# Pennine Lancashire UEC improvement plan

*Version for 19th July 2024 submission*

# Introduction and contents

This document shows the UEC improvement plan from Pennine Lancashire UEC DB as at 19th July, updated from the version submitted 28th June.

This document includes the following:

1. Aim of the UEC improvement plan
2. Synthesis of the key findings from the UEC Diagnostic
3. Our theory of change, showing the key areas of initiative that address the key findings from the UEC Diagnostic
4. A synthesis of the potential magnitude of impact (both quality/ safety and financial) from each area of the theory of change
5. UEC improvement plan workstream overview
6. Quantifying the impact of initiatives and de-escalating the UEC system
7. Plan for governance, reporting and monitoring of the implementation and impact of the plan at UEC DB level
8. Next steps and key risks to mitigate for onward development and implementation of the UEC plan

**Appendix 1 – UEC improvement plan quantification detail**
**Appendix 2 – Initial workstream detail UEC improvement plan**
**Appendix 3 – Place plans**

# **Section 1:** Aims of this UEC plan

*Aligns to LSC R&T plan

1. **Improve outcomes and experience** for patients by:
   - improving access and equality of access to services
   - reducing delays in care
   - providing care in the most appropriate setting

2. To drive **de-escalation of the system** enabling cost reduction and future cost avoidance by improving system flow, with substantial improvement in 24/25 and further gains planned for 25/26 and 26/27. Targeting:
   - elimination of corridor care
   - elimination of boarding on wards
   - improvement of performance against ED 12-hr and 4-hr targets

3. To provide the **outline of cost savings** for providers to complete the detail of their **24/25 CIP plans by the end of June**

4. To set out plans to deliver **end-to end improvement against access performance standards and flow KPIs**, quantified where possible, to potentially include: 1) UEC total costs of care; 2) ED 4 hour % and # of 12-hour breaches; 3) Ambulance handover minutes; 4) LOS; 5) NMCTR

5. **Plans linked to existing programmes** and aligned with the ICS UEC strategy

6. **Ownership** of plans delineated between Trusts, Place and system-wide (ICB)

**Our specific application of these aims to Pennine Lancashire:**

Our overarching aim is to **stabilise and reduce the costs of our UEC system by keeping people safe and well at home**.

We will do this through the delivery of **timely, well-coordinated, community-based support with safe and effective in-hospital provision** available when needed.

**Key priorities:**

1. Intervene with key populations and cohorts where the opportunity is greatest to reduce attendances and admissions, through keeping people safe and well at home and step-up, relative to investment required
2. Right size the acute bed base to support onward flow
3. Focus on optimising in-hospital flow through process optimisation

**Outcome Measures *specific to Pennine Lancashire System:***

1. Zero growth in AED attendances (2024-2025)*
2. Reduce AED attendances in 2025/2026*
3. Reduce the no. of patients receiving corridor care (zero by 2026)
4. NMCR to not go above 5%* (LSC system)
5. Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours by March 2025
6. Improve Cat 2 ambulance response times to an average of 30 minutes across 2024/25

**Cohort specific outcome targets**

***Frailty –*** *prevent 664 hospital conveyances and reduce admissions for people 65+*

***End of life*** *– reduce acute service utilisation in last 90 days of life, increase in % of people on EoL register who have an Advance Care Plan, reduce % of deaths that occur in hospital*

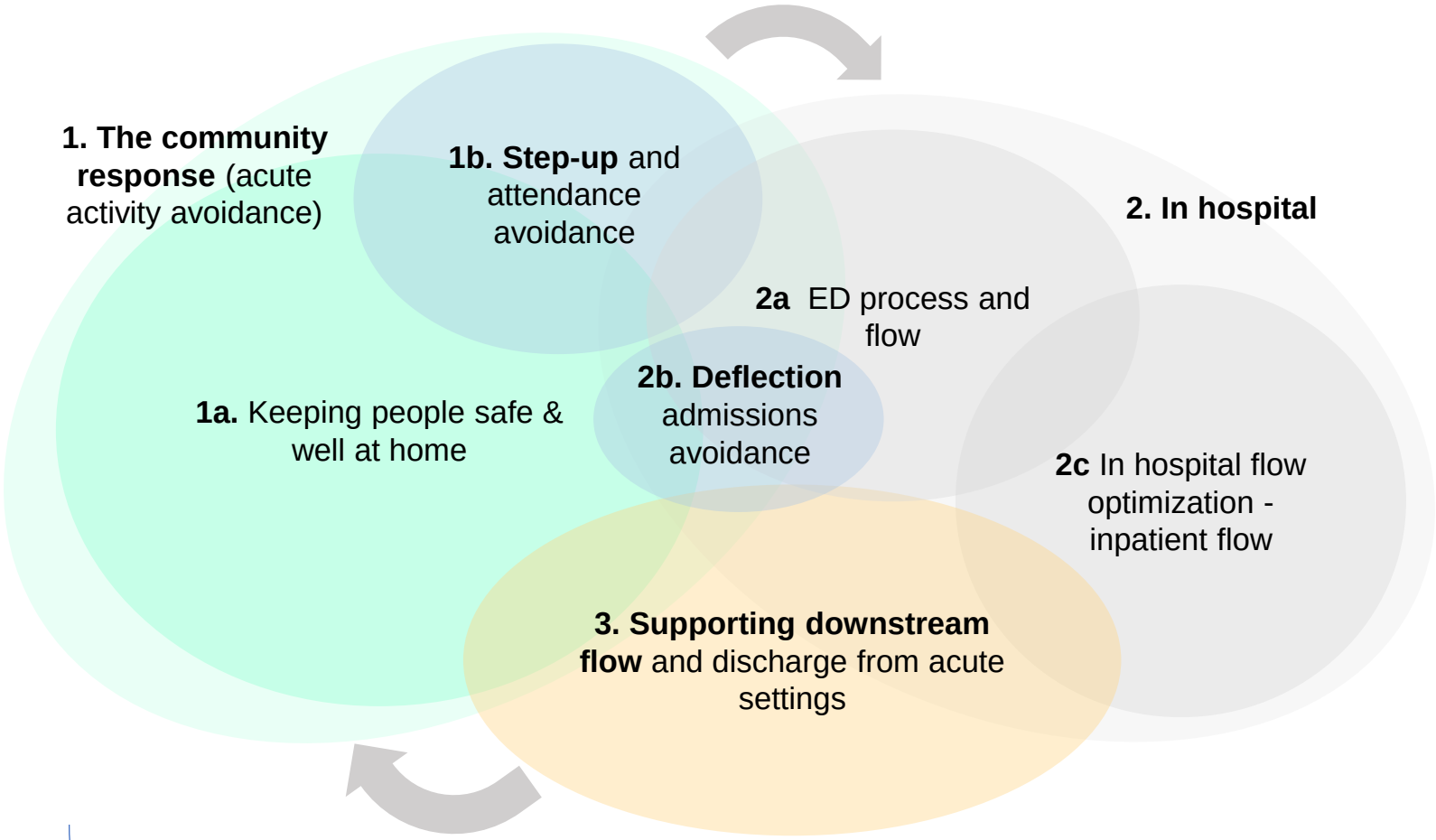
***Care sector –*** *reduce attendances and admissions from care homes*

# **Section 2 |** Synthesis of the key findings from the UEC Diagnostic

1. In-hospital UEC cost growth in Pennine Lancashire has been rapid (> 50% between 2018-19 to 2022-23), and is crowding out other areas of spend and activity, both in-hospital and out-of-hospital
2. There are data accuracy and availability problems that need to be resolved (including hospital EPR data to SUS; enhanced access GP appointment data to NHS England dashboard; visibility of social care waiting times data) for the UEC DB to have an accurate, up to date view of benchmarks
3. Based on data up to 2022-23, Pennine Lancashire's use of acute beds per weighted capita, and in-hospital UEC costs per weighted capita, are approximately in line with national average, and are lower than other areas of Lancs & South Cumbria
4. Pennine Lancashire has seen very fast growth in A&E attendances and faster-than-national-average growth in emergency admissions (principally in LoS <1 day)
5. Pennine Lancashire is an outlier on several primary care benchmarks, including: primary care workforce to weighted population; primary care appointment attendance to weighted population; in 2022/23 it received lower primary care expenditure per weighted capita than other parts of the Lancashire & South Cumbria system (BwD was approximately £3M below average on prescribing spend and £2M below average on services grouped as "list-based contract services)
6. The acute system is escalated in a way that compounds performance problems (i.e., knock-on impacts, vicious cycles). De-escalation of the acute system must be a part of the UEC plan
7. There are a number of operational opportunities in-hospital, particularly on wards, and also relating to ancillary services (e.g., optimisation of current services)
8. Social care saw much slower growth in total costs than was seen in UEC costs, with slow growth in number of people aged 18+ receiving long-term support: this growth was slower than the growth in weighted population. There was significant unit cost inflation which drove social care cost growth.

Occupied bed days absorb the most cost, and are the driver of corridor care and of waits for admission in ED. Targeting reductions in occupied bed days (e.g. through avoiding admissions) will support driving down costs, however there is also a need to right size the acute bed base to enable flow.

# **Section 3 - Theory of Change |** While improvement actions will be aligned to specific areas of focus UEC pathways are circular and have substantial interdependence




Enabled by: **4. System oversight of UEC performance and place management of improvement**

**The UEC system is highly interdependent. "De-escalation" is essential** to reverse the knock-on cycles which affecting quality, safety, and costs. This requires **collaborative place-based working across key 'areas'**. All areas are multi-organisation:

**1a.** Within the community (adult social care, primary care, community services, VCSF) – care, prevention, and intervention at home

**1b.** Response at the point of crisis to avoid acute activity and support people in the community

**2a.** From attendance at ED to admission to an inpatient bed or discharge from acute services

**2b.** Following attendance services to support admissions avoidance (e.g. SDEC, ASC step-up, community service transfer) to acute discharge

**2c.** Inpatient stay from admission to an inpatient ward to discharge from hospital

**3.** Process and services to support swift discharge from at the point of medical optimisation and support people through intermediate care

**4.** Place based leadership to enable UEC improvement including data and reporting to support evidence-based review of opportunities and progress

# **Section 4:** Synthesis of potential magnitude of impact, per area (1/2)

It is a priority to de-escalate the System (particularly acute settings), this can be achieved through several influencing factors as outlined in the theory of change. The below explore the relative priority of interventions outlined in the theory of change and maps current programmes of work to these areas.

| Area of opportunity* | Preliminary magnitude of opportunity | | Rationale | |
|---|---|---|---|---|
| | Quality and Safety | Finance | Blackburn with Darwen | East Lancashire |
| **1a.** The response in the community (acute activity avoidance) – **keeping people safe & well at home** | **Some opportunity**: expanded services will support earlier intervention and prevention | **Substantial opportunity:** Avoidance of acute activity and associated costs (supports de-escalation) | Weighted population growth (2%) and growth in deaths (5.6%) are substantially below System and National averages – although it should be noted that age standardised mortality rate is 29.5% above national averages. High levels of deprivation are apparent in BwD. BwD benchmarks low compared to National averages and others in the System against a range of Primary care metrics. This combined with high growth in attendances (24%), a relative increase in walk-in activity and work done by ELHT (reviewing attends that could have been supported in the community) suggests there is opportunity to keep people safe and well at home. | Weighted population growth rates (4%) and growth in deaths for Lancashire are similar to average System trends.<br>EL benchmarks slightly higher than BwD on some Primary Care benchmarks, but lower than System and National averages. This combined with high growth in attendances (24%), a relative increase in walk-in activity and work done by ELHT (reviewing attends that could have been supported in the community) suggests there is opportunity to keep people safe and well at home. |
| **1b.** The response in the community – **step up and attendance avoidance** | | | There are a number of initiatives in this space already, including mature community services, and evidence of these working well (e.g. reduced ambulance conveyance).<br>However, given the level of attendance and growth in attendance and that admissions avoidance is more cost effective and better for patients, there are likely to be opportunities to step-up or otherwise prevent admission (e.g. targeted work with care homes, increases clinical capacity in response teams). This is likely to particularly relate to frail/elderly populations – with a query on how this links to MH and those with multiple vulnerabilities. | |
| **2a.** In hospital flow optimisation **- ED process and flow** | **Some opportunity** | **Limited opportunity** | The level of crowding is driving operational efficiencies in what is otherwise a well-established and well-connected department. Onsite observations suggest there may be opportunities to adjust process to minimise the impact of crowding in the short term. In the longer-term wider de-escalation is likely to deliver financial savings as surge capacity can be stood down. | |

# **Section 4:** Synthesis of potential magnitude of impact, per area (2/2)

It is a priority to de-escalate the System (particularly acute settings), this can be achieved through several influencing factors as outlined in the theory of change. The below explore the relative priority of interventions outlined in the theory of change and maps current programmes of work to these areas.

| Area of opportunity* | Preliminary magnitude of opportunity | | Rationale | |
|---|---|---|---|---|
| | Quality and Safety | Finance | Blackburn with Darwen | East Lancashire |
| **2b.** In hospital flow optimisation **- Deflection** | **Limited opportunity** | **Limited opportunity** | *Data quality limited by CERNER implementation 2023/24 – onsite observations showed limited opportunities for improvement.*<br>Given the high level of attendances it may be that there are some opportunities to expand SDEC capacity to support deescalating ED (e.g. extending SDEC hours, SDEC estate to support bedded assessment). | |
| **2c**. In hospital flow optimisation **- inpatient flow** | **Some opportunity** | **Some opportunity** | *Data quality limited by CERNER implementation 2023/24 – onsite observations showed limited opportunities for improvement.*<br>Opportunity to deliver financial savings compared to benchmarks are limited due to the slower cost growth in ELHT below national average growth in 18/19 to 21/22 but accelerating for 22/23 (52%). De-escalating the system is likely to include increasing core beds. However, in parallel to this on-site observations indicated opportunities to optimise and standardise ward process – *noting that data quality means there are not up to date benchmarks for occupied or excess bed days.* This will deliver flow benefits, supporting wider de-escalation and improved patient experience. | |
| 3. Supporting downstream flow and discharge from acute settings | **Some opportunity** | **Limited opportunity** | Low NCTR and discharge generally reported as working well indicates minimal flow block. However onsite staff reported higher levels of delay relating to BwD supported discharge. Staff also noted that there were opportunities to build in hospital awareness and use of community services (e.g. virtual wards). | Low NCTR and discharge generally reported as working well indicates minimal flow block. Staff noted that there were opportunities to build in hospital awareness and use of community services (e.g. virtual wards). |
| 4. System oversight of UEC performance and place management of improvement | TBC | TBC | TBC – the extent to which altered governance and expanded reporting (e.g. frailty dashboard) will support sustainable implementation of initiatives and UEC improvement – including ongoing identification and targeting of opportunity. | |

# Section 5 | Overview of schemes

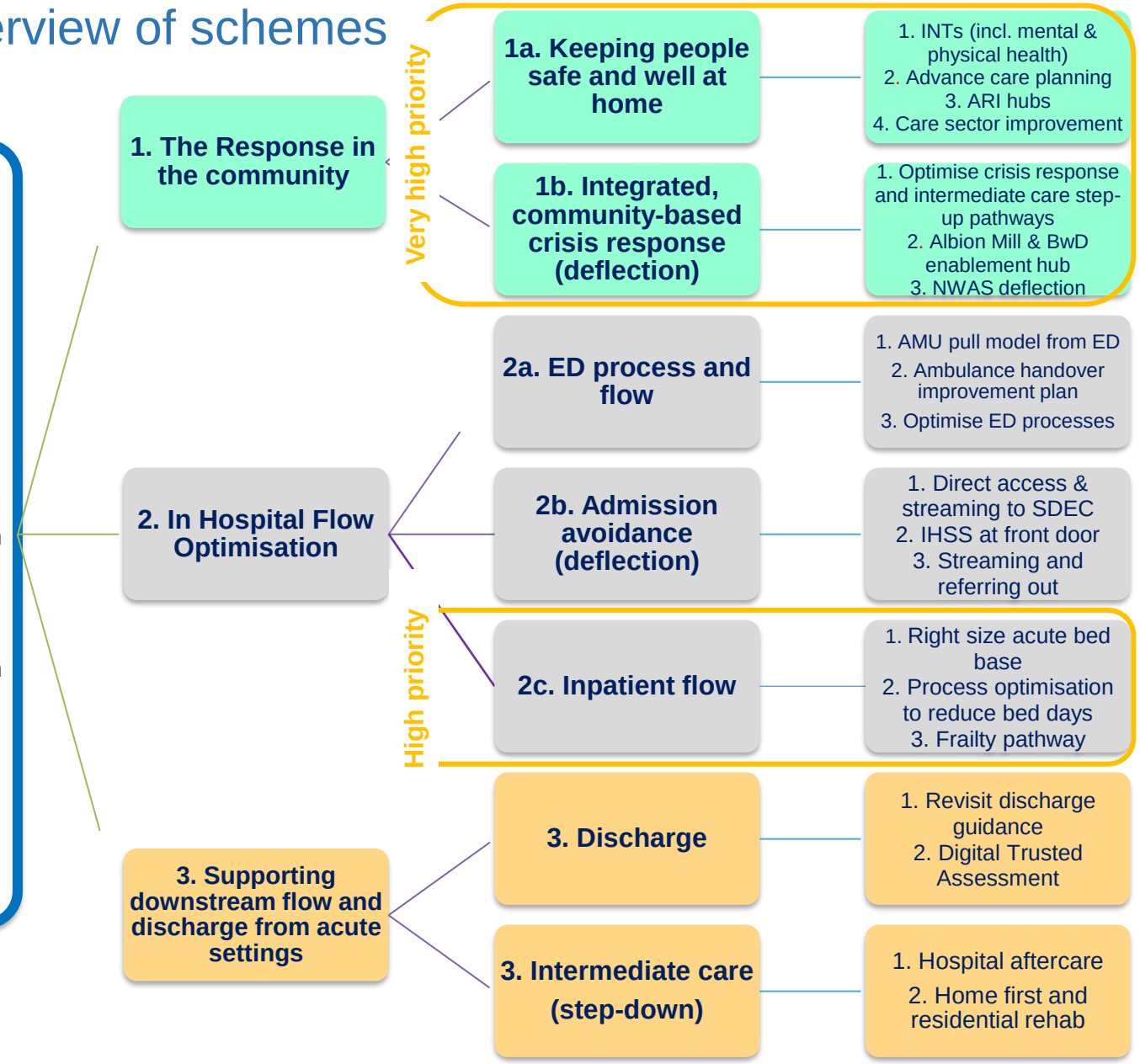
**Aim**

**To stabilise our UEC system by keeping people safe and well at home.**

**We will do this through the delivery of timely, well-coordinated, community-based support with safe and effective in-hospital provision available when needed.**

**Measured by:**

1. **Reduction/ elimination of corridor care**
2. **Reduction in delays and escalation level in ED**
3. **Financial savings associated with the above**




These priority schemes have been selected through discussions with a UEC implementation plan working group, which first worked to identify all schemes relating to each area of opportunity, and then collaboratively identified those of highest priority.

**4. System oversight of UEC performance and place management of improvement**

**ENABLERS >>**

- **Renewal of shared commitment to a step-up focused UEC system**
- **Changing our culture – collaborative delivery with collective accountability**
- **Simplified Governance/Reporting across Place/Place+**
- **Levelling up primary care funding**
- **Focused BI and Commissioning Support (Incl. Data Science)**
- **Communications + Engagement Support**
- **ICB enabled Data (111, General Practice)**
- **Developing a shared system view**

**Population Health, Primary Care, Mental Health, PCN/INTs, Local authority, VCFSE, ICB Programmes**

**Engagement, Enabling and Involvement: Ensuring our plan has residents and staff at the centre**

# Section 5 | UEC Improvement Plan | Key interventions

| Very high priority | | | | High priority | |
|---|---|---|---|---|---|
| **1a. Keeping people safe and well at home** | **1b. Community based crisis response** | **2a. In hospital flow - ED** | **2b. Admission avoidance (deflection)** | **2c. In hospital flow - inpatients** | **3. Discharge and intermediate care (step-down)** |
| Anticipatory care planning in INTs<br><br>Advance care planning for End of Life<br><br>End of Life training for care home and health and care staff<br><br>End of Life support for vulnerable people (Burnley & Blackburn)<br><br>Priority wards (BwD & Hyndburn)<br><br>GP quality scheme<br><br>Mental health MDTs<br><br>ARI Hubs (incl. deflection from ED)<br><br>Care sector improvement (BwD) | NWAS deflection of ambulatory activity (30%) into 2Hr UCR<br><br>Review and improve Initial Response Service (mental health)<br><br>Develop step-up pathways into intermediate care, hospice & community-based support (bedded and non-bedded) incl. IHSS, 2hrUCR, etc<br><br>Simplifying access to support for care homes<br><br>Mobilise BwD Enablement Hub<br><br>Mobilise intermediate care at Albion Mill<br><br>Calico extra care provision (Burnley)<br><br>Intermediate Tier management (access and navigation/transfer of care hub<br><br>Implement the 'Lancashire Model of Intermediate Care' (step up and step down) | Ambulance handover improvement projects<br><br>Optimise internal ED process (e.g. redistribute resources in ED)<br><br>Develop a "pull model" from specialities into AMU to support ED Flow. | Review of current streaming activity & future options for improvement<br><br>Continue UTC referrals to Community Pharmacy<br><br>Extend IHSS hours at front door – dependent on continuation investment<br><br>Increasing access & direct streaming into SDEC (incl. OPRA), including exploration of digital referrals<br><br>Mental health crisis intervention team – needs scoping and business case development<br><br>Test of change around ED acuity tool | Hospital frailty pathway - IHSS, OPRA, front-door therapy, outward facing for community as well<br><br>Streamline internal process: early discharges (e.g. use of discharge lounge, TTOs, performance targets for care home and community bed discharges)<br><br>Right sizing the acute bed base | <u>Discharge</u><br><br>Nurse led hospice at home provision<br><br>Discharge – review of guidance and pathway optimisation<br><br>Digital Trusted Assessment<br><br><u>Intermediate care step down</u><br><br>Short-Term help and support (formerly Hospital Aftercare)<br><br>Home First model & requirement for residential rehab |

Colour Key:

- Place ownership & delivery
- UECDB ownership and/or Pennine delivery
- Needs further development

# Section 5 | UEC Improvement Plan | Timescales for delivery (subject to capacity)

| | Intervention | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|
| 1a | INTs (incl. mental & physical health) | Mobilising | | Delivering | | | | | | |
| 1a | Advance care planning | Scoping | Mobilising | Delivering | | | | | | |
| 1a | ARI hubs | Scoping | Mobilising | Delivering | | | | | | |
| 1a | Care sector improvement | Scoping | | Mobilising | | Delivering | | | | |
| 1b | Define step-up pathways/optimise crisis response | Subject to mobilisation capacity | | | | | | | | |
| 1b | Albion Mill and enablement hub (BwD) | Albion Mill phase 1 | | | | Albion Mill Phase two scoping | | | | |
| | | Enablement Hub mobilising | | Enablement Hub delivering | | | | | | |
| 1b | NWAS deflection of ambulatory activity | Crews Pilot Mobilising | | Crews Pilot delivering | | | | | | |
| | | ELMS pilot scoping - mobilisation TBC | | | | | | | | |
| 2a | Optimise AMU pull model from ED | Mobilising | | | Delivering – subject to D2A clearance | | | | | |
| 2a | Ambulance handover improvement plan | Delivering – continual refinement and improvements ongoing | | | | | | | | |
| 2a | Optimise ED processes | Mobilising | | | Delivering | | | | | |
| 2b | Direct access & streaming to SDEC | Scoping underway – mobilisation TBC | | | | | | | | |
| 2b | IHSS at front door | Subject to discussions regarding mainstream funding continuation (ELHT) | | | | | | | | |
| 2b | Streaming and referring out | In place but opportunity to refine with broader partners and pathways | | | | | | | | |
| 2c | Right size acute bed base | B18 live | | | | | | | | |
| | | B6 mobilising but unfunded | | | | | | | | |
| | | B3 requires funding conversation | | | | | | | | |
| 2c | Process optimisation to reduce bed days | Discharge dashboard | | | | Medically optimised ward | | | Criteria led discharge | |
| 2c | Frailty internal flow and pathway | Mobilising | | | Delivering | | | | | |
| 3a | Revisit discharge guidance | Scoping underway – mobilisation TBC | | | | | | | | |
| 3a | Digital trusted assessment | Scoping underway – mobilisation TBC | | | | | | | | |
| 3b | Hospital aftercare service | Delivering | | | | | | | | |
| 3b | Home first and residential rehab optimisation | Mobilising | | Delivering | | | | | | |

# Section 5 Cohort sizing | To support definition and prioritisation of initiatives, we have assessed the size of key cohorts, and their impact on UEC system resources and performance

- We have quantified the size of each cohort across key metrics, as shown below
- We also know that cohorts are overlapping (e.g., some individuals who are in EOLC are also care home residents)
- And we know that as a result of population growth and ageing (as well as impacts associated with populations with multiple vulnerabilities), cohort 1 and cohort 3 are each growing at approximately 1% per annum

**Cohort Size - Absolute Metrics**

- The over 65 conversion rate is 38% and the conversation rate for care home residents is 54.8% - the conversion rate for individual frailty cohorts (e.g., with score of mild or moderate) is likely between these two

| Cohort | Population | ED attendances | Admissions (Low) | Admissions (high) | Occupied bed days | Simple estimate for cost per bed day | Simple estimate of cost of bed days for addressable cohort |
|---|---|---|---|---|---|---|---|
| Cohort 1: EOLC individuals aged over 65 - last year of life and also using "severe frailty" as a proxy for last year of life | Circa 5,000 individuals in last year of life at any one time | 8,258 | 5,197 | 7,085 | 45,342 | £350 | £15,870,000 |
| Cohort 2: Care home resident (over 65) | | 5,506 | 3,018 | 3,018 | 28,067 | £350 | £9,824,000 |
| Cohort 3: Individuals with a Secondary Care Frailty Score of Mild or Moderate (over 65) | | 22,408 | 8,540 | 12,282 | 110,798 | £350 | £38,779,000 |
| All adults aged 65+ | 101,118 | 53,798 | 20,503 | 20,503 | TBC | £350 | TBC |
| Pennine Lancs total (all ages) | 537,400 | 207,767 | 62,905 | 62,905 | 292,127 | £350 | £102,244,000 |

To avoid double counting, we have used an approximating assumption that the EOLC cohort and severely frail cohort are largely the same cohort. The figure of 5,198 emergency admissions comes from the EOLC daashboard, and the figure of 7,085 admissions comes from the frailty dashboard

The "care home resident" cohort will be partially overlapping with the "mild or moderate frailty" cohort, and will be partially

**Cohort Size - As a proportion of Pennine Lancs totals**

| Cohort | | Cohort share of Pennine Lancs ED attendances (all ages) | Cohort share of Pennine Lancs Emergency Admissions (all ages, lower range of estimated share) | Cohort share of Pennine Lancs Emergency Admissions (all ages, higher range of estimated share) | Cohort share of Pennine Lancs all ages occupied bed days |
|---|---|---|---|---|---|
| Cohort 1: EOLC individuals aged over 65 - last year of life and also using "severe frailty" as a proxy for last year of life | | 4.0% | 8.3% | 11.3% | 15.5% |
| Cohort 2: Care home resident (over 65) | | 2.7% | 4.8% | 4.8% | 9.6% |
| Cohort 3: Individuals with a Secondary Care Frailty Score of Mild or Moderate (over 65) | | 10.8% | 13.6% | 19.5% | 37.9% |
| All adults aged 65+ | | 25.9% | 32.6% | 32.6% | TBC |
| Pennine Lancs total (all ages) | | 100% | 100% | 100% | 100% |

Quote from Amanda Pritchard: Just last week I met with our clinical leads on palliative care and end of life care. They told me that a third of all bed days are accounted for by a tiny proportion of our population, around 1%, who are in their

# Section 5 | Priority interventions for our people | Aligning improvement actions in priority areas to patient cohorts

| 1a. Keeping people safe and well at home | 1b. Community based crisis response | 2c. In hospital flow - inpatients |
|---|---|---|
| **Cohort 1 - EoLC:**<br>End of Life training for care home and health and care staff<br>End of Life support for vulnerable people (Burnley & Blackburn)<br>Advance care planning for End of Life<br><br>**Cohort 2 - Care Sector:**<br>Care sector quality improvement (BwD)<br>Simplifying access to support for care homes<br><br>**Cohort 3 - Frail:**<br>Anticipatory care planning in INTs<br>ARI Hubs (incl. deflection from ED)<br>BwD enablement hub<br>Priority wards (BwD & Hyndburn)<br>GP quality scheme<br><br>**Cohort 4 - Mental health**<br>Mental health MDTs | **Cross cutting**<br>Develop step up pathways into intermediate beds, hospice care, and community based supporting. Including use of UCR, IHSS and ICAT<br>NWAS deflection of ambulatory activity (30%) into 2Hr UCR - to confirm cat 3 and 4 NWAS conveyances<br>Mental health<br>Review and improve Initial Response Service (mental health) | Hospital frailty pathway - IHSS, OPRA, front-door therapy, outward facing for community as well<br>Streamline internal process: early discharges (e.g. use of discharge lounge, TTOs, performance targets for care home and community bed discharges)<br>Right size acute bed base ahead of next winter and support the reduction of bed occupancy |

Colour Key:
- Place ownership & delivery
- UECDB ownership and/or Pennine delivery

# Section 5 | Priority interventions for our hospital | Rightsizing the acute bed base

**Initiative title:** Rightsizing the acute bed base
**Initiative description:** Review bed modelling for the Acute Trust
**Alignment to priority area:** 2c. In-hospital flow optimisation – in-patient flow

**2. Status of planning:**
Results of modelling exercise expected to be available in July 2024.
Early indications show there is insufficient bed capacity to meet demand and this is supported within the recent, PSC review.

**3. Evidence / rationale for prioritising this initiative:**
There has been a rise in ED attends and increase in acuity over the past 12 months. Despite ELHT increasing its escalation and surge capacity, together with continuation of the Winter Ward, patients are still spending extended times on both ED and main hospital corridors. Furthermore, extended waits elevate the risk of potential harm

**4. Resources and/or investments required to implement the initiative successfully:**
Pay and non-pay but working on the basis that the current cost of corridor care, exceeds the cost of a substantive ward and therefore reduces run rate expenditure and ultimately, improves the safety, quality and experience for patients

**5. Expected implementation timeline and milestones:** [add]

| Key milestones | Date |
|---|---|
| Unfunded Ward, currently being utilised (B6 – 22 beds) agreement made internally to extend opening for 2 weeks (25/6) – currently operational, but funding agreement required to maintain | Current |
| One ward available to occupy following essential fire works (B18 – 26 beds) – funding agreement dependent | 22/06/2024 |
| Mobilise winter escalation ward (B1 – 24 beds) – funding agreement dependent | November 2024 |
| | |

**6. Initiative ownership RACI:**
- Divisional Triad for Medicine and Emergency Care Division
- Trust Executive Team

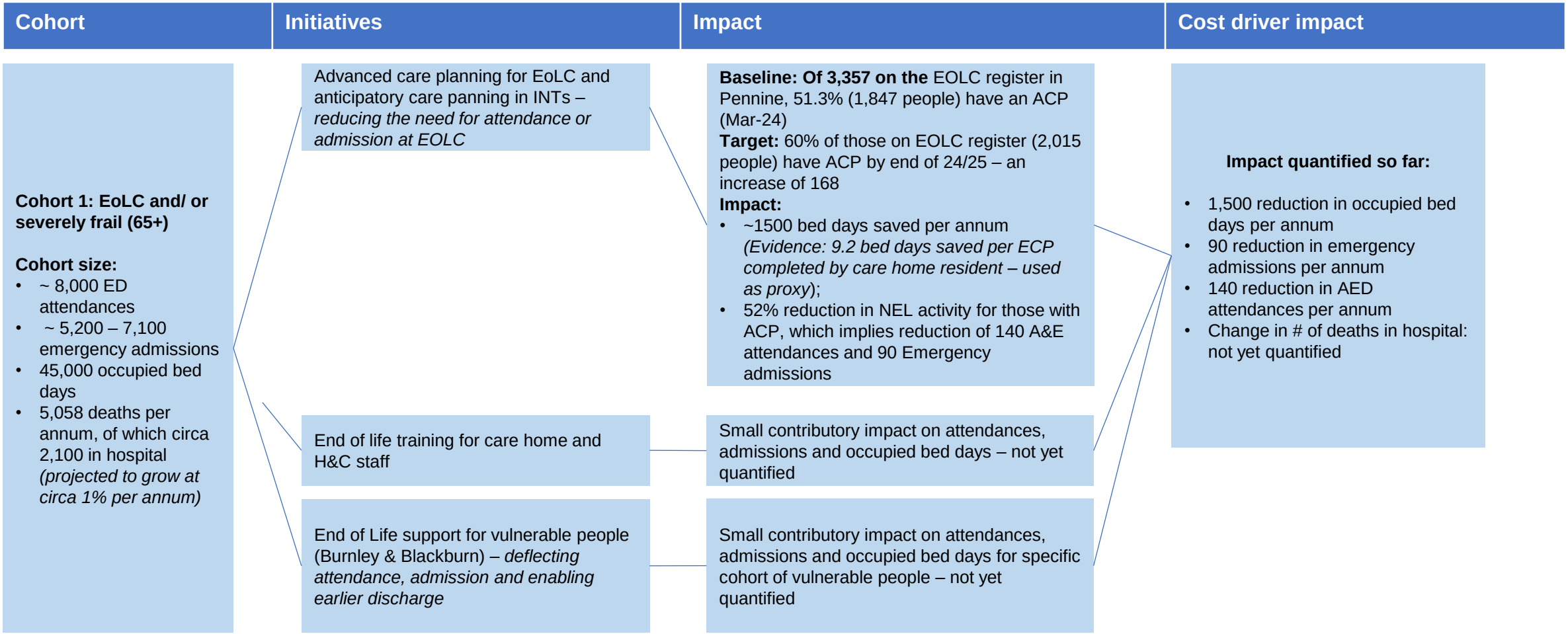
**7. Qualitative description of expected impact, including a note about KPIs expected to be impacted:**

| Description of impact | KPIs |
|---|---|
| | |
| +12-hour trolley waits in ED | Reduction in number of pts +12 hour waiting for admission |
| Financial Impact | Reduction in spend from current UEC run rate |
| Length of Stay (LoS) | Reduction in LoS |
| Harms and Incidents | Reduction in harms and Incidents reported because of overcrowding and delays in care |
| | |

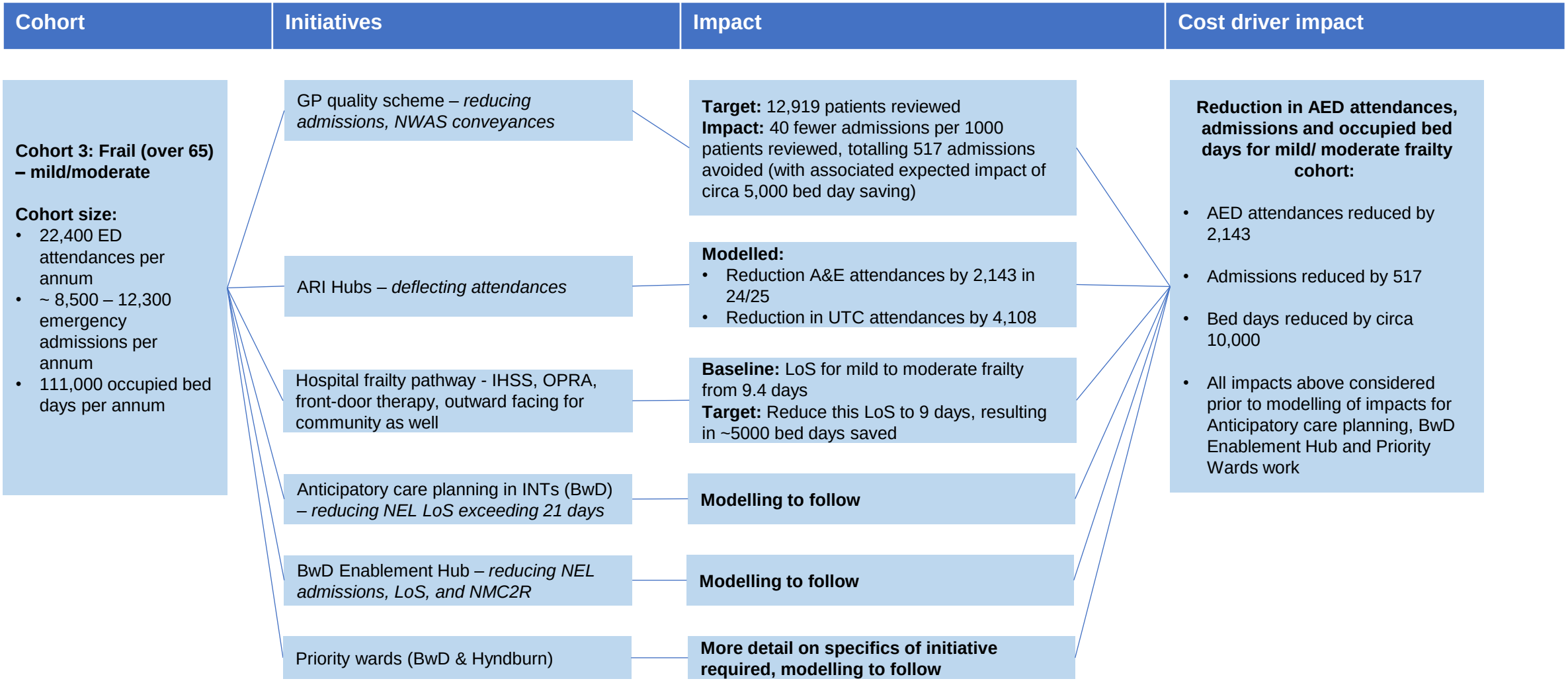
**8. Project risks: Not Increasing Bed Base**

| Description of risk | Score = likelihood (1-5) x impact (1-5) | | Mitigation |
|---|---|---|---|
| Patients spending excessive time on corridors safety, quality of care and patient experience | | | Continue to staff corridors with additional clinical and nursing teams providing wraparound care |
| Increasing LoS impacts flow | | | |
| Funding agreement not secured | | | |

# Section 6 | Quantifying potential impact| Example of using logic models to assess potential impact of interventions (example 1 of 2)



# Section 6 | Quantifying potential impact| Example of using logic models to assess potential impact of interventions (example 2 of 2)



# Section 6 | Financial impact and de-escalation | Outline de-escalation plan

Right-sizing of the acute bed base (intervention 2c), allows a transfer from corridor care to care of the same patients in a ward setting (e.g., B18).
Over time, this will enable the closure of escalation spaces, and consequently provide cost savings.

The proposed sequencing of this de-escalation is as follows:

1. Eliminate corridor care in the main hospital corridor
2. Then eliminate corridor care on the AMU B corridor
3. Then reduce crowding in ED and the use of ED corridor spaces through reducing in-ED delays associated with patients who have a Decision-to-Admit but who are waiting for a bed

Financial modelling has been robust, in order to avoid double counting and net off associated costs, as such there is a relatively high level of confidence in the savings level proposed. Delivery of the system wide interventions (1a, 1b & 3) will likely produce additional impacts on bed days and as such will contribute to additional savings if successful. However there has not been the time nor capacity to model through the timings of impact of these interventions, and therefore savings are not yet quantifiable. Further detail is outlined on the following slide.

| Escalation space | Baseline | Cost per annum (£000s) | Estimated cost reduction in year 24-25 | Full year effect | Q2 24/25 | Q3 24/25 | Q4 24/25 | Q1 25/26 | Q2 25/26 | Q3 25/26 | Q4 25/26 | Q1 26/27 | Q2 26/27 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Main hospital corridor | Up to 26 beds* | 2,500 | 3,900 | 6,000 | Open | Partially closed | Closed | Closed | Closed | Closed | Closed | Closed | Closed |
| AMU B corridor | Up to 8 beds* | | | | Open | Partially closed | Partially closed | Closed | Closed | Closed | Closed | Closed | Closed |
| ED corridor care | Up to 33 beds in main ED corridor, 3 beds in ED surge and 2 beds in Resus* | 9,600 | | | Open | Open | Partially closed | Partially closed | Closed | Closed | Closed | Closed | Closed |
| Additional beds on wards | | 2,000 | TBC | | Open | Open | Open | Open | TBC | TBC | TBC | TBC | TBC |
| NMCR2 > 5% | Currently ~6.7%; aim to reduce to <5% | 2,600 | TBC | | Open | Open | Open | Open | TBC | TBC | TBC | TBC | TBC |
| Escalation wards | | 1,500 | TBC | | Open | Open | Open | Open | TBC | TBC | TBC | TBC | TBC |
| ***TOTAL*** | | ***18,200*** | | | | | | | | | | | |

# Section 6 | Additional impacts | Outline de-escalation plan system wide interventions

The initiatives highlighted in section 5 and quantified in section 6 are expected to reduce AED attendances, emergency admissions and occupied bed days for the frailty, EOL and Care sector cohorts.

The impact from the initiatives modelled so far, shows a potential saving of 11,500 occupied bed days. The impact associated with the EOLC cohort and the Frailty cohort is sufficient to close beds in corridors, but as noted the timing and financial impact of this has not yet been modelled. An overview of potential impacts for all modelled schemes is below. This requires further modelling work to reduce any duplication of counting and confidence from all partners of impact.

## ELHT & Place partners

NWAS deflection & ambulance handovers

Right size the acute bed base

Internal process optimisation

Frailty pathway optimisation

Direct access & streaming

IHSS at front door

## Local Authorities & Place partners

**Care home quality improvement**

**Intermediate care delivery**

**Effective discharge**

**Hospital after care**

**Home First and Residential Rehab**

**Priority wards**

**INTs**

## Primary care & Place partners

2200 ED attends, 4100 UTC attends & 600 admissions

ARI hubs deflection

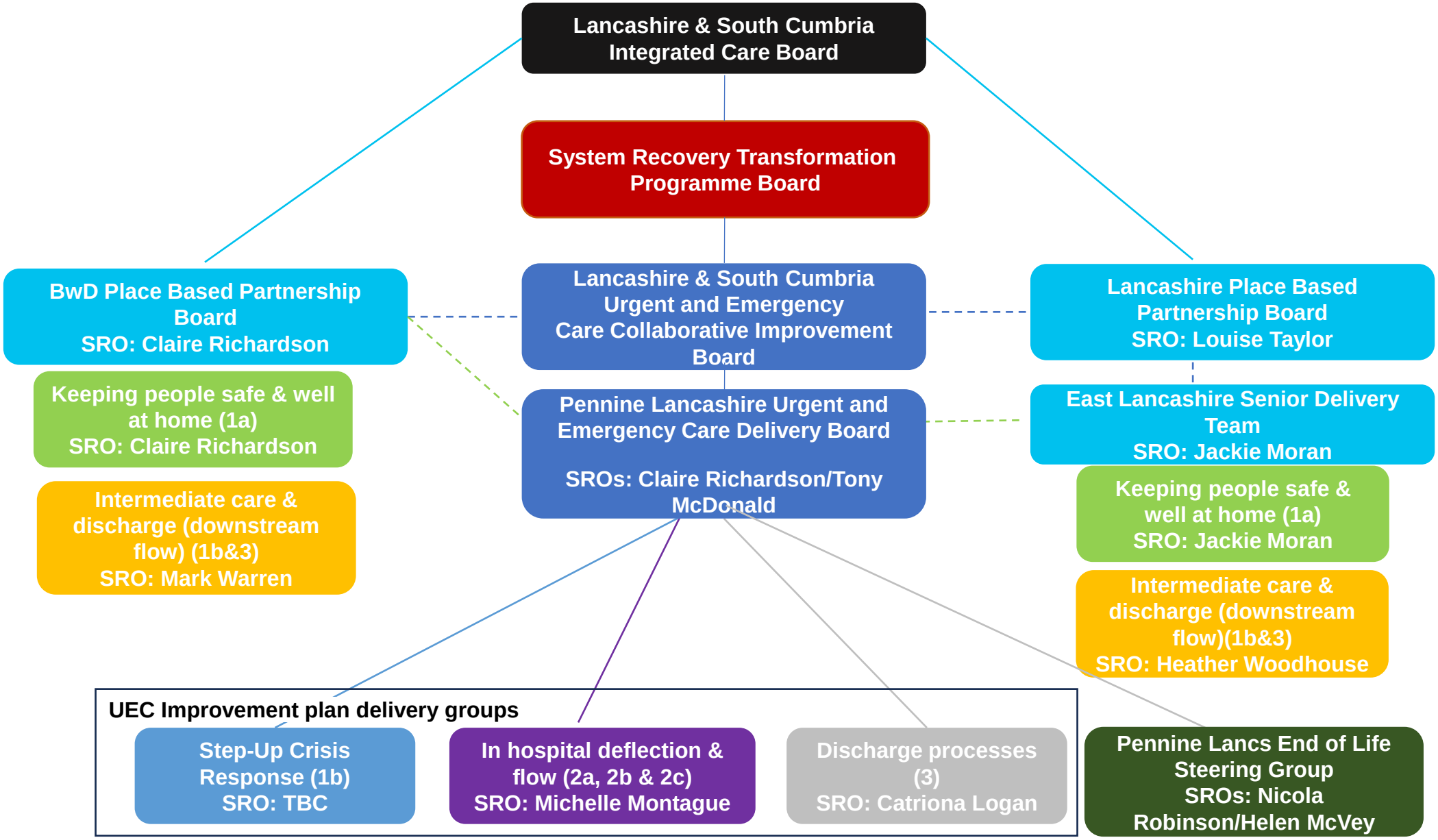
Frailty – quality contract

Early identification of End of Life

Advance care planning

Maximising existing provision (VW, 2hr, IHSS) to deliver more effective crisis response (step-up)
Not yet modelled

# Section 7 | Plan for governance



# Section 7 | Plan for governance, reporting and monitoring

| Board | Pennine Lancashire Urgent and Emergency Care Delivery Board | BwD Place Based Partnership Board/East Lancashire Senior Delivery Team | Workstream delivery groups |
|---|---|---|---|
| **Purpose** | The purpose of the Board is to ensure that patients access safe, timely and clinically effective urgent and emergency care (UEC) services, reducing waiting times and delays and improving quality<br><br>The Board will ensure that recovery and improvement plans are in place and priorities are being implemented, in accordance with evidence-based practice and national requirements.<br><br>It will resolve clinical, managerial, organisational, and strategic issues that impact on the delivery of UEC services and make decisions to both recover A&E performance and ensure continuous performance improvement across the UEC pathway, utilising the evidence base and national policy requirements. | To provide a vehicle for collaborative working and delivery of health and care services within Blackburn with Darwen/East Lancashire, connecting all partners to make joint recommendations as to the effective deployment of resources to drive integration and improved health outcomes.<br><br>To promote collective responsibility across all partners for the planning and delivery of health and care services within Blackburn with Darwen, in order to achieve the following aims:<br>• Improve the health and wellbeing of the population and reduce inequalities<br>• Provide services that are of consistently high quality, and that remove unwarranted variation in outcomes<br>• Achieve national standards / targets consistently across the sectors within the partnership<br>• Maximise the use of a place-based financial allocation and resources | Engage all health and care to drive the implementation of the agreed UECDB interventions. |
| **Key Responsibilities in relation to UEC plan** | • To oversee **UEC performance and to agree the actions required** and leads for delivery<br>• To **agree priorities (such as *respiratory, mental health, EOL and frailty*) that impact on UEC performance**<br>• To agree priorities for and **oversee delivery of the UEC Investment capacity funding**<br>• To **support planning for bank holidays, industrial action, pressure periods** e.g. winter<br>• To **oversee and agree the delivery and lead national requirement** e.g. UEC recovery plan, 10 high impact interventions<br>• To **oversee the UEC improvement plans/programmes of work and associated** interdependencies for Pennine Lancashire wide schemes<br>• To provide strategic direction and lead a collaborative approach to redesign integrated UEC.<br>• Ensuring insight, communications and engagement supports in and out of hospital flow | Setting the direction and overseeing delivery of the priority interventions outlined within:<br><br>**1a. Keeping people safe and well at home**<br>**1b. Integrated community-based crisis response -** through intermediate care step-up provision<br>**3.Discharge (downstream flow)** – through intermediate care step-down provision, reablement and aftercare<br><br>The place groups will be accountable to the UECDB for the delivery of these interventions.<br><br>The place groups will also influence and support delivery of the wider Pennine Lancashire workstreams through their engagement in the UECDB and its sub-groups | Develop action plans relating to each of the agreed interventions.<br><br>Progress delivery of each action.<br><br>Ensure progress reports against delivery (including relevant performance metrics) are provided to the UECDB on a monthly basis. |
| **Governance** | Reports to LSC UEC Collaborative Improvement Board<br>LSC ICB Resilience and Surge Planning Group holds a ring around winter plans and reports to UEC CIB. | Reporting structure:<br>• Blackburn with Darwen Place-based Partnership – LSC integrated Care Board<br>• East Lancashire Senior Delivery Team – Lancashire Place Partnership – LSC Integrated Care Board | Report to Pennine Lancashire UECDB |
| **Work Programme** | One single Improvement Plan in development, includes 4 workstreams<br>1. Step up crisis response<br>2. In-hospital deflection and flow<br>3. Discharge processes<br>4. Pennine Lancashire End of Life improvement | Place-based delivery plans covering aimed at keeping people safe and well at home by delivering against the following:<br>• healthy communities<br>• Integrated neighbourhood teams<br>• enhanced care at home (intermediate care)<br>• Wider place priorities | As defined within intervention plans |

# Section 8 | Risks to completion and implementation

**Risks:**

- X GPs contractual dispute – impacting on engagement and motivation to deliver differently, further compounded by reduced local capacity
- X Financial challenge of ICB system partners and knock-on impact on workforce
- X Short-term funding for UEC CIF schemes – late notification has delayed implementation, caused issues regarding recruitment and these projects will take time to deliver change
- X Community step-up pathway/response – development and full system sign-up to community-based step-up pathway is needed – risk that we don't have capacity to develop this; that our culture detracts us from getting to this model and delivering it; and the challenge of modelling impact
- X System capacity to deliver the programmes, including clinical and care professional support, front line staff and primary/community commissioning resource to facilitate changes to pathways
- X Professional risk appetite/risk aversion is currently a barrier – need to work with professionals to create new opportunities
- X VCFSE – capacity to support delivery programmes and communities; interdependency of UEC bid for Blackburn
- X Behaviour of our communities – needs an insight-based behaviour change approach
- X Potential that approaches focused on early identification will uncover unmet need and increase demands
- X Different local government arrangements across our footprint = different approaches to step up and step-down care

**Opportunities:**

- ✓ Community services consolidation – foundation for transformation
- ✓ CMHT co-location in existing neighbourhood teams
- ✓ Strong foundations in neighbourhoods
- ✓ Enablement test of change (UEC CIF)
- ✓ A good spread of 24/7 crisis response provision for step up which can be optimised and connected with more effective pathways to keep people safe and well at home
- ✓ Strong relationships with hospices and a willingness from all to deliver differently
- ✓ Willingness to learn from good practice and what works in other places/systems
- ✓ Strong, whole system commitment to getting it right for our people and keeping people safe and well at home
- ✓ Assign recurrent funding to UEC schemes to ensure greater impact

# Section 8 | What we need from the system to mitigate

- **Change in culture - a proactive/step-up community focused UEC system rather than the current reactive/step-down model**
- Change in culture - true collaboration, with shared ownership and mutual accountability
- Deliver equity in primary care and community investment for Pennine Lancashire, which has been identified as significantly under target
- ICB capacity deployed into Place/UEC to support joined up delivery including Primary Care, Community, UEC and MH commissioning resources, financial and impact modelling
- Availability of timely place level (alongside hospital level data) for admissions, attends, LOS and NMCR so we can target interventions within each of our place footprints
- Further analysis of mental health attendance, admissions and LOS, recognising that this is a significant (if not yet quantified) driver of activity in EDs
- Additional support for conducting insight and deep engagement with residents to find out why they are coming to hospital and alternatives
- Clarity of alignment to system programmes (e.g. TCC, recovery and transformation) and roles and responsibilities in relation to delivery - with capacity aligned accordingly

**System OD support**

# Section 8 | Next steps

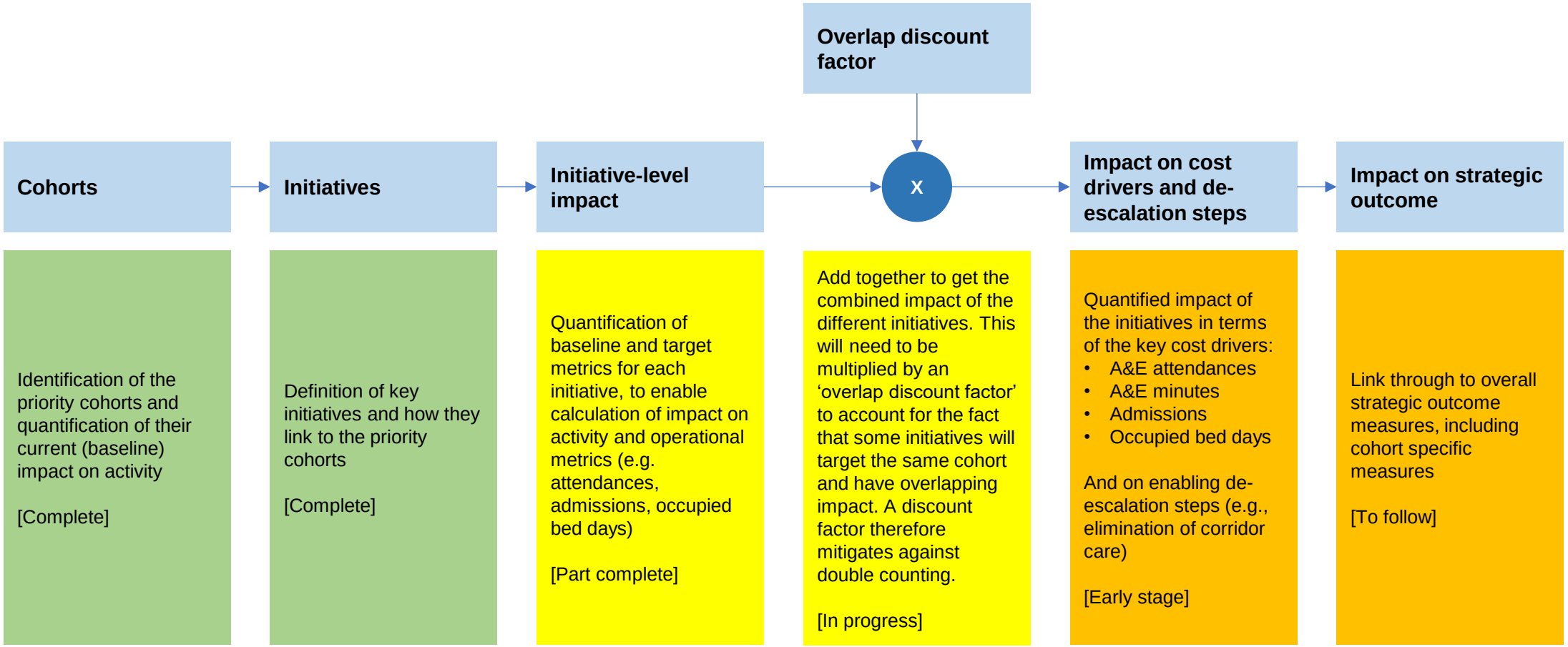
- Revised governance proposal including updated terms of reference, membership and sub-group membership to be agreed at UECDB on 8 August
- Mobilisation of all main schemes is underway and progress will be reported monthly at each UECDB meeting along with cross partnership planning for winter engagement with communities
- Subject to additional capacity – modelling for wider interventions including potential timescale for reduction of bed days/attends and costings to inform in-hospital de-escalation plan
- Subject to additional capacity – workshop to be held with all Pennine system partners in September to develop true step-up response model, maximising effectiveness of existing provision
- Work with LSCFT to understand mental health capacity and demand issues to feed into IRS review, development of case for crisis response intervention support – utilising Healthwatch deep dive to understand current situation in ED and how this feels for patients
- Agreement of system capacity to deliver, including commissioning resource

# Appendix 1 –UEC improvement plan quantification detail

# Current baselines against chosen metrics

| Metric type | Metrics | 2023/24 baseline |
|---|---|---|
| **General** | Zero growth in AED attendances (2024-2025)* | ELHT A&E attendances 23/24 at 207,767 |
| | Reduce AED attendances in 2025/2026* | As above |
| | Reduce the number of patients receiving corridor care (zero by 2026) | Findings from diagnostic (snapshot):<br>i. Within ED:<br>• ED corridor (33)<br>• ED surge capacity (up to 3)<br>• Resus (up to 2)<br>ii. Within admitted patient settings:<br>• Main hospital corridor (up to 26, noting that if 26 spaces are used constantly for corridor care that is > 9,000 occupied bed days per annum, at a cost of circa £3.3M; we can triangulate this with ELHT's estimate of non-ED corridor care as costing £2.5M per annum; we would need a reduction of circa 3% in occupied bed days to remove post-ED corridor care)<br>• AMU B corridor (up to 8)<br>iii. OVERALL (up to 72) |
| | % NMCR to not go above 5%* (LSC system) | 6.7% adult general and acute beds at ELHT occupied by patients no longer meeting the criteria to reside (Apr-23 - Mar-24) |
| **Cohort specific** | *Prevent 664 hospital conveyances and admissions for people 65+* | Baseline of 20,503 emergency admissions per annum for over 65s; we do not have a clear view of conveyances by age |
| | *Reduction in acute service utilisation in last 90 days of life, increase in % of people on EoL register who have an ACP, reduce % of deaths that occur in hospital* | Circa 8,000 A&E attendances per annum (last year of life and/or severe frailty);<br>Circa 5,200 – 7,100 emergency admissions per annum;<br>Total of 5,058 deaths per year across BwD and East Lancashire;<br>44.4% of deaths in hospital (BwD) vs 40.9% in hospital for Lancashire County Council catchment |
| | *Reduce attendances and admissions from care homes* | 5,506 ED attendances and 3,108 emergency admissions per annum (54.8% conversion to admissions) |

# Impact quantification logic model



# Appendix 2 – workstream detail UEC improvement plan

# See attached spreadsheet

# Appendix 3 – Place delivery plans

# Delivering Integrated Services in Blackburn with Darwen

Proud to be BwD

| Creating Healthy Communities | Integrated Neighbourhoods | Enhanced Care in the Community | Place+ Interface |
|---|---|---|---|

| Insight, engagement & co-production | Creating Healthy Communities | | Neighbourhoods | Community Health & Care | Mental Health, Wellbeing & Suicide Prevention | Intermediate Care/Enablement | Care Sector | Urgent & Emergency Care |
|---|---|---|---|---|---|---|---|---|
| Responding to insight | Health creation | SEND Strategy & Joint Commissioning | INT Development & Delivery | End of Life | CAMHS Transaction | Mobilisation of Albion Mill test of change | Joint Quality Assurance Framework | Keeping people safe and well at home |
| Embedding co-Production | Health Checks | Neurodiversity ASD pathway | Primary Care Neighbourhood Development | Ageing well/Frailty | Community MH Transformation | Develop model for alignment of fees | Workforce Development | Community based crisis response |
| Effective communications & engagement | Inclusion Health | LD&A "Big Plan" | | Community service transaction & transformation | CYP emotional health & wellbeing | Transform intermediate care – deliver enablement model | Strategic Development | In hospital flow |
| | Deliver Work Well BwD | Carers Strategy Actions | | | Strategy Development | Review of urgent response provision (2hr UCR/VW/IHSS) | Data, Intelligence and Digital | Admission avoidance |
| | | | | | | | Comms and Engagement | Discharge and iIntermediate Care |
| • Co-production of at least 1 PBP led service change | • (LD) Secure and non-secure inpatients post admission CTRs within 28 days of admission (75%)<br>• (HC/LD) Annual health check and health action plan (76%)<br>• QOF metrics for respiratory / CVD / diabetes | | • Increase INT utilisation and social prescribing<br>• Reduction in acute referrals<br>• Reduce avoidable admissions (BCF)<br>• Reduce emergency admissions due to falls (BCF) | • Increase in people dying out of hospital<br>• Admission avoidance<br>• Reduction in service variation<br>• Reduction in out of area placements (physical & mental health)<br>• Reducing all age utilisation of cost per case services, e.g. CHC, discharge, packages of care, etc | • Increase number of people supported with their mental health<br>• Increase in the people receiving timely access to support<br>• People reporting improved outcomes<br>• Reduction in inappropriate adult acute out of area placement bed days<br>• Increased talking therapy access | • Reduce avoidable admissions (BCF)<br>• Reduce permanent admissions to residential care (BCF)<br>• Reduce conveyances<br>• Increase discharges to normal place of residence (BCF)<br>• Increase utilisation of intermediate tier and urgent response<br>• Reduce emergency admissions from falls (BCF) | • Admission avoidance<br>• Reduce number of care homes in 'requires improvement'<br>• Reduction in falls<br>• Reduction in conveyances from care homes | • Zero growth in AED attendances (2024-2025)<br>• Reduce AED attendances in 2025/2026*<br>• % NMCR to not go above 5%* (LSC system)<br>• Prevent 664 hospital conveyances and admissions for people 65+<br>• Reduction in acute service utilisation in last 90 days of life, increase % of people on EoL register who have an ACP, reduce % deaths in hospital<br>• Reduce attendances and admissions from care homes |

**Safeguarding**

**Joint Commissioning and Insight**

**Engagement and Co-Production**

Living Better Lives in East Lancashire

**East Lancashire Plan on a Page 2024/2025**

# Vision: Living Better Lives in East Lancashire

**Our ambition is to Reduce early mortality and Increase healthy life expectancy**

**We will do this by: Being Champions for East Lancashire ,Working towards increased integration of ICB teams delivering at place, fostering collaborative working across all organisations in the East Lancashire partnership, investing time in relationships, sharing intelligence, seeking opportunities for joint resourcing, challenging competitive behaviours etc ,Upholding decision making at local level, Building and growing understanding of our community through data and deep conversation and Taking a Population Health Approach to developing programmes to work to deliver on our priorities**

## Enhancing Care in the Community (ECC)

Intermediate Care – (step up and down)
- Integrated approach to care management ( joint strategic integrated commissioning plans)
- Effective management of the care market (integrated brokerage model)
- Strengths based and outcomes focused short term support (optimum delivery model)

- Manage demand for care and support services across Lancashire (**virtual wards, 2hr UCR, remote monitoring & advanced care plans**)
- Maximise the use of the Lancashire pound – **understanding better the content of the BCF**
- **Identify frailty** earlier and provide proactive intervention
- Transform and transact **new model of community services**

## Integrated Neighbourhood Team Development (INT)

Develop an **agreed understanding** of INTs in Lancashire

Develop **a phased approach** to rollout across Lancashire Districts

Ensure **relationship** is in place = between MH, C&F, Adults and HWBP in each District.

## Creating Healthy Communities (CHyC)

- **Burnley**
  - housing and respiratory
  - Outdoor town / Beat the Streets
- **Pendle**
  - children, young people and their families
- **Rossendale**
  - Community Led Mental Wellbeing;
  - Physical Activity and Healthy Weight;
  - Developing Facilities to Support Health and Wellbeing;
  - Rossendale shaping local services
- **Hyndburn**
  - Children Best Start in Life;
  - LTC through behaviour choices – smoking alcohol, physical activity
- **Ribble Valley**
  - social isolation, Mental Health and connected communities

Support all PCNs and primary care to:
- develop **inclusion health approaches** to all delivery of primary care

## Improving quality and reducing unwarranted variation

Working across whole pathways
Reduce avoidable admission (start/live/age well) particularly in priority wards for ACSC

**LTC**
Focus on
- **Enhanced Health Checks**
- Early diagnosis of **cancer**
- **Diabetes** reduced variation across the pathway
- Implement the expectations of the quality contract – **respiratory, frailty and SMRs**
- **Primary care data** to identify areas of focus and practices in need of most support
- Reducing **variance in prescribing** across Lancashire East
- Taking a PHM approach to the **Big 6 Childrens conditions**