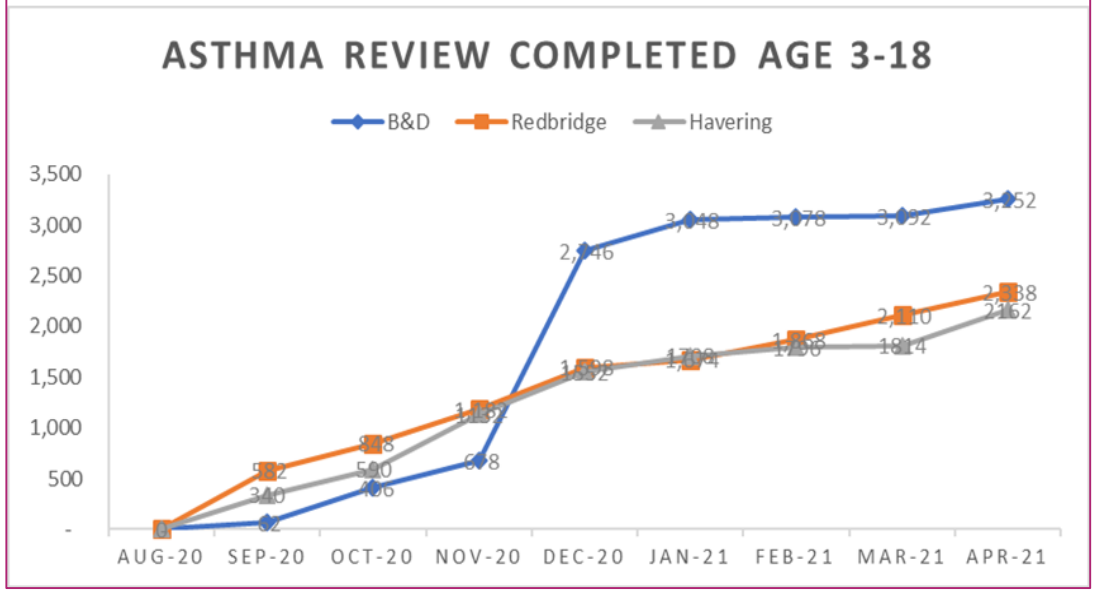
Key notes

- The Advice & Guidance service has continued to improve with an increase in the number of requests for Advice & Guidance on e-RS, whilst maintaining a 83% response rate within 48 hours.
- The improvements in the Trust Directory of Services and combined with the roll out of the Triage/RAS systems, has contributed to a 25% reduction (265 attendances) in the level of Consultant to Consultant (C2C) referrals.
- The C2C policy, following system agreement, is currently suspended and further communication and engagement is ongoing within the Trust to ensure that the legacy processes are reversed to support the reduction in demand on Primary Care.
- The Patient Initiated Follow Up (PIFU) pathways have been piloted in Neurology and the pathway will be rolled out to 4 further Specialties (Trauma & Orthopaedics, ophthalmology, gastroenterology and Prostate Stratified Pathways) in the next few months. The PIFU is aimed at empowering patients, with clinical oversight, to manage their own follow-up pathways based on their condition and requirements. This in turn is expected to reduce the number of unnecessary follow-up attendances going forward.



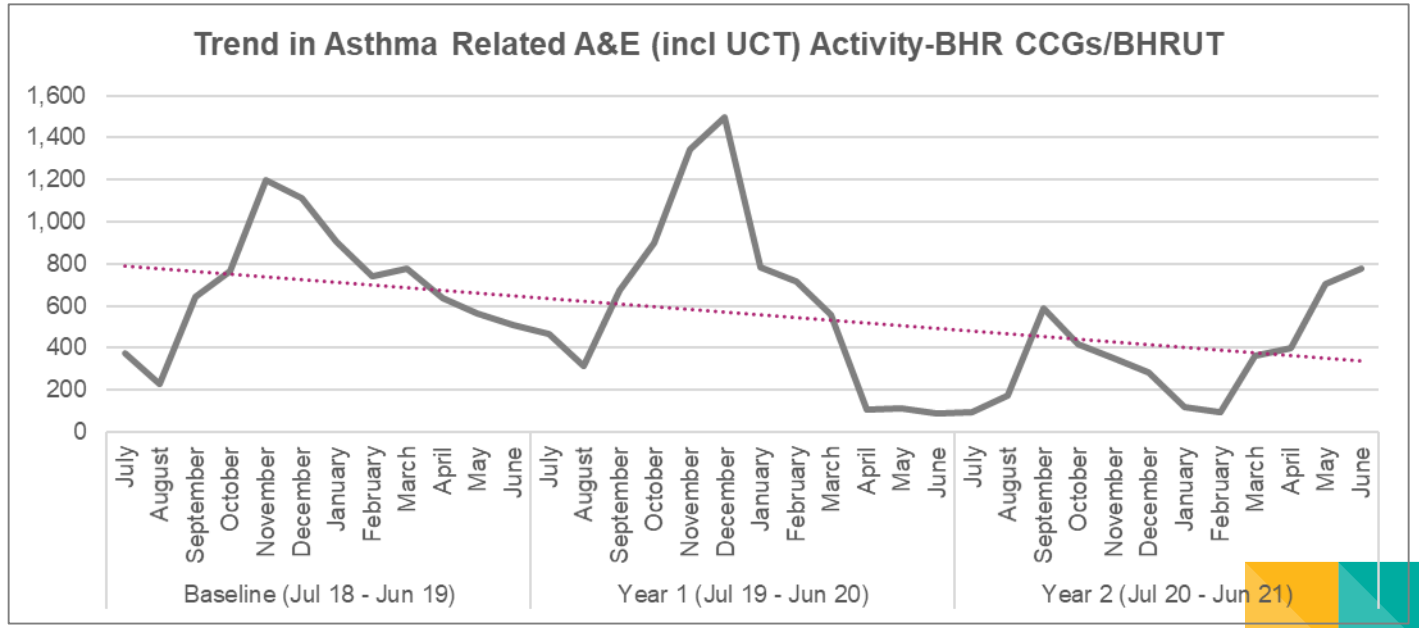
Children and Young People Transformation Board Impact Achievements



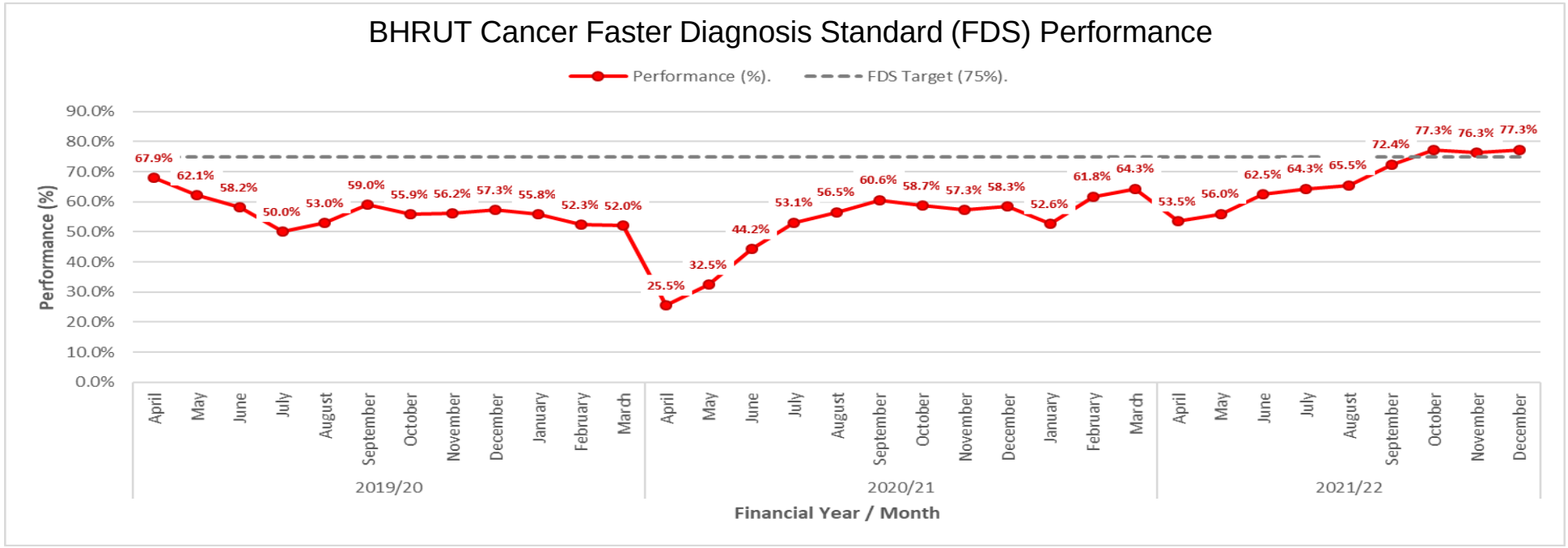


Key notes

- The Sustainable Asthmas LIS, which was implemented in 19/20 in response to the Regulation 28, focuses on providing education and support to children and their families to help manage the Asthma condition through the implementation of Care Plans. The service is an integrated service between Primary Care and Community services.
- The Sustainable Asthmas LIS, has resulted in a 200% increase in the number of care plans issued since its implementation (from 1,574 in August 20 to 4,790 at the end of March 21), with the impact of the care plans seen in the following months and years.
- The implementation of the LIS has contributed to a 48% reduction in Children's Respiratory related A&E/UCC attendances across BHR, (from 8,462 attendances (pre-LIS) to 4,360 over the past year)
- Paediatric Emergency admissions, which are directly attributable to minor Asthma conditions, has also reduced by 48% across BHR, from 405 admissions pre LIS (Baseline Year), to 208 admissions in year 2 of the scheme. Whilst some of the reduction can be attributed to the impact of Covid, admissions have not reached pre-Covid levels, in part, driven by the increase community base care provided by the LIS.



Cancer Transformation Board Impact Achievements



Key notes

- Significant work has been undertaken by the Trust to improve the Faster Diagnosis times including:
  - Dedicated clinical review clinics established with consultant time to sign patient off pathway
  - Local process agreed with Primary Care on endoscopy sign off process to support FDS compliance
  - Clinic capacity increased to reduce median waits
  - Clinical triage team booking directly onto Endoscopy list
  - Increased Radiology scanning capacity to support delivery of FDS and resource has been allocated to support Gynae and Urology specifically.

- This work has resulted in the current performance being back at pre-Covid levels. The FDS December 2021 Published information indicates a performance of 77.30%, 2.30% above the 75.0% Target.

- There has also been an improved position for the 28 Day FDS in Gynaecology and Upper GI seen in September 2021.