Meeting:	**Social Care, Health and Housing Overview and Scrutiny Committee**
Date:	**15 December 2014**
Subject:	**Winter resilience planning**
Report of:	**Dr Gail Newmarch, Executive Member for Bedfordshire CCG**
Summary:	This summary report sets out winter resilience activities taking place aimed at supporting Bedford Hospital's 4 hour A&E guidelines, reducing hospital emergency admissions and delayed transfers of care and importantly, positively impacting upon patient care and quality over the winter months.

Advising Officer:	Dr Gail Newmarch, Executive Member for Bedfordshire CCG
Contact Officer:	Paul Wilkins, Interim Urgent Care Operational Lead, Bedfordshire CCG
Public/Exempt:	Public
Wards Affected:	All
Function of:	Council

CORPORATE IMPLICATIONS

Council Priorities:

1. This summary report sets about explaining how winter resilience planning within the local health community contributes to achieving one of the County Borough Councils priorities, namely the promotion of health and wellbeing and protecting the vulnerable

Financial:

2. The health system is in receipt of an additional £2.4m to deliver winter schemes which will positively impact upon the delivery of health and wellbeing in Bedfordshire.

Legal:

3. No legal implication

Risk Management:

4. To ensure a focus is maintained upon risk management and effective delivery, a comprehensive risk register has been created, which is regularly scrutinised through the CCG's Operational Resilience Group. In addition to this, all initiatives have an agreed set of Key Performance Indicators' which are monitored via a visually effective dashboard, capable of identifying immediate performance slippage and underlying trends. The dashboard is monitored via the System Resilience Group (SRG) and the Operational Resilience Group (ORG).

Staffing (including Trades Unions):

6. Not Applicable

Equalities/Human Rights:

7. As part of its development this piece of work, its impact on equality has been assessed and no detriment has been identified.

Public Health

8. The winter initiatives, as set out have been targeted at supporting the 4 hour A&E guidelines, reducing hospital emergency admissions and delayed transfers of care and importantly, positively impacting upon patient care and quality.

   Each initiative has been developed to enhance current healthcare delivery as well as introduce new and innovative ways of delivering care. By focussing on reducing the time to assessment by senior healthcare decision makers, avoiding emergency admissions and re-admissions by accessing the right care, in the right place at the right time, then the winter initiatives will have a positive effect on the people's health and access to health services when needed.

Community Safety:

9. Not Applicable

Sustainability:

10. Not Applicable

Procurement:

11. Not applicable

RECOMMENDATION(S):

The Committee is asked to:-

1. Note the work being taken by BCCG and partner organisations in the delivery and monitoring of the winter initiative schemes.

Introduction

12. Following extensive work with all partners and the Local Area Team of NHS England, Bedfordshire Clinical Commissioning Group's winter funding bid was recently sanctioned, enabling £2.4m to enter the health system. This financial injection has enabled carefully considered initiatives to form an exciting but challenging portfolio aimed at supporting Bedford Hospital's 4 hour A&E guidelines, reducing hospital emergency admissions and delayed transfers of care and importantly, positively impacting upon patient care and quality. Additional funding has also been granted to Luton CCG to support similar activities with the Luton & Dunstable Hospital.

13. To ensure a focus is maintained upon sustainable delivery, a comprehensive set of key performance indicators have been agreed and have been worked in to a performance dashboard, capable of identifying immediate performance slippage and underlying trends. The dashboard is monitored via the System Resilience Group (SRG) and the Operational Resilience Group (ORG).

14 Please see below for details of the different initiatives that form part of the Winter plan.

Communications activity

15. To support the winter resilience plan, a communications strategy and action plan has been developed to support NHS services across Bedfordshire to manage the pressures of winter.

16. The communications and engagement team will work closely with local authority, public health, acute and community health colleagues to ensure the delivery of a consistent and robust winter communications and engagement programme.

17. The communications and engagement activities include:
- local implementation of national campaigns
- local targeted engagement activity
- awareness raising of services and how they should be used
- promotion of priority services to enhance reputations
- reassurance and promotion of services
- key ‘stay healthy in winter’ messages.

18. The programme will use established communications and engagement mechanisms; online, hard copy and face-to-face, as well as developing additional elements as required, such as commissioned materials and targeted engagement activities and events.

The winter resilience communications strategy and action plan will:

- Deliver clear and relevant communications with all stakeholders, internally and externally
- Deliver planned communications and engagement activity, reporting on its implementation, feedback and evaluation
- Link with health and social care partners on agreed communications and engagement activity, sharing content and resources, as appropriate
- Proactively promote the key messages and services within the plan; seeking opportunities for communications and engagement, and developing initiatives and activities, as appropriate
- Use current communications channels and materials, developing new ones as appropriate
- Aim to engage with, raise awareness and inform audiences
- Aim to improve communications to stakeholders, including primary care
- Develop overarching communications, as well as targeted communications, such as social media

A copy of this communications action plan is attached to this paper.

Winter resilience plan initiatives

Organisation	Scheme Name	Aim
Bedoc	Rapid Assessment and Triage	To carry out an effective eyeball assessment of patients to determine the level of care they require, this will allow patients to quickly be streamed to the appropriate services minimising the risk of patients waiting for assessment.
Bedford Hospital & SEPT	Clinical Navigation	A previously piloted clinical navigation team has been introduced to: (a) prevent unnecessary hospital admission and to facilitate discharge (b) direct patients to the appropriate care, act as a liaison between hospital and community services (c) provide a multidisciplinary assessment to address health and social needs, offer advice, support and sign post to the appropriate services which will allow the individual to regain their previous functional level, allowing the promotion of independence and well-being where possible in the patient's own home The Navigation team provides alternatives to inpatient care, either at A&E, Acute Assessment Unit or within 72 hours of hospital admission.
SEPT	IV in the Community – Responsive intravenous antibiotic therapy to be administered in the community	This initiative provides a responsive service that will accept referrals from the acute Trusts for patients who require treatment with a regime of intravenous antimicrobial in their own home or community in patient bed. This initiative helps alleviate pressure of acute beds and get patients back to their own homes safely and quickly.
BHT/Primary Care	Hospital at Home North	The aim of the Hospital at Home service is one where the hospital consultant retains responsibility for the patient who is discharged to their own home, then seen by a team of nurses. The service is for patients who do not fall within community health criteria or when they have insufficient nursing capacity to accept a patient. The basic philosophy of the service is that nurses are able to manage the acute episode at home under the care of the patients Consultant instead of in hospital. The service suits patients who may need one to three hours of direct clinical care a day but do not need to occupy a hospital bed for 24 hours.
BCCG	South Bedfordshire (L&D) Discharge to Assess (DST) Pathway	Patients can only be placed on the NHS Continuing Healthcare (CHC) pathway if they are deemed 'medically fit for discharge/ready for transfer'. This initiative provides an opportunity to discharge patients into a community setting following a CHC Checklist if they 'screen in' for a Discharge Support Tool. As per the previous 'Funding Without Prejudice' winter funded initiative in the North

		(BHT), this will serve to discharge those patients, releasing acute beds for acute patients.
Bedford Hospital	AAU staffing (6nurses) plus register including telephone advice	This scheme has introduced additional staff to support the delivery of rapid assessment by a Consultant and increase the number of discharges per day from the AAU, either to the base wards or back into the community. This will reduce the LOS (le4ngth of stay) and decrease the reliance on acute beds, delivering better patient outcomes, also, supporting the ring fencing of AAU Triage supporting rapid turnover of patients. The initiative will also support the flow of patient through A/E thus the achievement of the 95% target.
Bedford Hospital	7 day working including pharmacy and therapies	By providing additional staffing and processes, this scheme aims to enable more people to be discharged over weekends, freeing up acute beds and reducing the opportunity to be delayed from going home due to pharmacy or therapy service delays.
SEPT	Psychiatric Liaison – SEPT proposal for 2 x consultant plus nurses (North and South)	The overall aim of the service is to both improve the patient experience of acute hospital care and reduce the overall length of stay and delayed transfers of care through the provision of timely Psychiatric assessments, treatment planning, signposting to appropriate Mental Health services and timely discharge or transfer, of patients within all inpatient wards / units within the General Hospital setting. This will be accomplished by: Providing advice, specialist consultation, and joint working for people under the care of the Bedford Hospital in relation to psychiatric and psychological treatment of people presenting with mental health needs on the wards at the BGH hospital. This will be done by the provision of Mental Health Assessments to provide inpatients with a provisional mental health diagnosis to support appropriate treatment and after care planning.
BCCG via Totally Health	Health Coaching	Totally Health provide specialist Nurse led Health Coaching Services to promote self-care and bring about behaviour changes which impact positively on Health of people diagnosed with long term conditions.
EEAST	Hospital Ambulance Liaison Officer	This scheme has introduced Hospital Ambulance Liaison Officer (HALO) 7 day per week in Bedford Hospital. The HALO targets rapidly turning around ambulances, increasing their availability, enhances patient record compliance and is an integral part of the ambulance/hospital team informing process redesign.

Appendices:
Appendix A - Communications Action Plan