We have been working together to consider what the requirements set out in the NHS Long Term Plan mean for our residents, staff and health and care partner organisations across north central London (NCL). We have a collective commitment to deliver changes that will improve the health and wellbeing of residents and have listened to what residents told us is important to them.

We have developed a draft NCL delivery plan for reducing pressure on emergency hospital services and are now seeking the engagement and involvement of all local partners, stakeholder and residents to refine and finesse these plans. Over the next two months, we will cross-reference, financially cost and finalise our plan for submission in November.

*If you have any comments, queries or think we have missed important points relating to any of the sections please get in touch with the Alex Faulkes (*Alex.faulkes1@nhs.net).

Long Term Plan: The NHS will reduce pressure on emergency hospital services

1. Introduction

The NHS Long Term Plan (LTP) describes an emergency care system under real pressure in the midst of profound change. A&E attendances continue to rise and the number of A&E patients successfully treated in England within four hours is 100,000 per month higher than five years ago. For those that do need hospital care, emergency admissions requiring an inpatient stay are increasingly being replaced by Same Day Emergency Care. That, plus good results from action to cut delayed hospital discharges, means inpatient emergency bed days are now actually falling.

Over the period of the LTP, by expanding and reforming urgent and emergency care services, the practical goal is to ensure patients get the care they need fast, relieve pressure on A&E departments, and better offset winter demand spikes.

The North Central London (NCL) Sustainability and Transformation Partnership (STP) has a clearly defined Urgent & Emergency Care (UEC) programme of work that focusses on system-wide improvement underpinned by a strong governance framework between Clinical Commissioning Groups (CCGs), Hospital Provider A&E Delivery Boards (AEDB) and Mental Health partners. This work is overseen by the NCL STP UEC Programme Delivery Board. The Board, represented by provider CEOs with strong senior clinical input, will consider transformational work to support the delivery of UEC national standards and improved patient pathways and flow with a view to implementing operational/clinical best practice and standardisation where possible.

2. NHS Long Term Plan Milestones by 2021

2.1 **In 2019 England will be covered by a 24/7 Integrated Urgent Care Service, accessible via NHS 111 or online**

The NCL Integrated Urgent Care Service (IUC) is a 24-hour service that is accessible via calling NHS 111, Online or via an App. The Service is commissioned to a local specification but continues to develop towards the full national specification with direct booking to Extended Access Hubs, Urgent Treatment Centres and Primary Care, Mental Health Warm Transfer, Star Line capability, Clinical Revalidation and a high level of clinical assessment. The IUC service will continue to integrate across the healthcare system, contributing to reducing the burden on emergency departments and ensuring that patients receive the most appropriate level of care and treatment in the most appropriate setting.

2.2 **NHS 111 will be direct booking into GP practices and other points of care across the country**

The NCL IUC service has been successfully booking into extended access primary care services since the start of the current contract. Roll-out to include 'in-hours' primary care has commenced and is progressing at pace. Capacity has been secured and the direct booking functionality will be delivered via GP-connect system. NCL is a first of type site and is aiming for full implementation prior to winter 2019.

2.3 **Urgent Treatment Centres designated by December 2019 and will be fully operational, working effectively alongside other parts of the urgent care network by autumn 2020**

In line with national milestones, NCL will implement the UTC model by autumn 2020 to ensure a consistent offer for out of hospital urgent care. There are six Urgent Care Centres (UCC) within NCL and four Walk-in Centres (WiC). All six UCCs meet the majority of the UTC standards with the exception of direct booking from NHS111 and electronic prescribing. North Middlesex University Hospital (NMUH) designated on 01 April 2019. Whittington Health (WH), Royal Free Hampstead Hospital (RFH), Chase Farm Hospital (CFH) and University College London Hospital (UCLH) will designate by December 2019. All sites are working towards the implementation of the direct booking standard during September 2019.

With regards to Barnet Hospital (BH), there is a need to establish an appropriate and viable estate plan, workforce and operational plan to establish a fully functioning UTC within the financial envelope available.

The four WiCs will not be seeking designation to UTC but will become part of a primary care offer within current boroughs with the potential exception of the Cricklewood WiC. Barnet CCG is currently undertaking an engagement exercise on a proposal to not renew the Cricklewood walk-in service contract when it expires on 31 March 2020. No changes to services are planned until the end of March 2020 when the contract expires.

2.4 **Provide an acute frailty service for at least 70 hours a week. Work towards achieving clinical frailty assessment within 30 minutes of arrival**

Identifying frail patients within a few hours of their arrival to hospital enables prompt, targeted management based on a comprehensive geriatric assessment approach. It also allows screening and treatment to start with the appropriate skilled multidisciplinary team as soon as the patient arrives in hospital. Faster specialised same day treatment and safe discharge home with links to community services, enhances recovery and associated care planning (which can include end of life care planning) are all benefits of dedicated frailty services.

UCLH is working towards implementation of an acute frailty service through an MDT approach, upskilling A&E staff to support clinical frailty assessment within 30 minutes of arrival and the Ambulatory Emergency Care Unit (AEC) and Integrated Discharge team staff to support with comprehensive geriatric assessments, supported by Frailty nurses and doctors. The pathway will improve recognition of frailty in patients, increase their access to Comprehensive Geriatric Assessment, and reduce unnecessary admissions to hospital.

UCLH and Camden and Islington CCGs will work together in 2019/20 to review and strengthen the end to end model of care for older people, linking the acute frailty service to community-based proactive and reactive services, including LAS, to support frail older people.

Haringey CCG's new Ageing Well strategy contains a dedicated focus on 'Managing Crises or Major Health Episodes and Recovery Afterwards'. The strategy outlines the intention of providing acute frailty services within NMUH and WH. This will include stronger pathways between acute and community care; same/next day patient access to urgent assessment, diagnostic and treatment hubs and multi-disciplinary rapid response home crisis services.

The Hot Floor reconfiguration work at the NMUH emergency department will also see the development of a dedicated frailty assessment unit (FAU) and short-stay frailty area to speed up assessments (including the Rockwood clinical scoring methodology) and provide better targeted care. Discussions are focussed on strengthening this for winter 2019 through the provision of dedicated Hot Floor Rapid Response service.

Islington CCG's Aging Well Strategy also has a dedicated focus on 'Managing Crises or Major Health Episodes and Recovery Afterwards' with clear aims to reduce A&E attendances, non-elective admissions, re-admissions within 28 days average length of stays and excess bed day for this cohort of patients, including fall-related admissions.

WH has a fully embedded frailty pathway that uses the Rockwood clinical score in the emergency department. The pathway aims to improve recognition of frailty in patients, increase their access to Comprehensive Geriatric Assessment, and avoid unnecessary admissions to hospital. Currently 40% of all patients aged 75 years or older are screened within 30 minutes of arrival.

RFH and BH operate a TREAT service to support the management of elderly patients (80 years plus) within the emergency department to avoid an admission. Work is underway at both sites to review how the Trusts can provide additional cover to meet the requirements of the LTP.

Since 2018, both sites have also utilised the Rockwood score for all patients aged 65 and over presenting to the emergency department. The triage form on A&E Firstnet was updated in May 2019 to support completion of the score. Work is now underway to improve the proportion of patients for whom the score is documented within 30 mins of arrival. Frailty Multi-disciplinary Teams (MDTs) have additionally been mobilised by local primary care networks to support the management of frailty patients within primary care. In the next 12-18 months these will link to a seamless pathway to hospital to ensure that only those patients who are complex are conveyed to hospital.

2.5 **Provide Same Day Emergency Care services at least 12 hours a day, 7 days a week by the end of 2019/20. (Working towards increasing the proportion of total acute admissions discharged on the same day of attendance from a fifth to a third)**

Same day emergency care (SDEC) is the provision of emergency care on the same day for patients being considered for emergency admission. NCL recognises the transformational value of SDEC and has been collaborating as an STP to increase provision of SDEC services. All five hospitals within NCL have an existing AEC Unit, and in July 2018 the STP hosted a 'Best Practice Exchange for Ambulatory Emergency Care' to share information about current services, visions, and challenges faced, and to encourage Trusts to develop AEC action plans to increase delivery.

There are significant recognised benefits associated with treating people through SDEC services. These include:

- the ability for patients to be assessed, diagnosed and start treatment on the same day, improving patient experience and reducing unnecessary admissions
- avoiding unplanned and longer than necessary stays in hospitals, resulting in lower risk of infections and de-conditioning for patients
- financial benefits and cost savings for hospitals, and often for patients as well

Trust	Do you have an SDEC service?	Is the SDEC service available at least 12 hours a day?	Is the SDEC service available every day?	Is the provider's intention to meet the national ambition by September 2019?
North Middlesex	Yes	N (12 Hrs M-F; 8 Hrs S-S)	Yes	Yes
Royal Free Hospital	Yes	N (9Hrs)	Yes	Yes
Barnet Hospital	Yes	N (9Hrs)	Yes	Yes
The Whittington	Yes	N (12 Hrs M-F; 9 Hrs S-S)	Yes	Yes
UCLH	Yes	N (12 Hrs M-F; 8 Hrs S-S)	Yes	Yes

*Table 1.*Current provision and intention against the national 12hrs/7days a week ambition

Table 1 sets out the current NCL provision of SDEC services against the national standard of services being available at least 12 hours per day. With regards to the national aim for 100% of sites to deliver 30% of non-elective admissions via SDEC by March 2020, our understanding is that all NCL acute trusts are already meeting this aim, but this requires confirmation against the soon-to-be-published national methodology.

In addition to the national standards, the NHSE London Region has identified 12 priority 'must-do' SDEC pathways for implementation.

NCL is currently working with the London Ambulance Service (LAS) and WH to develop a direct access protocol for LAS to the AEC unit, to bypass A&E altogether for patients accepted in advance by the service. It is a NCL priority to bring forward LAS direct access into same day emergency care services at all acute units in advance of winter 2019. The NCL UEC Programme Board will be considering options at the September Board meeting

for how best to work collaboratively to achieve full implementation of the 12 hours/7 days a week requirement, as well as of the 12 priority pathways, in 2019/20. The national intention is to develop a new activity type within the Emergency Care Data Set (ECDS) for capturing SDEC activity consistently across sites. RFH is one of the development sites for this. Six exemplar sites across London are taking part in the AEC Accelerator Programme, one of which is WH.

NHSE has additionally signalled that it is very probable that BH will receive significant capital funding to develop the SDEC unit subject to national funding being made available.

2.6 **Aim to record 100% of patient activity in A&E, UTCs and SDEC via ECDS by March 2020**

Recording same day emergency care via a consistent data set is an important part of improving urgent and emergency care services. The data set collates information on SDEC services and uptake, addressing the need to better understand how and why people use services. Having access to this data means we can improve planning and reduce pressure on the system, ultimately leading to better patient experience and outcomes.

The emergency care data set (ECDS) was introduced in October 2017 to emergency departments. As part of the national SDEC model, the ECDS will be expanded to include SDEC services, and will enable a more comprehensive view of patient flow across the UEC system.

Through the implementation of the new enhanced patient record system (EPIC) at UCLH there is an expectation that 100% of patient activity will be recorded via ECDS by March 2020. The ECDS dataset has been built as part of the EPIC implementation and whilst uploading is currently not providing the full comprehensive range of information, we continue to have an improving dataset. To ensure that the CCG retains a contractual lever, this requirement will be included in the information schedules for relevant contracts 2020/21.

Both RFL hospital sites implemented ECDS in April 2019 and are completing 99.9% against the emergency care attendance categories. A small number of coding issues are still being resolved by the Trust to ensure full compliance.

WH has been fully compliant in the implementation and utilisation of the ECDS since March 2018. NMUH has also implemented and is utilising the ECDS.

2.7 **Test and begin implementing the new emergency and urgent care standards arising from the Clinical Standards Review, by October 2019**

NHSE continue to field-test a number of new urgent and emergency care standards across a range of London providers with the view to developing a definitive set of new measures that will then be adopted across all London providers when available.

2.8 **Length of stay for patients in hospital for 21 days and over will be further reduced beyond the March 2020 ambition of 40%**

All Acute Trusts in England are now required to submit a regular Discharge Patient Tracking List (DPTL) data return to NHS England. The DPTL give boards and systems visibility of the constraints that may be producing discharge delays whilst supporting escalation processes. It is an essential building block to support delivery of the ambition in reducing patient length of stay in hospital for 21 days and over. The DPTL falls out of the weekly long stay reviews undertaken at an operational level by staff.

Trust	Baseline	Ambition	Reduction against baseline	Reduction against baseline (%)	Move to date (%)
NMUH	82	49	-33	-40%	**7%**
RFL	186	112	-74	-40%	**-17%**
WH	52	31	-21	-40%	**-29%**
UCLH	168	102	-66	-39%	**-20%**
Total	**488**	**294**	**-194**	**-40%**	**-15%**

Table 3. NCL Long length of stay reduction progress against ambition

Through the analysis from DPTL, system partners will be able to identify patients earlier and put in place the relevant interventions to reduce long length of stays. To support this numerous projects are contributing towards this ambition:

- On-going implementation of the Supporting Patients Choice to Avoid a Delayed Discharge choice policy
- Regular MADE events to be held from September 2019
- Expansion of Discharge to Assess
- Star Chamber to continue to make rapid decisions on disputed patients
- Escalation processes to out of area to be focussed upon to ensure actions are taken earlier for potential stranded patients

UCLH also have numerous actions that support an extended length of stay action plan as well as a system improvement plan (which tackles internal and external discharges). The key challenge facing the system on this ambition is the high volume of patients.

There has been some success in reducing long length of stay through the weekly Length of Stay and Platinum Command meetings at NMUH. The former is an internal clinical meeting that focuses on delays to patient recovery, whilst the latter is an external senior meeting that problem-solves blockages to patient discharge. Themes and trends are escalated to AEDB for system discussion.

An Integrated Discharge function is currently being trialled (summer 2019 to summer 2020) for Haringey patients at NMUH, which is improving the skills and capabilities of the hospital discharge team - who are now under shared community/social care management, with ambitions to incorporate Continuing Health Care (CHC) and health step down aspects over winter 2019.

WH has been successful in reducing stays for patients in hospital over 21 days by 38%. This has been achieved by embedding rapid identification of patients at risk of prolonged inpatient stay, embedding services that offer rapid identification, assessment and initiation of treatment (Rapid Response, Frailty service and Gynaecology Assessment Unit) and effective processes to systematically review patients with stays of 21 days with weekly senior ward rounds.

BH and RFH have in place extended length of stay action plans, which include a focus on 'safari style' long length of stay reviews, Multi-Disciplinary Team (MDT) expert panels, reviewing complex long stay patients, a Quarter One project at RFH identifying golden patients for discharge, training and education workshops for ward staff. The RFL system is focused on continued implementation of the NCL Choice Policy, review of Fast Track pathways, and development of NWB and delirium pathways, including improved system-wide discharge monitoring and reporting. Barnet CCG and the London Borough of Barnet has developed an action plan to make improvements to Discharge to Assess (D2A) pathway 3. A system workshop is being arranged in October 2019 supported by the Emergency Care Intensive Support Team (ECIST).

2.9 **A reduction in delays of handover of patients from ambulances to A&E, with the aim that no one waits more than 15 minutes**

A handover delay does not necessarily mean that the patient waited in the ambulance – they may have been moved into the A&E department, but staff were not available to complete the handover. This is regarded as one of the most important indicators of a system under pressure, as it often occurs as a result of a mismatch between A&E/hospital capacity and the number of elective or emergency patients arriving.

ECIST are providing a significant level of support to UCLH to improve the handover delays. A front door challenge was recently completed which will support the current delivery plan. In addition the implementation of a new standard operating procedure for the Rapid Assessment & Treatment model will also include a full capacity model and escalation. Significant improvement has been made in recent months and we expect to deliver the trajectory agreed.

In June NMUH submitted its Ambulance Handover plan, which detailed how it would reduce the number of handover delays of more than 30 minutes to zero by June 2020. The plan includes a number of initiatives such as better use of the 'fit to sit' area, closer oversight by the Silver/senior on-call leadership, and immediate investigation by emergency department managers following a recorded delay to understand causes and implement appropriate remedial actions. The Ambulance Handover Plan also confirms protocol to safeguard patient safety if a delay does occur.

LAS direct access to UTC & AEC is being trialled in WH. The learning from this pilot will inform the implementation of a similar initiative in NMUH. There is also an intention to introduce UTC GP/LAS crew 'shadowing' in order to develop closer understanding and connections between the services. This initiative will begin as soon as new GP posts are filled at the Trust. The Hot Floor Reconfiguration project currently in progress will further improve handover times, with improved access to AEC and frailty assessment areas and more tailored staffing designations to support better ambulance flow.

RFH and BH both have ambulance handover plans in place which set out an ambition to ensure 100% of handovers within 15 minutes by September 2019. RFH has recently completed a LAS handover challenge, led by ECIST and are in the process of implementing the recommendations. A 5% improvement in performance has been seen since May 2019. BH is arranging a date for it handover challenge, which includes the development of ambulance handover standard operating procedures to reflect the frailty pathway and 'Care in a Chair'. Performance is largely impacted by estate constraints and flow within the current emergency department.

3. NHS Long Term Plan Milestones by 2023

3.1 Clinical Assessment Services will act as the single point of access for patients, carers and health professionals accessing integrated urgent care services, and to support admissions avoidance or facilitate discharge from hospital

The Clinical Assessment Service (CAS) will provide specialist advice, treatment and referral from a wide array of healthcare professionals, encompassing both physical and mental health supported by collaboration plans with all secondary care providers. Access to medical records will enable better care. The CAS will also support health professionals working outside hospital settings, staff within care homes, and paramedics at the scene of an incident and other community-based clinicians to make the best possible decision about how to support patients closer to home and potentially avoid unnecessary trips to A&E.

Camden health system currently have a Single Point of Access (SPA) which coordinates offers from community and intermediate care services. Working with the existing provider, commissioners are looking to build upon this model and scope the potential of further services being integrated into the SPA. By 2023 the ambition will be to transition into a fully functional Clinical Assessment Service (CAS).

The Barnet health system is in discussion about changes to discharge pathways and improvements to its current SPA. Opportunities for a truly integrated CAS will be taken forward through the newly developed Barnet Integrated Care Partnership Board, which includes all health and social care providers including emerging Primary Care Network and Primary Care Federation.

The Haringey and Islington health system is also in initial discussion regarding the development of CAS.

3.2 Delayed Transfers of Care will have further reduced below 4,000 people per day

A Delayed Transfer of Care (DTOC) occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice. DTOCs can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care, as delayed transfers reduce the number of beds available for other patients.

Borough	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Barnet	21	17	20	21	25	25	29	28	26	28
Camden	12	16	9	14	11	18	13	12	7	14
Enfield	14	15	15	12	10	16	11	8	10	9
Haringey	17	17	15	16	13	18	10	12	10	17
Islington	14	12	19	21	21	25	26	22	14	17
NCL partners in health and social care total	**79**	**77**	**78**	**85**	**80**	**101**	**89**	**82**	**69**	**85**
NCL partners in health and social care trajectory	**87**	**87**	**87**	**87**	**87**	**87**	**87**	**87**	**87**	**87**

Table 4. NCL Delayed Transfers of Care performance against trajectory

As at May 2019, the NCL system has met its Delayed Transfers of Care (DTOC) target in eight of the previous ten months for the number of NHS, social care and jointly attributable DTOCs per day (Table 4). In 2017, health and social care partners developed and implemented an NCL D2A model to support a reduction in DTOCs with health partners working together to implement key principles and best practice. This has included the development of a standardised NCL referral forms to D2A pathways and District Nursing Services.

In addition, a NCL 'Supporting Patients Choice to Avoid a Delayed Discharge' policy has been developed by health and social care partners and Healthwatch and launched in October 2019. The policy aims to reduce the time that patients spend in hospital, when they are ready to depart and no longer need acute care, but are delayed whilst making decisions about or making arrangements for their ongoing care. An NCL-wide training session was held with staff and the implementation is being monitored by local AEDBs.

Camden continue to focus on the local DTOC using the Better Care Fund (BCF) as a platform to improving performance. Joint interventions focussing on placement without prejudice and trusted assessor models for care homes will ensure that work will support the continued DTOC reductions. The CCG team provide on-going support and input to the trust to reduce DTOC levels. Regular escalations calls remain on-going. One of the key challenges which is being addressed locally is a strong and sustainable care home market.

Within Haringey further improvement initiatives are being developed with the support of ECIST through the Integrated Discharge Working Group. This group also tackles DTOCs by identifying ways for system partners to work together (such as the daily huddle between SPA and CHC teams), minimising avoidable delays (e.g. encouraging training for hospital staff on Choice Policy conversations) and targeting key blockage areas (i.e. improving flow through community beds).

Within Islington a whole system approach is applied to the management of DTOCs through daily MDT huddles and regular weekly Multi-Agency Discharge Events (MADE) to discuss complex patient discharges. This aim is further supported by the OUTFLOW Working Group as part of the AEDB Improvement Programme and acts as a resource in improving the system flow and resolving any blockages and/or cross-organisational issues to ensure effective transfer and discharge of patients from both the Emergency Department and wards. This is achieved by embedding clear transfer processes with partners in the system and maximising the impact of existing integrated care initiatives.

Barnet CCG is considering opportunities to further develop 'home-first' pathways for non-weight bearing, delirium and patients with braces; undertake a greater number of assessment of complex patients outside of hospital and switching residential beds into nursing home beds to meet increased demand from an ageing population. It is the intention that these initiatives, which are in partnership with acute, community and local authority colleagues, will bring about a reduction in DTOCs within the next 12 months.