Barking and Dagenham,
Havering and Redbridge
Clinical Commissioning Groups

NHS System Intentions 2019-2021
Barking & Dagenham, Havering and Redbridge System

1. Introduction

This document sets out the NHS System Intentions for the Barking & Dagenham, Havering and Redbridge (BHR) System. Historically, NHS Commissioners (via Clinical Commissioning Groups or CCGs) have issued 'NHS Commissioning Intentions' but given the changing relationships and structures across BHR this year the Commissioning Intentions has been replaced by a set of System Intentions that have been collaboratively produced by the NHS Partners drawing extensively from the work of our Clinically and Professionally led Transformation Boards that contain representation from all NHS Partners as well as from our Local Authority partners across BHR.

The 3 CCGs covering BHR are part of the wider North East London Commissioning Alliance (NELCA) consisting of 7 CCGs. In addition, BHR as a System is part of the North East London Sustainability & Transformation Partnership (STP) called locally the East London Health & Care Partnerships. The specific System Intentions laid out in this document are aligned to the emerging direction of travel across North East London as encompassed within the submission that is being provided to respond to the challenges set out in the NHS Long Term Plan.

The System Intentions outlined in this document are also aligned to the aspirations set out in our NHS BHR Financial Recovery Plan (FRP) that was published in March 2019. The FRP focuses on transforming services, improving outcomes for the population we serve and improving performance and access. It is recognised locally by the NHS Partners and by our Regulators that this transformational approach will deliver not only significant improvements for our population but will ensure the financial sustainability of the system. It is also noted that delivery of these System Intentions will require substantial time and investment in a wide range of enablers such as Workforce Development, Estates, Digital and the development of integrated services built around our Primary Care Networks (PCNs).

The System Intentions set out in this document will be developed further through the period from their launch on the 1st October 2019 throughout the period to the end of March 2021. Where required, the detailed work behind any of these intentions will involve co-design with partners and our public and we will meet our obligations with regards to engagement and/or consultations where required as well as our contractual requirements around notice periods.

Given the on-going and increasing pace of transformational change across BHR we may have to introduce additional initiatives and programmes not flagged within these System Intentions but will do so giving the appropriate notice and also ensuring we meet all of our statutory obligations concerning engagement/consultation.

This is an exciting time for the BHR System with increasingly close relationships between the partners, confidence across the system that the changes we are implementing are the right ones for our population and an increasing pace of change to deliver the transformational change that will not only deliver our local commitments to the NHS Long Term Plan (LTP) but also the requirements of our Financial Recovery Plan.

We continue to welcome comments and questions on our collective system intentions.

2. Index

3. Overview of Our Population

The Barking & Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups (CCGs) are co-terminus with the three London Boroughs of Barking & Dagenham, Havering and Redbridge and this section provides a brief commentary on the local population. The information is drawn from various documents including Health & Wellbeing Strategies, the Joint Strategic Needs Analysis, the Global Burden of Disease (2019) and others.

Overview of Barking & Dagenham

Barking and Dagenham's population is projected to increase by 8% between 2019 and 2023, from 215,100 to 232,200 residents. Most of the growth will be concentrated in 4 wards in the South of the borough. Looking further ahead, the borough's population is projected to increase by 27.3% between 2019 and 2029, from 215,100 to 273,800 residents. From 2023, these projections suggest that population growth will be focused in the South and West of the borough. Increases are projected for Whalebone and, to a lesser extent, Valence. All other wards are projected to grow only marginally (< 1%) or decrease in size, with three wards predicted to decrease in size by 5% or more (Parsloes, Alibon and Becontree) relative to 2019.

Half of the residents are younger than 32.1 years (a lower median age than London or England) but the largest percentage increases are projected to be in the population aged 40 and above.

The leading cause of death is ischaemic heart disease, dementia, lung cancer, chronic lower respiratory disease, stroke. B&D also has the lowest life expectancies in London and also low healthy life expectancy. Predicted Prevalence Gaps (the gaps between those people with a known disease and the estimated number within the total population) are stated below for three key diseases:

Prevalence Gaps	Hypertension	AF	Diabetes
Number of People	18,146	1,262	2,388

Overview of Havering

The population of Havering is projected to increase from 257,514 in 2018 to 303,769 in 2033 (18% increase). The population aged 25-64 will remain the largest age group up to 2033 but from 2018 to 2033, the largest increases will be seen in children (5-10-year olds: 19%; 11-17-year olds: 43%), and older people (65-84-year olds: 26%; 85+ year olds: 54%). Therefore, if the population continues to be affected by ill health at the current rate then the demand for health and social care services will grow (particularly services for frailty and dementia; long term conditions and child & adolescent mental health).

There is an increasing birth rate in the borough and whilst there is a lot of green space the borough is constrained by poor north to south transport links. Increasing number of Children & Young People (CYP) have SEND (Special Educational Needs & Disability) issues requiring integrated health and social care/education support and there is an increasing prevalence of CYP Mental Health (MH). Late identification of Cancer and the failure to tackle adult MH issues are significant contributors to premature mortality in the borough. Predicted Prevalence Gaps (the gaps between those people with a known disease and the estimated number within the total population) are stated below for three key diseases:

Prevalence Gaps	Hypertension	AF	Diabetes
Number of People	20,417	2,548	4,227

Overview of Redbridge

From 2015 to 2025, Redbridge's population is projected to grow by a further 43,679 people (15 %), and by the year 2041, the population is projected to reach 370,433 people, a 32% increase on the 2011 population. 64% of residents are from a black or minority ethnic group (the largest of which are Pakistani (13.9%) and Indian (18%)). Only 72% of the residents are employed, lower than the London average and 1 in 5 children under 16 live in families in receipt of out of work benefits or tax credits.

Life expectancy is slightly above the London average but there is a higher than average prevalence of diabetes (8.1% compared to the London average of 6.3%). Redbridge also has high number of admissions for cardio-vascular disease (including alcohol related) and tuberculosis. Predicted Prevalence Gaps (the gaps between those people with a known disease and the estimated number within the total population) are stated below for three key diseases:

Prevalence Gaps	Hypertension	AF	Diabetes
Number of People	23,906	2,611	5,078

Years of Life Lost (YLL) Across BHR

The following information, drawn from the Global Burden of Disease (2019), shows the leading causes of Years of Life Lost (YLL) which is a predicted value for the population of premature mortality caused by issues amenable to healthcare.

Table 1: Top ten causes of YLL in BHR, age-standardised rate (ASR) per 100,000, 2017

Barking & Dagenham		Havering		Redbridge	
Causes	**ASR**	**Causes**	**ASR**	**Causes**	**ASR**
All causes	*9,491*	*All causes*	*8,513*	*All causes*	*7,321*
IHD	1,115	IHD	993	IHD	914
Lung cancer	792	Lung cancer	607	Lung cancer	458
COPD	548	COPD	416	LRIs	330
LRIs	420	Stroke	376	Stroke	322
Neonatal disorders	395	Dementia	369	Dementia	320
Stroke	382	LRIs	355	COPD	287
Dementia	348	Breast cancer	317	Neonatal disorders	267
Bowel cancer	276	Bowel cancer	283	Breast cancer	252
Breast cancer	266	Self-harm	281	Self-harm	236
Cirrhosis	259	Neonatal disorders	263	Bowel cancer	215

Based on age-standardised rates, the three leading causes of YLLs across BHR are ischaemic heart disease, lung cancer and COPD (Barking and Dagenham and Havering) and lower respiratory infections (Redbridge). Ischaemic heart disease on its own accounts for 12% of the YLL rate across all three boroughs.

Barking and Dagenham has the highest all-cause age standardised YLL rate (9,491 per 100,000) of the three boroughs, followed by Havering (8,513 per 100,000) and Redbridge (7,321 per 100,000). Barking and Dagenham has a significantly higher all-cause YLL rate than the England average. Rates are also significantly higher than England for causes including ischaemic heart disease, lung cancer, COPD (Chronic Obstructive Pulmonary Disease) and lower respiratory infections.

In Havering, rates for lower respiratory infections, dementia, and breast cancer are significantly higher than the England average.

Table 2: Leading causes of YLLs in BHR, London and England, age-standardised rate (ASR) per 100,000, 2017

Cause	B&D	Havering	Redbridge	London	England
All causes	*9,491*	*8,513*	*7,321*	*7,603*	*8,521*
IHD	1,115	993	914	838	928
Lung cancer	792	607	458	519	563
COPD	548	416	287	345	379
LRIs	420	355	330	308	317
Neonatal disorders	395	263	267	349	403
Stroke	382	376	322	320	396
Dementia	348	369	320	311	335
Bowel cancer	276	283	215	227	270
Breast cancer	266	317	252	228	259
Cirrhosis	259	218	199	225	244
Self-harm	251	281	236	232	314
Congenital birth defects	243	192	183	207	252
Pancreatic cancer	188	170	155	151	161
Drug use disorders	168	132	114	161	186
Road injuries	146	165	131	128	166

Key					
	Significantly lower than the England average		Similar to the England average		Significantly higher than the England average

Males have a substantially higher age standardised YLL rate than females (around 40% higher than females in Havering and Redbridge and 65% higher in Barking and Dagenham). This compares with around 50% and 45% higher rates for London and England males respectively compared with females. In part this reflects what we already know about differences in life expectancy by sex, but it suggests male premature mortality in Barking and Dagenham is a particular cause for concern.

Ischaemic heart disease is a key contributor to this gap; males in Barking and Dagenham have 3.2 times the female rate of YLLs from ischaemic heart disease, while the male rate is around 2.7 times higher than the female rate in both Havering and Redbridge.

The top three causes of YLLs in males mirror the overall top causes across the three boroughs (ischaemic heart disease, lung cancer and COPD/lower respiratory infections). For females, lung cancer, breast cancer and ischaemic heart disease make up the three leading causes for all three boroughs but in different orders. The top causes are lung cancer in Barking and Dagenham, breast cancer in Havering and ischaemic heart disease in Redbridge.

The amount and causes of YLLs across different life stages vary substantially. These are summarised in Table 3 (as age-specific rates).

Table 3: Top three causes of YLLs by age group, rate per 100,000, BHR, 2017

Age	*All-cause YLL rate*	Top cause	2nd largest cause	3rd largest cause
Under 5	*B&D: 7,758* *H: 5,656* *R: 5,809*	Neonatal disorders	Congenital birth defects	Sudden infant death syndrome
5–14	*B&D: 565* *H: 626* *R: 573*	Brain and nervous system cancer	Congenital birth defects	Other malignant neoplasms *(B&D)* Road injuries *(Havering)* Leukaemia *(Redbridge)*
15–49	*B&D: 3,614* *H: 4,176* *R: 3,015*	Self-harm	Drug use disorders *(B&D)* IHD *(Havering/Redbridge)*	IHD *(B&D)* Drug use disorders *(Havering/Redbridge)*
50–64	*B&D: 20,489* *H: 18,707* *R: 15,530*	IHD	Lung cancer	COPD *(B&D/Havering)* Breast cancer *(Redbridge)*
70+	*B&D: 64,638* *H: 56,222* *R: 50,425*	IHD	Dementia	COPD *(B&D/Havering)* LRIs *(Redbridge)*

The differences between the boroughs are driven by both population size and structure. Redbridge has the largest population (315,800), followed by Havering (252,600) and Barking and Dagenham (208,300). Havering's higher crude number of YLLs than Redbridge – despite its smaller overall population size – reflects its older population; as seen in Table 3, the YLL rate increases dramatically with age. There are 32,900 people aged 70 and above in Havering: 7,500 more than in Redbridge and 19,800 more than in Barking and Dagenham.

Tobacco (a category comprising smoking, passive smoking and chewing tobacco) is the single largest risk factor for YLL across the three boroughs, with a notably higher rate of YLLs attributable to tobacco in Barking and Dagenham, especially when compared with Redbridge.

Other key risk factors include dietary risks (e.g. diet low in whole grains), high systolic blood pressure, high body mass index (excess weight) and high fast plasma glucose (indicative of diabetes/diabetes risk).

Years Living with Disability (YLD) Across BHR

The following information, drawn from the Global Burden of Disease (2019), shows the leading causes of Years Living with Disability (YLD). The three leading causes of YLD across BHR are low back pain, headache disorders and depressive disorders (Table 4). Addressing these is therefore likely to be important for improving healthy life expectancy.

Table 4: Top ten causes of YLDs in BHR, age-standardised rate per 100,000, 2017

Barking & Dagenham		**Havering**		**Redbridge**	
Causes	**ASR**	**Causes**	**ASR**	**Causes**	**ASR**
All causes	*11,511*	*All causes*	*11,401*	*All causes*	*11,304*
Low back pain	1,459	Low back pain	1,459	Low back pain	1,457
Headache disorders	844	Headache disorders	844	Headache disorders	839
Depressive disorders	625	Depressive disorders	625	Depressive disorders	623
Neck pain	491	Neck pain	491	Neck pain	490
Dermatitis	402	Falls	401	Falls	398
Anxiety disorders	397	Anxiety disorders	397	Anxiety disorders	395
Falls	397	Diabetes mellitus	378	Diabetes mellitus	378
Diabetes mellitus	384	Asthma	364	Asthma	363
Asthma	361	Neonatal disorders	357	Neonatal disorders	359
Neonatal disorders	361	Age-related and other hearing loss	316	Dermatitis	313

Barking and Dagenham had the highest age standardised YLD rate (11,511 per 100,000) in BHR, although all three boroughs had similar rates. This relates to a limitation in the data available to model YLDs.

Unlike YLLs, where rates are higher in males, age standardised rates of YLDs are higher for females, albeit to a lesser extent. Females experience 12–14% higher rates of YLDs than males in Barking and Dagenham, Havering and Redbridge. This is in line with London (12%) and England (14%). YLDs by age group are summarised in Table 5 (as age-specific rates).

Table 5: Top three causes of YLDs by age group, rate per 100,000, BHR, 2017

Age	*All-cause YLD rate*	Top cause	2nd largest cause	3rd largest cause
Under 5	*B&D: 3,057* *H: 2,822* *R: 2,839*	Dermatitis	Neonatal disorders	Asthma *(B&D/Havering)* Congenital birth defects *(Redbridge)*
5–14	*B&D: 4,902* *H: 4,641* *R: 4,675*	Dermatitis	Neonatal disorders *(B&D)* Asthma *(Havering/ Redbridge)*	Asthma *(B&D)* Neonatal disorders *(Havering/Redbridge)*
15–49	*B&D: 12,315* *H: 12,337* *R: 12,128*	Low back pain	Headache disorders	Depressive disorders
50–64	*B&D: 17,726* *H: 17,871* *R: 17,689*	Low back pain	Neck pain	Headache disorders
70+	*B&D: 27,116* *H: 26,845* *R: 26,784*	Low back pain	Age-related and other hearing loss	COPD

High body mass index (excess weight) is the leading risk factor for YLDs in BHR (except for Barking and Dagenham, where tobacco is the leading risk factor). 'Occupational risks' is a group of work-related causes of ill health, with the main contributor to YLDs being low back pain caused by work.

Analysis by condition suggests that the condition groups with the largest preventable burden are diabetes and chronic kidney disease, and musculoskeletal disorders for all three boroughs.

4. NHS System Intentions

The following pages give the detail of the specific actions to be taken to improve outcomes for our population and also to ensure the on-going improvement in the NHS financial position across BHR. These System Intentions have been put together by each of the clinically and professionally led Transformation Boards for BHR. The Transformation Boards have representation from across the system including providers such as North East London Foundation Trust (NELFT) who provide the Community and Mental Health Services for BHR, Barking, Havering & Redbridge University Hospitals Trust (BHRUT), our Primary Care Federations and our partners including Social Care (Adult & Children) and Public Health as well as NHS Commissioners and various supporting managers. The makeup of each Transformation Board varies depending on the focus of the board. In total there are 8 Transformation Boards and the specific System Intentions for each of them are detailed in the following sections. The System Intentions set out below are also consistent with our local commitments to the NHS Long Term Plan.

4.1 Older People & Frailty Transformation Board

The board was established in 2019 and is focused on supporting Older People and those who are frail. The aim of the board is to design care that meets the needs of individuals and maximises their independence. The Transformation Board has set out a challenging 3 year plan to transform the model of care for Older People and the System Intentions below detail the specific actions designed for 20/21.

Prevention Workstream: Focused on preventing/delaying the onset of poor health and reduce the health and social care needs arising.		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Develop the Community Prevention Offer with the aims of improving/maintaining the health and wellbeing of older residents.	Empowering residents to support personal and community resilience and prevent/delay the onset of health and social care needs.	Proposal to be agreed by Integrated Care Partnership Board in October 2019
Pilot the Local Area Co-ordinator model in a locality in Havering and Redbridge and develop the case for further expansion.	Improve the quality of lives for residents with complex needs.	Q4 2019/20
Pilot the core Reconnections approach to tacking social isolation in older people in Barking and Dagenham and Havering.	Improve the quality of life for socially isolated individuals.	December 2019
Expand the Falls Prevention Strategy to include proactive and prospective case finding of people at risk of falling.	Reduced acute admissions due to falls where primary diagnosis is fracture of arm, elbow, or neck of femur and length of stay is 0-30 days.	Full year effect of initiatives introduced in 2019/20

Place Based Care (PBC): Focused on delivering care designed to meet the needs of specific localities within BHR		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Roll out a placed based model of care for older people across BHR, applying common principles at a locality level including dynamic risk stratification, access to multi-disciplinary team support, care coordination and engaging residents in decisions about their health and wellbeing. Linked to this is also work to ensure that IAPT Services (Improving Access to Psychological Therapies) and the diagnosis and post-diagnosis support meet the needs of Older People and those with Dementia.	Improved independence and the ability of older people to self-manage and a reduction health and care needs. In addition PBC is expected to improve staff, carers/families and patient experience and satisfaction and will improve dementia diagnosis rates.	1st April 2020

Care Homes (Nursing & Residential): Improving care for people in Care Homes		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Building on the learning from the Integrated Nursing Home Service launched in 2019 commission an enhanced Primary Care Service for all Care Homes ensuring alignment to new GP contract arrangements.	Reduction in attendances and emergency admissions from care homes and an increase in those people who, at end of life, die in their preferred place of death.	1st April 2020
Subject to evaluation of the Havering pilot, extend the Trusted Assessor arrangements to care homes in Barking and Dagenham and Redbridge.	A reduction in DTOCs (Delayed Transfers of Care) related to discharges to care homes and a reduced number of hospital admissions due to UTI (Urinary Tract Infections) and Sepsis.	Quarter 4 19/20
Continue to support the work to ensure the appropriate use of antibiotics and reduce anti-microbial resistance (AMR) including visits to Care Homes.	Reducing AMR in care home patients and reduced hospital admissions due to a UTI.	Ongoing
Continue with a rolling programme of Significant 7 training to care homes aimed at training Care Home staff to spot patients at risk of developing symptoms requiring hospital admission.	Increased knowledge base within the care sector leading to a reduction in avoidable hospital admissions.	Ongoing

Hospital Based Workstreams: Three integrated workstreams focused on improving outcomes and reducing admissions/readmissions		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Home is Best (HIB) Workstream Commission a single integrated community based intensive support team across BHR with patients accessing the service assessed through one SPOC (Single Point of Contact) and including coordination of all support needed for patients post discharge including drug administration/tests, access to overnight carers/sitters, the use of telemedicine for remote monitoring and short term reablement at home as needed. Integrated with this Local Authorities (LAs) are proposing to commission a single escorted discharge service across BHR and both LAs and CCGs will develop a new Discharge to Assess (D2A) Pathway that supports the concept of 'Home First' rather than patients entering into a care setting for assessment.	Reduction in hospital admissions, length of stay and readmissions to hospital. Improved access to community support (including reablement) and a common model of care across BHR.	Phased roll out in 2019/20 with full implementation from April 2020/21
Front Door Support in the Emergency Department (ED) Workstream Full implementation of the single enhanced integrated ED based team at Queens Hospital (QH) in Romford and to look to develop a similar approach at KGH (King George's Hospital) consisting of a Consultant Geriatrician, Therapist and Nurse with links to Social Workers, Therapy Assistant and Social Prescribing Support. This team will work closely with the Home is Best (HIB) team to ensure that patients can be discharged into their care.	Reducing hospital admissions/readmissions and improved patient outcomes through reduced risk of infection and reduced deconditioning syndrome.	Full implementation April 2020
End of Life (EoL) Workstream A coordinated approach to improve the identification of people approaching EoL so personalised care planning can be proactively given. This includes access to support 24/7, electronic palliative care record sharing and a review of the EoL Beds available in local hospices and nursing homes. The work will involve commissioning a BHR wide integrated service model with training to help professional and staff provide care for EoL Patients and deal with difficult conversations.	An increase in the number of people who die in their preferred place of death (PPD) and improved care for those at EoL.	Full implementation by April 2020.
Pressure Ulcers We will implement a pressure ulcer strategy to provide a consistent approach to the prevention and management of pressure ulcers in all health and social care settings including people's homes. Each organisation will be expected to develop its own local policy that is aligned to the principles.	This will improve patient care and reduce overall activity of pressure ulcers across BHR.	Quarter 4 2019/20
Dementia Care We will progress implementation of the "Challenge on Dementia 2020" national strategy to ensure equality of access, GP leadership in coordinating care and meaningful care following diagnosis with people empowered to exercise choice and control over decisions affecting them. This will also cover training for appropriate NHS staff.	This will shorten the time for assessments and therefore the time spent in inappropriate settings	Q1 2020

4.2 Unplanned Care Transformation Board

The board was established in 2019 and is focused on supporting people of all ages who have Unplanned Care needs (including Urgent & Emergency Care). The board is aligned to the A&E Delivery Boards for BHR and has a key priority in ensuring that access to unplanned care support is provided equitably across BHR and that we continually improve the performance of our main A&E departments at Queens Hospital and King George's Hospital.

Unplanned Care Transformation Programmes for 20/21		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Community Urgent Care We will complete the procurement for four Urgent Treatment Centres (UTCs) and a GP home visiting service by 1st July 2020. The UTC sites will be at Queens Hospital, King George's Hospital, Harold Wood and Barking Community Hospitals. We will also work with the BHR GP Federations to ensure full utilisation of the GP Hub Services and transition of bookable appointments into Loxford Polyclinic and South Hornchurch ensuring that booking from 111 is fully embedded.	This work will improve access for people with unplanned needs who do not need to attend ED and through this will ensure our various EDs can improve performance for those with urgent and emergency needs.	July 2020
Co-Located Urgent Treatment Centres (UTCs) Work with BHRUT seamless pathways between the co-located UTCs and A&E's at Queens Hospital and King George's Hospital including the management of minor injuries and training of junior doctors.	This will ensure both seamless provision of care for people moving between the UTCs and EDs as well as improve the skills of our clinicians working in both settings.	July 2020
Direct to Specialty Referrals in the Emergency Department (ED) Work with BHRUT to implement a clear and accessible pathway for referrals from GPs (community and UTCs) to reduce attendances in ED and ensure that patients get to the right treatment first time and that appropriate tariff charges and recording practices are in place.	This will reduce the time for a patient referred to hospital by a GP with an urgent need seeing a specialist.	June 2020
London Ambulance Service (LAS) Work with London Ambulance Service to ensure that current and future ACPs (Appropriate Care Pathways) are fully utilised in order to, where possible, avoid conveyance to hospital. In addition, work with LAS to introduce Direct Despatch for CCG Schemes and will also look to strengthen the Pioneer Schemes given the specific challenges within NEL.	This will reduce the number of inappropriate conveyances to hospital.	November 2019

Delivering the Same Day Emergency Care (SDEC) Target of 30% We will work with BHRUT's two hospital teams and Whipps Cross Hospital (WX) (through Waltham Forest (WF) CCG) to ensure that we are compliant with the national SDEC definition and meet the national target of 30% of non-elective admissions being seen through SDEC pathways and we are maximising the opportunity to manage patients in the same day to improve flow and reduce avoidable admissions.	This will reduce the pressure on beds and help reduce avoidable admissions. Where appropriate patients will be discharged to the Home is Best (HIB) service referred to under Older People.	March 2020
Reduction in Long Lengths of Stay We will work with BHRUT and WX (through WF CCG) to ensure that we reduce long Length of Stays (LoS) by focusing on all patients with a LoS over 7 days. We will support the trusts to ensure that patient escalations are quickly addressed and any repatriations to support best patient case and flow.	This will help patients to go home safely more quickly and help reduce the risk of deconditioning syndrome arising.	Ongoing
High Intensity Users We will work with BHRUT, NELFT, LAS and the Local Authority services to identify the patients who need increased support to reduce their use of emergency services in order to ensure that they have better and more patient focused support and pressure on emergency care services is reduced.	This will reduce pressure on 111, ambulance conveyances and UTC/ED attendances.	Ongoing
Unregistered Patients in ED Our community urgent care providers and acute providers will work with us to signpost unregistered patients to a surgery closest to their home and advise on registration process. This requirement has also been included as part of the community urgent care procurement.	This will reduce pressure on ED but could require additional capacity in primary care.	Ongoing

Note: In addition to the schemes detailed above the Unplanned Care Transformation Board are also involved in the work being undertaken to support Older People at the Front Door of ED (led by the Older People Transformation Board) and to improve support for people with primary Mental Health needs who present in ED (led by the Mental Health Transformation Board).

4.3 Planned Care Transformation Board

The Planned Care Transformation Board is focused on improving access for elective care including appropriate services are available Out of Hospital (OOH) and closer to home. A key priority for the board is the development of new pathways and new models of care to make it easier for people to access care in a timely manner.

Planned Care Transformation Programmes for 20/21		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Improving Referrals Together (encompassing the Integrated Approach to Referral Management (IRM) Programme Continuing the rollout of clinically agreed pathways of care across BHR with all main acute providers and continuing to improve the efficiency of Advice & Guidance (A&G) services. This programme encompassed the Integrated Approach to Referral Management programme that is designed to work with Primary Care to use the IRT Pathways, Single Points of Access and to support the Out of Hospital agenda.	This will lead to a reduction in inappropriate referrals and an improvement in access for patients.	On-Going
New Models of Care for Outpatients Working with BHRUT and Primary Care to develop a new model for managing outpatients including the use of enhanced triage, virtual clinics and the development of new Single Points of Access and community services. We will also seek to have a similar arrangements with Whipps Cross Hospital.	This will dramatically increase outpatient capacity facilitating the delivery of elective access standards and improving care for patients.	Pilots have already commenced and will rollout throughout the rest of 19/20 and into 20/21
New Model of Care for MSK (Muscular-Skeletal) Services MSK remains one of the largest areas of activity for the NHS and this programme aims to transform how care is provided primarily within primary care including therapy and lifestyle management support and community based hubs. This work will also develop in conjunction with the new physiotherapy services that will be provided within Primary Care Networks (PCNs)	This will reduce waiting times (particularly for physio) as well as reducing C2C referrals and in time we expect a reduction in acute activity through better and earlier management of patient needs.	The new model will be agreed by providers and commissioners during 19/20 and will commence rollout throughout Q4 19/20 and into 20/21

Spending Money Wisely (Wave 3) In partnership with the rest of North East London we will be rolling out a wave three of the Spending Money Wisely Programme that expands/changes the service restrictions and procedures/treatments deemed to be PoLCE (Procedures of Limited Clinical Effectiveness). To align with the NEL Programme this will be renamed 'Evidence Based Interventions' (EBI) and may also include a potential further enhancement during 20/21 based on further National/Regional updates.	This will reduce inappropriate elective activity and free up clinical resource to focus on delivering higher quality care.	November 2019
Repatriation of Care Through the transformation of Outpatients at BHRUT we hope to be able to repatriate higher acuity care that currently flows out of our system and often into higher cost settings. This programme will continue to respect patient choice where expressed but will ensure that patients get both timely and local access to high quality care.	This will improve access locally for higher acuity care and will also reduce costs to the system through reduced use of higher cost settings.	It is likely this programme will roll out from April 2020
Development of an Independent Sector (IS) Framework We will work with our Independent Sector Provider partners to agree a framework for managing NHS care providing in non-NHS provider settings to ensure equity of treatment and to minimise the risk of excess costs being incurred by the NHS.	This will ensure continued access but will seek to balance care in the IS with NHS provided care at lower cost.	From Q1 20/21 with amendments following on from STP level discussions
Phlebotomy Services We will enact the outcomes of the phlebotomy consultation that is due to occur in the Autumn of 19/20.	This will lead to a reduction in waiting times for patients and complaints for CCGs and providers.	It is likely that the outcomes of the 19/20 Consultation will roll out from April 2020
Diagnostic Community Services Following a consultation we will enact from Autumn 19/20 we will undertake a procurement based on the consultation outcomes to standardise provision of community diagnostics across BHR, which complies with the pathways to be developed as part of the diagnostics demand management scheme which commenced during 19/20. This will include the ability for BHRUT to access additional capacity to manage peaks in demand for MRI, Endoscopy and Ultrasound.	Improved access to diagnostic support across BHR and the standardisation of pathways.	Commencement of a new service is likely to start from 31st December 2020 (sooner if possible)
Complex Wound Care & Lymphoedema We will continue the agreed pilot between NELFT and Accelerate CIC to provide optimised complex wound care services and BHR-based lymphoedema services.	This will return care from Mile End to BHR and also reduce dressings expenditure.	On-Going

Anticoagulation Services Following a consultation we will undertake in the Autumn of 19/20 we will enact the outcomes through a procurement to secure community anticoagulation services across BHR for patients medicated with Warfarin. It is likely this will be linked to the Atrial Fibrillation (AF) Hub that is being developed and will also involve the initiation of DOACs.	This will improve access and ensure consistency across BHR.	1st October 2020
Simple Wound Care Following a consultation we will undertake in the Autumn of 19/20 we will enact the final stages of the procurement that is currently paused to establish a simple wound care service across BHR which provides standardised care and equitable access for all BHR registered patients.	This will improve access and reduce the number of non-elective attendances and admissions.	1st February 2020 (subject to consultation feedback)
Balance Unit We will reviewing the benefits of establishing a balance unit working with defined pathways that helps to rapidly diagnose people with ENT problems related to balance and ensure they are diagnosed and referred for the correct onward treatment in a timely manner.	This will improve the outcomes for ENT patients with balance related issues and ensure they receive the treatment needed from the correct sub-specialty in a timely manner.	Q4 19/20

4.4 Cancer Transformation Board

The Cancer Transformation Board operates across North East London and is focused on all aspects of Cancer Care from prevention through to supporting people post-treatrment.

Prevention Workstream (Cancer)		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Continue to support the national *Be Clear on Cancer* campaigns: to increase presentation with suspected symptoms	Improved patient awareness and earlier presentation for treatment.	Ongoing
Reduce smoking rates: To take a whole system approach by working with Public Health colleagues to understand current provision of smoking cessation services, encouraging 'very brief advice' in clinical settings and make recommendations for investment in services.	Reduction in smoking rates and improved outcomes for lung cancer patients	Q3 19/20 for baseline with Q4 for plan and delivery from Q1 20/21
Develop and deliver an education strategy for primary care	Improved awareness of signs and symptoms and increased utilisation of referral pathways.	Planning will occur during Q3/Q4 19/20 with delivery starting in020/21
Establish Health Promotion Champions to engage with BME and other hard to reach groups. The intention is to recruit five health promotion champions recruited per CCG locality drawn from the local community.	Increased engagement with hard to reach groups and therefore improved outcomes.	Delivery during Q3 & Q4 19/20 with evaluation starting Q1 20/21
Establish a programme of 'Teachable Moments' for patients who have had an all clear following a 2WW at BHRUT	Improved lifestyles for at risk patients and therefore improved longer term outcomes.	In development - TBC
Implement a school based competition to raise awareness and increase uptake of the HPV vaccine.	Increased uptake of screening and therefore improved outcomes.	Delivery from Q3 19/20

Primary Care Workstream (Cancer)		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Action plan to improve scores in National Cancer Patient Experience survey.	Improved patient experience and improved NCPES scores	TBC
Roll out Practice and Network visits by Macmillan GPs and CRUK (Cancer Research UK) facilitator to improve the knowledge/skills of practices and better utilise data to improve outcomes.	Increased awareness of risk assessment tools and improved referrals	Ongoing
Roll out of Cancer Care Reviews (CCR) including training for practice nurses.	Improve personalised care for patients and better care management/experience.	TBC
Implement Out of Hours cervical screening to improve uptake (note this will be a National Transformation Funded project).	Improved access and ultimately increased earlier diagnosis of cancer.	Delivery from Q3 19/20
Work to increase the uptake of bowel screening programme (this is a National Transformation Funded project).	Increased screening rates and ultimately earlier diagnosis and better outcomes for patients.	TBC

Planned Care Workstream (Cancer)		
Specific Intentions	**Expected Benefits**	**Target Implementation**
We will work with partners to deliver the 28-day cancer diagnosis standard across BHR.	Patients receiving an ‘all clear’ or cancer diagnosis earlier	Delivery from Q1 20/21
Agree and implement stratified follow up arrangements for prostate patients, breast patients and colorectal patients	Improved care and outcomes for patients with care provided Out of Hospital.	Delivery during 20/21
Implement lung, prostate and colorectal optimal pathways.	Improved care and outcomes for patients with care provided Out of Hospital and a reduction in repeated diagnostics.	Delivery during 20/21
Development of Rapid Diagnostic Centre at Queen’s Hospital.	Speeding up of diagnosis (or the all clear).	Delivery during 20/21
Continued delivery of the Recovery Package including Treatment Summaries, Holistic Needs Assessment and Health & well-being events.	Improved outcomes for patients.	Ongoing
Implement Integrated Oncology Service for BHR.	More care delivered closer to home and an improved patient experience.	Delivery during 20/21

Unplanned Care Workstream (Cancer)		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Review the referral pathway for patients suspected of having cancer following attendance in Urgent Care/Hub settings to ensure optimal patient experience and speed of access	Earlier diagnosis of cancer and improved patient experience and outcomes.	Delivery during 20/21

4.5 Long Term Conditions (LTC) Transformation Board

The LTC Transformation Board is focused on supporting people of all ages with one or more LTCs. The board has developed a 3 Year Plan to transform the model of care for people with LTCs and improve outcomes. The strategy is focused on four themes; Prevention & Early Identification, First Response, Managing Well and Supporting Complex Patients.

Long Term Condition Programmes for 20/21		
Specific Intentions	**Expected Benefits**	**Target Implementation**
LTC Multi-Disciplinary Team (MDT) We will pilot a cross speciality MDT (Cardiology, Renal and Diabetes) for patients with two or more LTCs, who have required 2+ acute stays in the last 30 days. We will evaluate the outcomes and may make further changes to the service during 20/21 giving the appropriate notice.	Improve quality of care and outcomes which should help reduce non-elective re-admission episodes for complex patients	Pilot from Q4 19/20 with assessment in 20/21
IAPT & MH Services We will agree a phased approach to improving access to those people with a physical LTC who require IAPT and Mental Health (MH) Service Support.	This will ensure that both the physical and mental health needs of people are supported in a coordinated manner.	TBC
LTC Local Incentive Scheme (LIS) Following the success of earlier LIS's for AF and Diabetes we will continue this work under a single framework where GPs and Pharmacists can proactively case-find, treat where applicable, signpost people to (or provide) self-care information, care planning and ongoing management (first response model) for AF, Diabetes and a range of other LTCs.	Improved identification, management and outcomes for patients.	Q4 19/20

Prevention We will work with Primary Care and Public Health to increase the identification, management and support for people with hypertension who are currently undiagnosed. In addition, we will strengthen our commitment to prevention as laid out in the NHS Long Term Plan working in partnership with our Social Care and Public Health colleagues.	Improved outcomes for people with currently undiagnosed hypertension.	From Q1 19/20
AF Opportunistic Screening We will establish an integrated AF Pathway with Primary, Secondary Care, and Community Pharmacists in creating a one-stop AF clinic (hub and spoke model) and also implement 'opportunistic' screening of people who may have AF but are currently undiagnosed.	Improved outcomes for people with currently undiagnosed AF.	From Q4 19/20
Community Service Redevelopment We will continue the development of Whole System Pathways and will implement new models of care across BHR to improve support for patients in the specialties of Cardiology, Respiratory and Diabetes (including introducing a new Redbridge Diabetes Service based on that in Havering).	Consistent and effective care across BHR and improved outcomes for patients.	From Q4 19/20
LTC Diabetes We will commission a NICE compliant Diabetic Foot MDT and implemented a more effective approached Diabetes Structured Education. In support of this the North East London Sustainability Transformation Partnership have agreed funding to provide training for Type 1 Diabetes Education. Note this also encompassed the work on the National Diabetes Prevention Programme (NDPP) that is being retendered where we will work with Primary Care to ensure high levels of uptake from eligible patients.	Reduced incidence of foot amputations and other complications and improved diabetic awareness across all people with Diabetes.	Q2 2019/20
Social Prescribing & Community Interventions We will support the establishment of Social Prescribing as a 'business as usual' support to people across BHR and will explore the development of additional community interventions to help people with complex health and social care needs.	This will both enhance care for people with complex needs and reduce the pressure on health services.	Throughout 2020/21

4.6 Children & Young People (CYP) and Maternity Transformation Board

The Board focuses on the integrated health and care needs of CYP across BHR and incorporates support to the maternity pathway.

Vulnerable Cohorts (VC) Workstream		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Monitoring of VC addition provision: We will establish standardised coding and identification process with full IT inter-operability to maintain oversight of LAC and VC additional entitlements.	This will ensure a consistent approach to how we monitor VC additional provision.	Initial agreement by Q4 19/20 with implementation through 20/21
New Models of Integrated Support: We will agree and establish a new multi-agency matrix of support for VC across Education Health and Social Care and interfacing with Early Intervention and Emotional Wellbeing and Mental Health outcomes.	This will improve levels of readiness for school and reduce the number of foster placement breakdowns and escalation into more acute services.	Initial agreement by Q4 19/20 with implementation through 20/21
Integrated Transition Model: We will implement standardised and integrated transition processes for VC with agreed timetables. Based upon existing CQUIN transition best practice.	This will lead to a significant reduction in post transition escalation in acuity for both physical and mental health conditions.	Initial agreement by Q4 19/20 with implementation through 20/21
Learning Disability (LD) / Transforming Care Partnership (TCP): We will establish an LD Crisis Response Team and expand the consistent use of LD health checks within primary care and the implementation of robust follow up actions.	This will lead to improvements in life expectancy for LD cohorts and a reduction in Tier 4 needs for the system.	Funding and pilot for LD Crisis team agreed by Q4 19/20 with LD Health Checks integrated into Primary Care during 20/21
ASD (Autism) work: We will establish a pre-diagnosis familial interventions service working alongside a clear diagnostic pathway operating with agreed wait times.	This will lead to a reduction in waiting times for ASD diagnosis.	Initial agreement by Q4 19/20 with implementation through 20/21

Early Intervention Workstream		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Consistent Universal Offer for Speech and Language (SALT): We will implement a pan-BHR common approach between Education and Health to deliver integrated SALT provision utilising best practice skills mix and early intervention models. This will include clear links into high needs SALT utilising revised skills mix across pathways.	This will lead to a significant reduction in late interventions and accompanying improvements in cognitive development and readiness for schools attainment.	Multi-agency agreement by Q4 19/20 with service and skills mix amendments throughout020/21
Targeted Interventions: We will work with partners in social care, education, public health, acute and community to implement data driven service reforms delivering empirically proven 'downstream' benefits in 'readiness for school' including physical health, cognitive and social and emotional development.	This will lead to increased early contacts with hard to reach and vulnerable cohorts.	T&F Groups to agree targeted interventions by end of start of Q3 19/20

Emotional Wellbeing & Mental Health (EWMHS) Workstream		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Whole family EWMHS Structures: We will develop a multi-agency child and carer offer covering health and social care including targeted EWMHS and linking with vulnerable cohorts and early interventions.	This will lead to a reduction in CYP experiencing MH issues.	Model by Q4 19/20 with roll out through 20/21
Pan BHR CAMHS (Children & Adolescent Mental Health Services) Parity: We will work with providers to achieve commonality of resourcing and delivery across BHR with agreement on the validated transformation pilot outcomes being taken forward into commissioned services for CAMHS.	This will improve the clarity for service users on the ASD offer including accurate diagnostic wait times and pre-diagnosis support.	Model by Q4 19/20 with roll out through 20/21
Autism Spectrum Disorder (ASD): We will establish a multi-agency framework to address diagnosis, symptomatic resilience and familial support, crisis management and LAC/CiN additional targeted support.	This will lead to a reduction in MH escalation due to strong resilience building and targeted early interventions being in place	Q4 19/20

Other CYP Programmes for 20/21		
Specific Intentions	**Expected Benefits**	**Target Implementation**
SEND: We will agree joint definitions and shared outcomes across providers to agree pan-BHR approaches to SEND assessments and areas of responsibility. This will encompass a pan BHR approach to EHCP appears and the removal of communication barriers between education and health to ensure effective demand and capacity planning.	This will lead to a reduction in the use of clinician assessment time increasing therapeutic input capacity across BHR and reduce duplication.	Updated SEF by Q4 19/20 with actions being implemented into 20/21
Complex Children & those with LTCs: We will implement the London Asthma Standards to include primary and secondary care and education. We will also work with BHRUT, NELFT and Primary Care to provide more services out of hospital focusing on specific areas such as ENT to release capacity in secondary care and improve RTT performance.	This will lead to a reduction in asthma related incidents including ED attendances and increased self-management skills for people with asthma.	Q4 19/20 for agreement with phased delivery 2020/21
Community Services: We will undertake multi-agency work to deliver a pan BHR model for the Children's Community Nursing Team (CCNT) able to support efficient discharge from secondary care and operating within the revised IT interoperability structures. We will further undertake a capacity and demand study to look at the capability of our community services to support our growing and changing CYP population.	This will increase the number and effectiveness of community discharges.	Agree specification during Q4 19/20 and roll out during 20/21
Allergies Service: We will seek to establish an allergies service and/or additional support to CYP with allergies in the community to reduce the risk to patients, the concern of parents and the number of exacerbations and attendances at hospital.	This will bring care closer to home and reduce the risk to CYP with allergies.	From Q1 20/21
Pre-Conception Care: We will seek to commission a pre-conception care service to support and advise people with pre-existing conditions and help them to prepare for a healthy pregnancy.	This will reduce the number of issues occurring during pregnancy and post-partum.	From Q1 20/21
Improving Asthma Management for Children & Young People: We will continue our work to improve the management of CYP with Asthma and improve their long-term outcomes.	This will reduce the risk to CYP with Asthma and improve outcomes.	On-Going
Improving the Timeliness & Quality of Assessments for LAC: We will commission a new model of care for assessments for Looked After Children (LAC) and will also review the support available to (and how charging is managed) for LAC placed outside of BHR.	This will reduce risks arising from delayed assessments and also improve consistency in approach.	From Q1 20/21
New Safeguarding and Child Death Review Processes: It is expected that all organisations will fully participate in the new safeguarding partner arrangements and work together to develop	This will ensure a consistent and effective process is operated across BHR.	By the end of Q3 20/21

arrangements within an ICS. This includes delivery of the statutory requirements for the child death review process.		

4.7 Learning Disabilities (LD) Transformation Board

In 2016/17, the Transforming Care Programme was established to improve health and care services for people with a learning disability and/or autism. The LD Transformation Board is focused on supporting the priorities of the Transforming Care Board as they transition and also the work set out in the NHS Long Term Plan around inpatient care, crisis management, health inequalities and improving services to reduce admissions for CYP with LD needs.

Reducing Health Inequalities Workstream		
Specific Intentions	**Expected Benefits**	**Target Implementation**
We will accelerate the roll out of Personal Health Budgets for people with a learning disability and/or autism.	Improve peoples' choice and control of their care.	Q2 2020/21
We aim to ensure that at least 75% of people over the age of 14 with an LD receive a high quality annual Learning Disability Health Check.	Early identification and treatment of health conditions to prevent premature mortality.	Q4 2020/21
We will expand the STOMP (Stopping the Over Medication of People with Learning Disabilities) and STAMP (Supporting Treatment and Appropriate Medication in Paediatrics) programmes across BHR.	Reduce the overuse of psychotropic medicines and increase the quality of life for people supported	Q4 2019/20
We will ensure that Learning Disabilities Mortality Review Programme (LeDeR) reviews are undertaken within 6 months of the notification of death and themes and recommendations are published.	This will help reduce health inequalities for people with an LD.	Q4 2019/20

Inpatient Care & Crisis Management Workstream		
Specific Intentions	**Expected Benefits**	**Target Implementation**
We will maintain a focus on reducing inpatient beds in line with Transforming Care targets and reduce the length of time that people stay in an inpatient setting.	This will support a reduction in the average LoS for people with an LD	Q4 2019/20
Through the mental health transformation programme, enhance the crisis and community-based support and develop alternatives to hospital admission for adults and children; conclude the business case to remodel Moore ward.	Reduced admissions to inpatient care and reduced CYP attendances at A&E due to crisis.	Q4 2019/20

Review and strengthen the existing Care, Education & Treatment Record (CETR) and Care Treatment Record (CTR) policies, in partnership with people with a learning disability, autism or both, families and clinicians to assess their effectiveness in preventing and supporting discharge planning.	This will lead to a reduction in avoidable admissions to inpatients beds and length of stay.	Q4 2019/20
Work with NHS England to commission specialised mental health, learning disability and autism services from a clinically led provider.	This will improve patient experience and outcomes.	Q4 2019/20
Through the Positive Behaviour Support (PBS) practitioners' network, continue to deliver the PBS strategy including commissioning training and embedding 'Challenging Behaviour Clinics' in our community teams.	This will improve and coordinate support for people with challenging behaviour.	Q4 2020/21
We will focus on improving the quality of inpatient care across the NHS and independent sector and ensure that our out of area patients are visited on a regular basis. We will also work with NHS England to develop and implement a Quality Framework for commissioning learning disability and mental health services.	This will mprove support during an inpatient stay for both BHR and Out of Area patients with an LD and a common quality framework across BHR.	Q4 2019/20

Children & Young People (CYP) Workstream		
Specific Intentions	**Expected Benefits**	**Target Implementation**
It is acknowledged that children and young people wait too long for an autism diagnosis. Over the next three years, autism diagnosis will be included alongside work with children and young people's mental health services to test and implement the most effective ways to reduce waiting times for specialist services	Reduction in the time taken for a positive diagnosis of autism.	Review complete early in 20/21 with roll out to follow
We will jointly develop packages to support children and their families going through the diagnostic process. To do this we will identify CYP going through the diagnostic process, and those on the waiting list, for each borough. We will also identify an appropriate assurance mechanism (likely the ECSLs (Enhanced Care & Support Lists)) to monitor these cases and ensure that any identified needs are being met.	Children and young people will receive support at the earliest possible opportunity, to enable them to achieve the best possible outcomes.	Q2 2020/21
By 2023/24 children and young people with a learning disability, autism or both with the most complex needs will have a designated keyworker. Our ECSLs ensure that all CYP on the list have a named worker. We will develop this further to ensure that a key worker is recorded, before rolling out to the wider cohort.	Children and young people will have a named person responsible for co-ordinating their support across health, social care and education.	ECSL work to be completed by Q4 2019/20.
All boroughs should have an admission avoidance register for children and young people, and training should be delivered to teams on how to use this.	Children and young people with a learning disability and/or autism will be better supported to avoid an admission.	Enhanced Care and Support Lists (ECSL) are in place in all boroughs

4.8 Mental Health (MH) Transformation Board

The MH Transformation Board aims to support people of all ages with an MH need to receive the treatment and outcomes they need and deserve. The board is focused on the delivery of the NHS Long Term Plan for Mental Health, continuing to improve delivery of the mental health constitutional standards and developing new and better models of care for people with a Mental Health need. The Long Term Plan specifies a number of fixed deliverables for mental health which are set out in https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/. In addition to the fixed deliverables the local NHS System Intentions are set out below.

Mental Health Programmes for 20/21		
Specific Intentions	**Expected Benefits**	**Target Implementation**
Prevention & Wellbeing We will develop an enhanced mental health primary care model in BHR. This will include 3rd sector, social care and better support around self-management.	This will improve the support to GPs and other clinicians in primary care in treating and managing patients with mental ill-health, reduce secondary care mental health presentations and improve the ability of people to self-manage elements of their care.	Proposal to be agreed in Q4 19/20
IAPT We will complete the transformation of the IAPT service to a new model, which will include a dedicated LTC component.	This will decrease the waits for patients from 1st to 2nd and subsequent treatment and meet the national standards for IAPT for access and for recovery rates from treatment.	End of Q3 2019/20
Crisis Care 1 – Psychiatric Liaison Services Following the successful bid to NHS England (NHSE) for the psychiatric liaison service (PLS) at KGH we will enhance the current service from 24/7 status to Core 24 standard in line with mental health Five Year Forward View ambitions.	This will reduce breaches at BHRUT due to patients facing a mental health crisis attending A&E and reduce extended lengths of stay on wards for patients with a secondary diagnosis of mental health.	April 2020
Crisis Care 2 – Crisis Resolution & Home Treatment Following the successful bid from NHSE for the alternatives to crisis pathway. We will enhance the current Crisis Resolution and Home Treatment Team provision across BHR. We will Improve the provision for patients with a diagnosis of PD.	This will reduce the number of inpatient overspills that are being managed outside of BHR and reduce the number of A&E attendances as well as reduce the number of patients with a diagnosis of PD that are managed outside of BHR.	Quarter 3 2019/20

Crisis Care 3 – Inpatient Beds Following completion of a demand and capacity review of acute mental health services in 2019/20, and a review of the mental health model of care, to a) determine whether there is a need to commission additional inpatient mental health acute beds and b) develop a commissioning plan for female PICU.	This will reduce the number of out of area placements to zero. This will also ensure access to female PICU beds as close to home as possible.	April 2020
Dementia Diagnosis & Care We will continue to promote and support dementia diagnosis across BHR and to improve the availability of post dementia diagnosis support. We will also seek to provide integrated support to people with young onset dementia and to enhance support for people suffering from delirium and for dementia patients who are in crisis. Lastly, we will undertake a review of services for dementia associated with people with Learning Disabilities.	Through this all BHR CCGs will achieve and sustain the national measure for dementia diagnosis and this will also help promote early identification and diagnosis of dementia.	June 2020
Health Based Place of Safety (HBPoS) – Section 136 Suite We will commission an additional S136 suite at Goodmayes Hospital in line with the London Model for HBPoS.	This will lead to a reduction in the number of BHR patients with a mental health crisis needing to access S136 suites outside of BHR.	1st April 2020
Personal Health Budgets We will increase the take up of personal health budgets for patients with mental illness and learning disabilities.	This will increase overall satisfaction for people receiving care and support and increase autonomy and involvement in activities that are meaningful to individuals.	Quarter 4 19/20
Mental Health Patients in Primary Care & A&E We will work with colleagues in Primary Care and in the Unplanned Care Transformation Board to reduce the number of people with a primary Mental Health need who are attending primary care and A&E and therefore receiving sub-optimal care.	This will both improve the care for people with a primary MH need and also reduce the amount of activity occurring in Primary Care and A&E associated with people with a primary MH need.	Q2 20/21