Appendix 1 – Population of Focus

This data provides a robust overview of the older population across our region, specifically those aged 65 and over with complex needs – the primary cohort for INH delivery in 2025/26. We have worked with system partners to ensure this analysis draws from reliable local and national data sets, giving us confidence in the scale of opportunity for proactive, coordinated care. It also highlights the clear relationship between frailty, emergency care use and inequality – reinforcing why this group has been prioritised. This intelligence continues to underpin local delivery plans and is shaping the development of neighbourhood teams focused on anticipatory care, complex case management and urgent community response.

- 65+ people with complex needs (now and 2035)
- 656,000 residents (+167,000)
- 177,000 classified as frail (+46,000)
- X10 use of UEC services (housebound)
- 46,000 living with loneliness (+12,000)
- 39,000 confined to house (+9,000)
- On average accounts for 23% all ED attendances
- 1/3 of Type 1 A&E attendances from most deprived areas
- +18,000 attendances and +£4M in Type 1 A&E attendances
- 6% of Category 1 and 3/4 999 calls are from most deprived areas
- 460 extra days in ambulance conveyances of Category 1 and 3/4 calls
- 44% of all hospital attendances conveyed by ambulance are for 65+
- 37% of 111 calls are from most deprived areas (+11,000 calls)
- On average account for 44% of all hospital admissions
- 31% of 0/1 LOS are from most deprived areas
- +8,155 patients per year (22 per day) and +£76M in Emergency Admission

Appendix 2 – Urgent Care Statistics for the Population of Focus

Appendix 2 presents key metrics on urgent and emergency care usage by the population eligible for proactive care, building a clearer picture of avoidable demand across our system. These figures have been developed in partnership with Local Delivery Teams and provider leads, ensuring they reflect real-world activity. The insights confirm both the scale and nature of need – including the high number of non-urgent attendances and conveyances that could be prevented with earlier intervention. This data continues to guide our joint work on care coordination, urgent neighbourhood services and integrated intermediate care.

- 570,000 people in NENC eligible for proactive care:
- Over 8,000 had five or more A&E attendances
- 6,000 were admitted for an avoidable condition
- 29.5% of all A&E attendances were recorded as having ‘non-urgent’ illnesses
- 51% of UTC attendances were recorded as having ‘non-urgent’ illnesses
- 26.9% of ambulance Cat 3/4 calls result in conveyance to hospital
- Of all admissions, 10.2% were avoidable with an average length of stay of 5 days, which equates to 191,230 bed days
- Nearly 36,000 emergency spells for people with palliative care needs per year
- 531 people were in a hospital bed with NCTR week ending 5/1/25

Appendix 3 – Strategic Planning Session: UECN and LAWP

This summary captures the shared priorities and agreed actions from the joint meeting of the Urgent Care Network and the Living and Ageing Well Partnership held in May 2025. It reflects the broad partner participation across primary care, providers, local authorities and VCSE colleagues, and sets out a unified direction for how urgent and neighbourhood care must work together. The session reaffirmed our commitment to using shared data to guide decision-making, accelerating single points of access, and improving pathways for respiratory illness and frailty ahead of winter. This approach – combining population insight with partnership delivery – will remain central to how we progress the INH agenda over the months ahead.

Purpose: Joint session between the Urgent and Emergency Care Network (UECN) and the Living and Ageing Well Partnership (LAWP) to align priorities and actions for urgent and emergency care improvement, especially ahead of winter.

1. *Shared Vision and Priorities*
    - Integrated Care Coordination (ICC) and urgent community response are central to improving patient outcomes and system efficiency.
    - A single point of access (SPA) and multidisciplinary team (MDT) approach are essential for managing complex patients, especially those with frailty and long-term conditions.
    - Neighbourhood health and urgent care are not separate agendas—they must be aligned and integrated.
2. *Winter Planning Focus*
    - Respiratory illness is a major driver of winter pressures across the system.
    - There is strong support for developing a coordinated respiratory pathway that includes:
        - Proactive care planning and vaccination
        - Enhanced access to general practice
        - Better use of ARI hubs and virtual wards
        - Improved oxygen provision and discharge support
    - Norovirus and staff sickness also significantly impact capacity—these must be factored into winter planning.
3. *Care Coordination and Access*
    - There is consensus on the need to accelerate care coordination models (e.g., ISPAs) across all areas.
    - Emphasis on ease of access for clinicians and patients—ideally through a single contact number and simplified referral pathways.
    - Importance of standardising terminology and models across the region to reduce confusion and improve efficiency.

4. *Role of General Practice*
    - General practice is seen as a cost-effective and scalable solution for urgent care.
    - Calls for investment in general practice capacity, especially for managing mental health, palliative care, and respiratory conditions.
    - Recognition that out-of-hours access and continuity of care remain challenges.

INH Appendix 3

5. *Patient and Public Engagement*
    - Need for a communications strategy to manage public expectations and explain changes in service delivery.
    - Importance of involving patients and carers in pathway design to ensure services meet real-world needs.
6. *Next Steps*
    - Develop a regional respiratory pathway as a priority for winter 2025/26.
    - Continue to progress frailty and care coordination workstreams.
    - Use existing data and insights to target interventions and avoid assumptions.
    - Plan a follow-up joint session to review progress and refine priorities.