NHS
Bedfordshire
Clinical Commissioning Group

Bedfordshire Whole System Winter

Responsibility:	Bedford Hospital A&E Delivery Board
Effective Date:	01/10/17
Review Date:	TBC
Reviewing/Endorsing committee	Bedford Hospital A&E Delivery Board
Date Ratified by Bedfordshire A&E Delivery Board	TBC
Version Number	1.7

Planning – 2017/18

Bedford Hospital NHS
NHS Trust

NHS
Essex Partnership University
NHS Foundation Trust

East London NHS
NHS Foundation Trust

Bedford Borough Council

better care, better value, better health

Winter Plan Development Process

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Board approval

Committee/Group	Date	Status
Bedford Hospital A&E Delivery Board	17/08/17	Reviewed
Bedford Hospital A&E Delivery Board		

Version Control

Version	Date	Name	Change
1.0	31/07/17	Corinna Welbourn	Development of new document
1.1	17/08/17	Denise Bricknell	Updated formatting
1.2	17/08/17	Emma Hunt-Smith	Update with narrative
1.3	08/09/17	Corinna Welbourn	Update in response to NHSE queries
1.4	15/09/17	Corinna Welbourn	Updated with graphs & narrative
1.5	19/09/17	Corinna Welbourn / Emma Hunt-Smith	Updated with data & narrative
1.6	26/09/17	Corinna Welbourn	Updated with narrative
1.7	28/09/17	Corinna Welbourn	Updated with narrative

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Introduction

Throughout this document the term ‘winter’ refers to the period 1st October 2017 to 3rd April 2018.

Last winter was a challenging period for the NHS. There are various factors driving this, in particular that there is an increase in the proportion of older people attending A&E and in the proportion of people who need to be admitted to a hospital bed as an emergency. Increasing numbers of patients with severe illnesses and complex health conditions are one of the key factors behind rising pressures, especially on A&E departments.

The Keogh review into the urgent and emergency care system expressed concerns that the fragmented provision of services makes the system confusing for the public. In response to these concerns, the NHS Five Year Forward View aims to help patients ‘get the right care, at the right time, in the right place’ by making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies.

With this in mind NHSE and NHSI have mandated that local systems ensure their winter plans meet specific priorities as well as ensuring preparedness to meet the expected increase in demand on the health and social care system over the winter months.

The Bedfordshire system has been working tirelessly to improve patient flow and experience and is in the process of implementing the Urgent and Emergency Care Delivery Plan priorities, in correlation with the winter plan. This plan provides a response to these requirements and to the requirements of NHSE and Public Health England’s ‘Cold Weather Plan for England’.

The following sets out plans that are being implemented across the Bedfordshire Health and Social Care system to ensure that appropriate arrangements are in place to provide high quality and responsive services not just for the 2017/18 winter period but for future years.

These programmes of work collectively aim to meet the national requirements of reducing delayed transfers of care, Primary Care Streaming, reducing variation in best practice and reducing A&E attendances. Performance against each project / programme is monitored closely through the comprehensive governance systems in place across the Bedfordshire Health and Social Care system.

Winter Arrangements

Bedfordshire Clinical Commissioning Group

Bedfordshire Clinical Commissioning Group (BCCG) works closely with all system partners to ensure good patient flow from the time a patient enters the health system, through their recovery to discharge.

The CCG coordinates the Bedfordshire systems response to demand surge including ownership of the A&E Delivery Board's Operational Plan and the system wide capacity escalation framework. This includes informing and providing system partners and NHSE with updates around the implementation of priorities and responses to demand when required.

To support Bedfordshire Health and Social Care provision the CCG maintains the Directory of Services locally, ensuring its accuracy thus enabling system partners to access service details to signpost patients to the most appropriate service. Bedfordshire CCG is also working closely with Luton CCG and the 111 provider to establish the possibility of providers amending the DoS in an emergency for out of hours and over weekend.

Bedfordshire Health & Social Care provision

The expectation is that Bedford Hospital, Essex Partnership University Trust, Bedford Borough Council, Central Bedfordshire Council, East London Foundation Trust, Herts Urgent Care, Patient Transport Services and East of England Ambulance Services Trust will have sufficient capacity in place during the winter period to manage demand. Accordingly their winter plans will be closely monitored throughout the winter period by CCG commissioners to ensure delivery.

The objective of this plan is to reduce activity at Bedford Hospital by a minimum of the below along with maintaining the DTOC level:

Activity Reduction	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Non-elective Admissions	138	138	138	138	138	138
A&E Attendances	956	956	956	1025	1025	1025
Short Stay Tarriff Reductions	72	72	72	72	72	72
Excess Bed Days	120	120	120	120	120	120
GP Referral - Outpatient/Followup	168	168	168	168	168	168
DTOCS	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%

Discussions underway re implementation of a remote monitoring/Telemedicine pilot at STP level, utilising the Estates and Technology Transformation Fund (ETTF), confirmed at the end of August 2017. Now funding has been confirmed consideration is being given to fast track implementation to support winter pressures.

A table top exercise to test system wide response to winter pressures is being arranged. Special focus will be on the mini MADE and OPEL processes along with locally designed escalation processes focused on outcomes. Bedford Hospital has been running internal exercises throughout August and their internal processes have evolved, still includes daily Red 2 Green with recording on the ExtraMed system.

The CCG and Primary Care are working together to establish a system (through SystmOne) to provide weekly data by practice of arising health issues e.g. Respiratory conditions, in order to alert the Health and Social care system to enable early escalation and response to demand surges.

Monitoring
Monitoring of key indicators happens at many levels including:

- BHT Daily bed meetings
- Weekly Bedford hospital executive team meetings – length of stay, stranded patients, 4 hour performance, bed occupancy, home by lunchtime, weekend discharges
- Bedford A&E delivery Board – comprehensive monthly dashboard and daily activity and performance system dashboard against schemes identified

Winter Communications Plan

Proactive Communications
A proactive communications plan *(Appendix 1)* has been developed to encourage the public to use A&E responsibly, to promote self-care and other NHS services and to 'save' A&E for the acute and life-threatening injuries. The aim of the plan is to help reduce attendances at A&E for minor injuries and illnesses that could have been seen elsewhere in the NHS system.

In addition the BCCG communications team will support and promote the NHSE Winter communications plan which focuses on the preventative message of 'staying well' and only accessing A&E in emergencies.

Reactive Communications
In line with the 'Operational pressures escalation levels framework', BCCG communications team will work closely with the communications teams of the acutes and providers to ensure external and public facing communications are clear and consistent. The aim of the external communications will be to;

- Communicate operational pressures and actions taken to reassure patients and public
- Portray an accurate picture of operational pressures to the staff and public, with the aim to reduce the amount of queries received
- Accurately inform the public of the pressures on the services in the local area and advise on any actions or response required of them

The messages will be delivered via local media, social media, and websites and via staff and GP Member practices.

Care Homes
In compliance with the BGS Guide on Care Home medicine Care Home Pharmacists are in place and a programme for a further 2 Care Home Pharmacists at Multi-Disciplinary Team (MDT) level working with Clinical Pharmacist in General Practice and link to Complex Care Team is in place. The Pharmacists provide clinical support to the GPs, review medications and support MDT annual reviews, with action plans instigated where required and communication back to Community Pharmacists.

It is planned that the 'red bag scheme' principles identified in the Urgent & Emergency Care Delivery Plan will be implemented across care homes including residents details, vital health information, medicine supplies and a change of clothes to accompany those residents who are admitted to hospital ensuring continuity in patients care by the end of Quarter 4 2017/18.

Seasonal Flu Programme

Flu is a key factor in NHS winter pressures. It impacts on both those who become ill, the NHS services that provide direct care, and on the wider health and social care system that supports people in at-risk groups. Flu occurs every winter in the UK. Seasonal Flu immunisation is one of the measures that help to reduce illness in the community and unplanned hospital admissions, and therefore pressure on health services generally and A&E in particular.

Admissions with Influenza and Influenza related illness as a primary diagnosis 2016/17

Admission with Influenza and Influenza related illness as a primary diagnosis	NHS BEDFORDSHIRE CCG (2015/16 Total registered population 466,465)		
Age group	Number of admissions	Total cost	Number of Deaths
Children 0-4	61	£96K	0
Children 5-18	38	£68K	0
Adult 19-64	395	£981K	15
Adult 65 and above	1297	£4,031K	130
Total	1791	£5,176,029	145

(Data source SUS retrieved through Mede analytics)

More than 60% (2/3) of all the admissions with Influenza or its complications as its primary diagnosis were from people age 65 and above.

- 7-10% of people who were hospitalised due to influenza and its complications died
- Out these deaths, 80-85% people were from the age group of 65 and above
- Crude rate of admission due to Influenza related illness ranges between 33 to 38/10,000 registered population
- Average inpatient cost/ of admission is around £2900/day.
- Frontline Health and social care workers:
- 'Flu is a common illness, affecting on average around 20 percent of staff. Evidence suggest that 'flu vaccine reduces the risk of illness in healthy people by 70 percent. This converts to a 43 percent reduction in absenteeism, or 74 fewer lost days per 100 employees,'
- Cost of absence relating to flu in the health and social care sector is £113.84 (average) FTE per day off. On an average sickness absence rate in an organisation is around 3.79%. Out of this 3.79%, it was observed that flu related absences accounted for 1% (appx 25% of the total)
- Absences due to flu related illnesses cost one NHS trust £1.44 million a year, which is equivalent to 12,649 working days and 56.22 FTE staff (http://www.nhsemployers.org/your-workforce).

In 2017/18, those eligible for flu vaccination are:

- people aged 65 and over,
- people aged under 65 with specific clinical conditions,
- all pregnant women, all two and three year-olds,
- healthcare workers with direct patient contact,
- carers and children in reception class and school years 1, 2, 3 and 4

Public Health are responsible for the seasonal Flu Programme and further information is contained within the Seasonal Flu Communication Plan 2017-18. *(Appendix 2)*

Community Nursing Caseload Flu Vaccination Service is being reinstated (commences 9 October). The community nurses will ensure that all patients on their caseload will be vaccinated along with signposting carers to have their jab at their GP Practice. This will free up GP and Practice Nurse time to see more patients in the practice.

Last year 36 out of 54 practices used the service. The reasons given for not using the service were:

- change of Practice Management (caretakers)
- practice closure
- historical distrust of the Community Providers
- preference for PGD due to perceived medicolegal issues

All who used the service said that it had freed up valuable clinical time and were keen for it to be repeated this year. The majority of those practices that were not involved have expressed their interest in being involved this year. Of the 52 Bedfordshire practices only 3 have stated they will not be taking part in the service for 2017/18.

Season	Flu Imms Offered By DNs	No. Refused	Imms Provided
2015/16	83	8	83
2016/17	569	87	482

Flu Cohort	Uptake Compared to 2015/16
65+	-1.3%
Under 65 at Risk	+5.3%
Pregnant Women	+5.1%
Carers	+2.6%

Although there is no evidence that proves the service improved the uptake of those at risk and their carers, Public Health (PH) and the members of the Flu Steering group believe that the continued communication routes, relationships with EPUT staff, EPUT signposting of carers and improved communications between BCCG and PH did improve uptake in the desired areas

Risk areas identified and being mitigated as part of Flu vaccination programme include:

- Assurance that practices In caretaking arrangements have a robust vaccination programme
- Support from PH & pharmacy from any practice struggling with resilience
- Assurance that maternity patients are offered vaccination (this is being carried out with BHT, seeking assurance via quality team from L & D)
- More robust Comms plan for at risk groups' e.g. GP on local Radio, PowerPoint packs for GP surgery waiting rooms etc.
- New protocols working with Urgent Care Team, Resilience and community service for outbreaks in care homes

Flu is a key factor in the NHS winter pressures planning and plays a key factor in the local plan, particularly increasing the 'at risk' group up-take and intensifying usage by practices of the excellent support from community nursing teams. It also impacts on both those who fall ill and the NHS services that provide direct care, and on the wider health and a social care system that supports people in at-risk groups.

This local annual immunisation programme is a critical element of the system-wide approach for delivering robust and resilient health and care services throughout the year, helping to reduce unplanned hospital admissions and pressure on A&E.

The CCG is a member of the regional Flu Planning and Implementation Group which supports the annual seasonal flu program thereby minimising the impact of seasonal flu on the populations within the areas defined by the Midlands and East Area Team (Bedfordshire, Luton, Milton Keynes, and Hertfordshire). There is variation in the uptake of flu vaccination across the area and by working together to address the barriers that are faced, it is anticipated that the group will ensure that communications and strategies for improving flu uptake within each area are fully supported.

Primary Care capacity for flu jabs now includes all 4 year olds in schools being vaccinated by school nurses; and a weekly flu newsletter is produced.

Infection Control

Providers are expected to have, and are responsible for, individual plans around the management, containment and avoidance of infectious diseases such as norovirus and gastroenteritis and the impact of infectious diseases closing beds which are monitored daily by the CCG.

Acute, Community and Mental Health Providers have infection prevention and control teams in place to manage outbreaks of infectious illness. They are expected to manage outbreak within their premises as per their outbreak management plan to include system-wide outbreak meetings with membership from Bedfordshire Clinical Commissioning Group, Public Health England (PHE) and Public Health (Local Authority). Public Health England provide daily weekday outbreak reports covering the care homes in Bedfordshire.

Care homes are expected to inform PHE of any outbreak in their premises and then follow PHE advice on the management of the outbreak.

Any outbreaks (i.e. Norovirus) are reported via Public Health England and are included on the daily weekday System Resilience Reports.

Bedford Hospital Winter Planning

Front Door:
In Hours - Urgent Primary Care Streaming will commence from 8th September 2017. Therefore patients who present at the front door of A&E with primary care needs will be eyeballed by a BHT nurse (using an agreed clinical protocol) and if appropriate, they will be streamed to the onsite GP practice, Cauldwell Medical Centre.

BHT and Virgin Care are actively working together in order to ensure suitable patients will be 'streamed' from A&E to Cauldwell Medical Centre for urgent primary care assessment and interventions. Virgin Care will be expected to provide streaming capabilities between 08.00 and 18.30 hours. Appointment slots for Cauldwell Medical Centre can be accessed by A&E staff via System One compatible computer modules. There is an agreement between BHT and Virgin Care, to provide additional Urgent Primary Care appointment slots, particular in winter, to match the expected activity surges, for instances, between the hours of 1.30pm to 6.30pm.

It is anticipated that urgent primary care streaming will reduce the cohorts of patients arriving and discharged from A&E with Urgent Primary Care needs as shown below with the Health Resources Group (HRG) coding (Minors) (as shown below M1 to M4 actual activity against the three HRG codes). This equates to 20 patients a day, 420 a month.

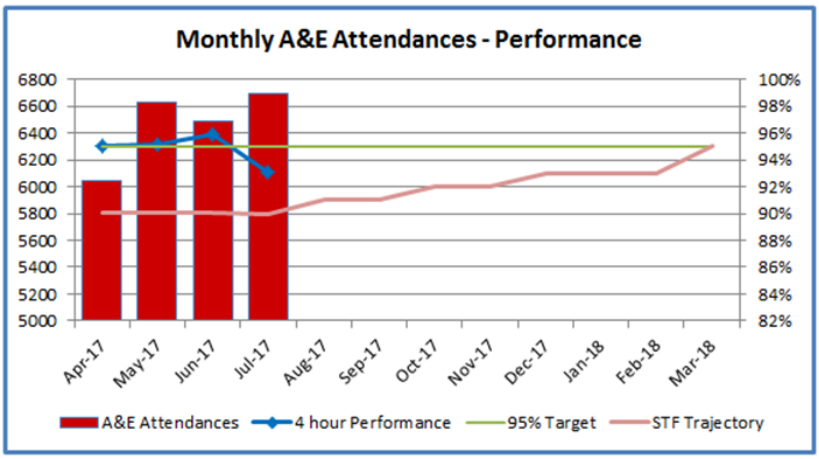
	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Urgent Primary Care streamed Activity	420	420	420	420	420	420

Out of Hours – BCCG are working closely with HUC, the provider of the Integrated Urgent Care service to ensure improved service delivery, including increased number of clinicians on shift.

Whilst there are challenges with the current integrated urgent care service, the model is expected to deliver the desired reduction in A&E attendance.

Activity Reduction	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Integrated Urgent Care (111 and Out of Hours)	83	83	83	83	83	83

Patient Flow:
The Bedford health system has performed relatively well this financial year in terms of the 4 hour target and the graph shows below shows current performance and the trajectory to achieve 95% by Q4.



Performance has been achieved through a number of measures aimed at achieving effective flow and further detail is provided.

Bedford Hospital has been using Red and Green days and SAFER methodologies on all wards as business as usual. It is clear that whilst systems are mainstreamed the impact that they have lessens over time as behavior becomes normalised. The Trust is employing different strategies to keep patient flow alive for example a Perfect 'Reset' Week was held from 3st July to 6th August which involved the Ward Managers actively undertaking in-patient reviews twice a day with silver and gold command structures to unblock issues and expedite discharges.

A series of strategies will be employed in the lead up to and over winter as we systems are refined. Length of Stay meetings will be increased from once a week to twice a week and will focus on every patient stay over 5 days. The Ready for Transfer calls will continue to be held thrice weekly.

A number of processes have also been implemented to manage flow and prevent overcrowding in A&E. These include:

i) A&E process – streaming away from A&E when alternative pathways exist – in hours urgent care from 8th September, Ambulatory care fully functioning. Plans to change the model of frailty in Oct / Nov
ii) Flow leadership – Site team 24/7 support the emergency care pathway from A&E through the hospital, escalating delays and planning ahead: 2 hourly rounding in A&E as a minimum, estimating beds required and planning ahead, escalating to manager of the day, / senior manager on call when problems are foreseen.
iii) Bed meetings x 4 a day with a structured agenda, senior support and action planning.
iv) Complex discharge planning – daily identification of medically optimized patients, three times a week ready to transfer call to hold partners to account, weekly moving to twice weekly length of stay meetings.

Bed Capacity Modelling
Bed capacity modelling has been undertaken at intervals over the past year with further refinement of the tool in March supported by NHSE's bed occupancy tool kit. Bedford Hospital Trust (BHT) has 364 adult and paediatric general and acute beds. The bed capacity modelling tool demonstrated that a further 37acute beds will be required to meet winter pressures. In winter and under escalation the bed base can be increased to a total of 401 beds by utilising:

- 5 x Folwell – CDU
- 12 x Tavistock – Day surgery
- 8 x Riverbank - Paediatrics
- 2 x contingency – 1 x AAU, 1 x ARAS room
- 10 x Victoria – (the discharge lounge is converted to overnight stay but is only used as an absolute last resort)

It is anticipated that all hospital bed capacity will be required in January to March 2018 including contingency areas even if Discharge to Assess and the additional community / Local Authority capacity works.

The NHSE tool kit also shows that Bedford Hospital bed occupancy is currently at 97.6% which is well above the national acute hospitals target of 87%. The day case rate is 88.8% so there is little room for improvement here. Zero length of stays are relatively low at 26.3%. Length of stay has improved to 6.19 although this always increases in the winter. Delayed transfers of care has increased to 3.7%.

The schemes agreed by BCCG for BHT –

- Community Geriatrician,
- Hospital at Home,
- enhanced discharged planning and
- heart failure,

along with internal efficiencies will all contribute to achieving bed savings at Bedford Hospital. The reduction of the medically optimised patients through discharge to assess pathways will also make a major contribution to the Trusts existing plans.

Referral to Specialty team
An enhanced mental health team commences in October and a revised agreement about point of referral i.e. at 2 hours has improved flow.

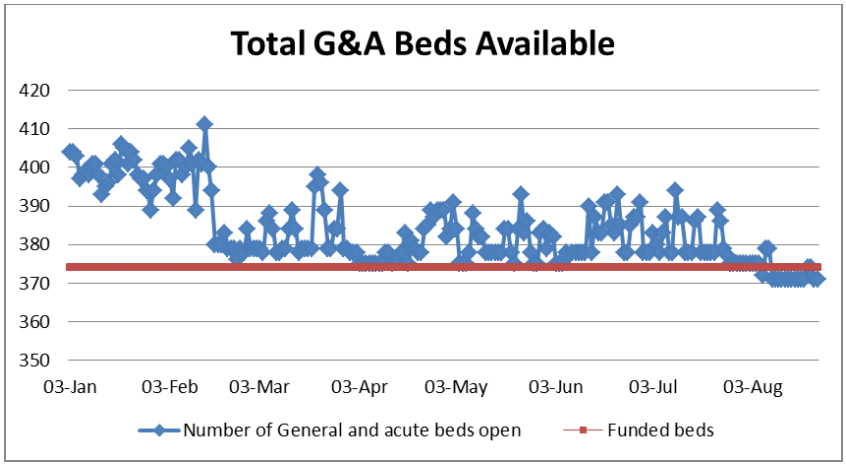
A new protocol clarifying the admission criteria by specialty has been implemented to support medical teams with allocation of patients. Specialty delays have improved and will improve further once the SAU is implemented.

Increase to Discharge Planning staff:
BHT have expanded the discharge planning team and will have one discharge planner per ward working in teams to ensure resilience, effective from the end of September. This means that the Discharge Planning team can take on the broader remit of starting discharge planning for every patient, not just complex, from admission and ensure proactive and safe discharge in line with national CQUIN 8a and 8b KPIs.

Complex Discharges:
The Discharge Planning team along with Community and Local Authority partners will continue to operate a complex discharge tracker (PTL). This enables transparency about every patient, their discharge date, plans and organisational accountability. An escalation process is in place and three times a week 'Ready to Transfer' teleconferences are held to hold organisations to account for delays.

The OPEL plan is being revised with triggers of 45 medically optimised and / or 12 delayed transfers of care. The response from organisations is being re-evaluated along the lines of mini MADE and a table top is being arranged as discussed above to work through a more robust response.

The Trust has used a number of contingency beds since January, peaking at 412 in February 2017 with a baseline of 364 beds. The graph below shows how the measures that we have taken have reduced the number of contingency beds used and also the variation. We are able to utilise all contingency areas this winter if required, however, the plan is to utilize the discharge to assess and Hospital at Home capacity as an alternative to reduce bed occupancy pressures.



A series of strategies will be employed in the lead up to and over winter as systems are refined. Length of Stay meetings will be increased from once a week to twice a week and will focus on every patient stay over 5 days. The Ready to Transfer calls will continue to be held thrice weekly.

There are limiting factors to flow in A&E related to its size. Changes have been made this year to increase the cubicles and implement a CDU. However, the capacity falls short at peak periods in both minors and majors. There is limited opportunity for further expansion without major works.

Medical workforce out of hours has been a recent challenge which the organisation is addressing through an increase in medical staff and changes to shift patterns. The trust is also working with the CCG and partners to address the impact of the new out of hour's contract on A&E attendances which is going to be a critical success factor for winter.

Reconfiguration of beds:
The bed pool is being re-configured to accommodate more AAU and short stay beds. It will also enable a frailty pathway to be strengthened. The bed configuration is underpinned by a bed model using demand and capacity information. Bed modelling shows a shortfall across the system and achievement of flow over winter is dependent on increasing capacity outside of the acute unit to discharge to assess; Home First and bed based care.

Ambulatory Emergency Care:
A five day Ambulatory Emergency Care (AEC) model is in place and is located above A&E. Patients are directly referred to AEC via A&E or via the patient's own GP for same day assessment. When the referral comes via the GP, this bypasses the need for the patient to present at A&E. When the Ambulatory Emergency Care Unit is closed, the patient will instead be directed to the Clinical Decision Unit. Through the contracting and monitoring process the CCG will ensure that there is an increase of GP referrals into AEC unit rather than A&E.

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
GP Referral Activity to AEC	56	56	56	56	56	56
Non-Elective Spells activity reduction	20	20	20	20	20	20

Elective Care
Ring fenced elective beds with dedicated co located SAU to manage elective/emergency activity, supported by the following operational process:

- Focus on consistency of the daily board round process in determining and arranging timely post-acute pathways. Leadership, regular scrutiny and constructive challenge to facilitate discharge and reduce length of stay;
- Collect more data in key areas as a one-off. In order to test assumptions - for example, opportunities for diversion to avoid admission - through further data collection and interrogation;
- Discharge planners assigned to mitigate multiple staff 'progress chasing' and to alleviate pressures on ward staff;
- Reduce Delayed Transfers of Care & Complex Discharges (creation of an Integrated Discharge Team)
- Initiatives to reduce patient ward Length of Stay & Early Supported Discharge

Flu Vaccinations
Plans are in place to vaccinate front line staff. Last year's campaign was very successful and the Trust expects to achieve similar levels of vaccination.

Bank Holiday Planning
Bank holiday planning is undertaken for at least six weeks prior to a bank holiday to ensure that staffing plans, access to ward rounds and diagnostics is in place. Breaking the Cycle or reset events are undertaken prior to a bank holiday to maximize bed availability.

Luton and Dunstable University Hospital

The Luton and Dunstable (L&D) has consistently maintained good performance against national targets with well-established processes in place which are constantly reviewed and refined as necessary. The Trust will continue to focus on early identification of patients going through A&E requiring assessment by specialties and will engage with specialty teams early in the patient's pathway. The Trust has invested in additional senior nurse resource to support A&E flow in the late evening when peaks of activity occur.

The Trust is fully engaged with the SAFER - Senior Review. All wards have consultant led board /ward rounds before midday which are able to make management and discharge decisions. Midday discharges have increased due to the recent introduction of a surgical discharge lounge. All patients will have an Expected Discharge Date (EDD) assuming no unnecessary waiting.

Flow of patients from assessment units to inpatient wards happens throughout the 24hr period. The Trust is working with the wards to encourage early appropriate discharges. A systematic multi-disciplinary team (MDT) is in place to review patients with extended lengths of stay (>7 days). Red2Green has been implemented on a number of wards with a rollout programme for all remaining wards by October 2017.

The Trust has a daily SITREP meeting chaired by the CEO that looks at the number of delayed patients and actions are taken to escalate any barriers to discharge. Good working relationships are in place with key partners such as Cambridge Community Services, Essex Partnership University Trust and the local CCGs to unblock any barriers identified.

Work is underway for pre assessment for elective patients, two members of staff from the Integrated Discharge Team (IDT) are leading on this alongside trust specialist nurses, and robust board rounds with attendance from all disciplines is enabling Social Workers to discharge patients effectively. The IDT is now focusing more on health delays as Adult Social Care delays are currently managed. Systems are in place to monitor and manage patient flow out of the Trust across a seven day service. More than 80% of checklists are carried out outside of hospital. Central Beds- Workshops are being undertaken to develop and support the discharge process for Central Beds patients out of the acute Trust. An agreement with BCCG for checklists to happen outside of hospital is in place. .

Integrated Working

High Impact Change Model and Primary Care Home Model
Bedfordshire CCG proposes to follow the principles set out in High Impact Model for Managing Transfers of Care between the Home and the Hospital and through the development of the Primary Care Home Model with particular focus on frail and elderly patients and young children. A combined model will commence deployment across Bedfordshire CCG from 1st October and will continue to be implemented over the next 3-6 months as service specifications develop and recruitment to posts are achieved.

The development of the Primary Care Home model, redesigned community beds, and the enhanced intermediate care team, will improve patient flow and support discharge to assess for patients along with managing more care outside of hospital. To ensure the health and social care economy can effectively support the population in the future, partners in Bedfordshire are working together to transform the way services are delivered through a new model of care that pulls together existing and new services.

The programme will develop the process, systems, models and people to support a reduction in unnecessary non-elective attendances and admissions. It will also reduce delayed transfers of care, length of stay and excess beds days by improving proactive case management for patients with more complex needs and rapid response interventions to prevent hospitalisation and support care closer to home. The aim of the programme is to align multidisciplinary teams (MDT) across the eight geographical clusters in Bedfordshire to deliver more joined-up, personalised care planning and management.

Community Geriatrician
Plans are in place to develop a Community Geriatrician service with Bedford Hospital Trust to work with Primary Care and Care Homes in the care and management of the frail and elderly. Development of the Community Geriatrician specification and job description has been approved by the Royal College of Physicians. Bedford Hospital are looking to release Geriatrician resource to initially support community Multi-Disciplinary Teams (MDT's) in two localities by November 2017. The CCG and BHT will look to expand this over all eight clusters by January 2018.

The Community Geriatrician will provide GPs with advice and guidance, work as part of MDTs across geographic Clusters, Care Homes and the Acute Trust, running Hot Clinics, undertaking Comprehensive Geriatric Assessments, supporting Risk Stratification and Case Reviews along with providing high level clinical support to community and pharmacy teams to avoid unnecessary admissions. This will support patients to remain in their home.

Additional Home Care Packages
Bedfordshire is working towards a commencement date of 1st October as part of the Primary Care Home model programme:

- Bedford Hospital Trust have discharge planners in place and new DPs recruited and undergoing training, ready to commence service from 1st October.
- Discussions to produce additional beds for patients requiring additional assessment underway.
- Discussions with Bedford Borough Council and Central Bedfordshire Council to increase capacity for packages of care in the community and beds for reablement.

Placement without Prejudice
The Bedfordshire CCG Continuing Health Care Dispute Policy refers to a funding without prejudice agreement with both Bedford Borough Council and Central Bedfordshire Council, which both local authorities are signed up to.

In cases of dispute, to ensure that care provision is commissioned rather than waits until a dispute is finalised, either the CCG or the LA agree to fund the care. Once a dispute is resolved, if either the local authority or the CCG has been funding inappropriately, the CCG and local authority agree to reimburse these fees.

When considering individuals who require urgent provision from the acute who clearly have a health need and would not be appropriate to be discharged via the new commissioned routes of home first or commissioned bed they should be considered by the CHC department to fund directly. Once the person has been within their provision for up to 28 days a checklist and DST should be completed. These would be people with significant challenging behaviour who would not be appropriate to have a number of commissioned provisions/ventilated individuals etc.

Trusted Assessor
Development and implementation as part of the Out of Hospital/Primary Care Home programme:

- Agreement has been reached with partner organisations to cease CHC checklists for 85% of acute in-patients. These checklists are to be completed out of hospital as part of discharge planning.
- Bedfordshire is using the Trusted Assessor Guide to design and implement a single trusted assessor model across Bedfordshire CCG with partner organisations, including care/residential homes.

Discharge to Assess activity savings (Children 0-4 and Over 65's)
Activity savings identified and monitored through the Managing Transfers of Care between Hospital and Supporting Care Outside of Hospital QIPP work streams are as follows:

Activity Savings (Children 0-4 and Over 65's)	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Non-elective Admissions	138	138	138	138	138	138
A&E Attendances	159	159	159	159	159	159
Short Stay Tariff Reductions	72	72	72	72	72	72
Excess Bed Days	120	120	120	120	120	120
GP Referral - Outpatient/Follow Up	168	168	168	168	168	168

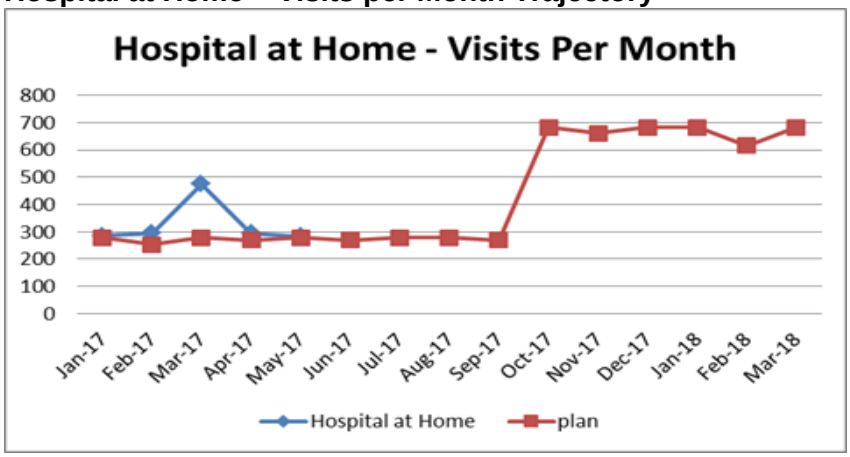
Hospital at Home and Clinical Navigation:
Winter funding of £1.3m was given to Bedford Hospital in 15/16 and 16/17. This reduced to £850k in 17/18 and was built into the baseline to support delivery of the 4 hour target. This funding supports the Hospital at Home Team and Clinical Navigation team as well as a contribution to weekend Pharmacy services to enable weekend discharges. Hospital at Home enables patients to be managed at home whilst remaining under the care of a Hospital Consultant. Patients are in three cohorts;

- those who we can prevent admission,
- those who have a short length of stay so are within the short stay tariff and
- those who are would have had long lengths of stay.

This scheme proved very successful and has been extended for this winter.

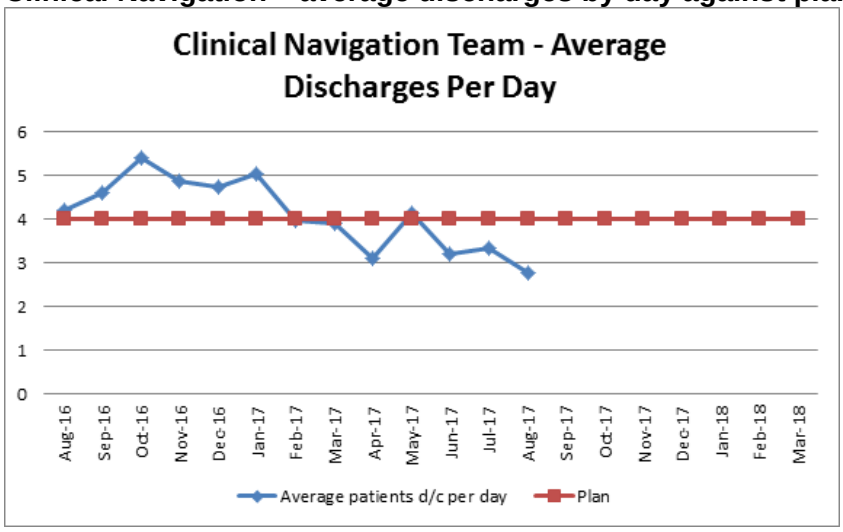
The team has been expanded to enable more patients to be managed by acute nurses under the care of a Hospital Consultant rather than remain in hospital, in their own home or place of residence, rather than remain in hospital. The additional resource will be in post by the end of September and will have their own caseloads by 2nd October. This will enable the service to be extended to 22:00hrs and increasing the number of patients that can be managed at home and increase the number of visits to patients in a day from 8 to 24.

Hospital at Home – Visits per Month Trajectory

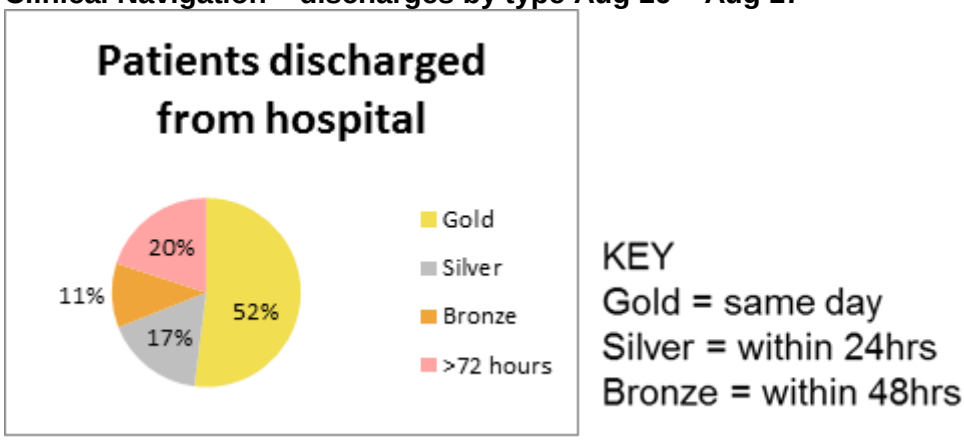


Clinical Navigation is a small team of nurses and therapists who identify patients in A&E and enable discharge rather than admission where possible. They also track frailty patients to enable discharge within 48 hours where possible.

Clinical Navigation – average discharges by day against plan Aug 16 – Mar 18



Clinical Navigation – discharges by type Aug 16 – Aug 17



Primary Care

Providing services to support patients before they become unwell or present as an emergency. This involves prevention services, primary care and anticipatory care planning:

- Ongoing shift of care to Community and Primary Care Settings to take pressure of local DGH department's e.g. Anticoagulation and Phlebotomy
- Supporting prevention with a particular focus on 'at risk' groups for influenza vaccine and where appropriate pneumococcal
- Monitoring activity to reduce surges in activity from primary to secondary care takes place monthly through scrutiny of activity dashboards, emails to practices to raise concerns of outliers and detailed coverage at Locality Boards
- Ensuring that the Primary care commissioning team working with secondary care and localities has a robust and well-rehearsed escalation plan in place including measures to support primary care and community services.
- Localities and their primary care teams are working to increase the times that patients can directly access primary care. Detailed conversations are taking place at Locality Boards during September around Implementing Extended Access, facilitated by the CCG.
- Primary Care will utilise the Elective Frailty Index and share information with the Community Geriatrician to support patient care and management

In addition, specific locality transformation plans aimed at reducing unplanned admissions such as:

- Increasing clinical input into care homes as part of anticipatory planning. The Ivel Valley care home visiting project is being developed to be delivered by Bedoc on the 'Complex Care Team' approach that currently exists in Bedford. The approach involves Ivel Valley GPs commissioning Bedford to provide a care home visiting service based on the Complex Care Team going into care homes and managing patients coming out of hospital, checking their medications. The project will have a full time nurse, a half time pharmacist and a dedicated administrator. It is hoped that, in the second year, the team will be extended to see patients with a long term condition at home too. Up to 20% of A&E admissions to hospital are currently from care homes so it is hoped that this approach, with a triage 'first point of contact' each morning between care homes and the CCT will impact on this. The pilot intervention is funded by BCCG Practice Transformation Funding and the improved Better Care Fund.
- Pilot project to employ an Advanced Nurse Practitioner (ANP) for early morning home visiting. This pilot is well advanced in West Mid Beds Locality with an ANP being recruited and starting October 2017.
- Primary care triaging during peak periods

An independent supplier, National Services for Health Improvement Ltd. (NHSI Ltd) have been commissioned to provide mentorship and training to all nurses and to work with GP practices in the management of asthma in patients, along with developing personalised asthma action plans (PAAP).

The Respiratory Service Improvement Group is supporting the development of a system to provide weekly data by practice re: respiratory conditions of all ages and to review all patients (adult and children) with Asthma and adults with COPD, which will inform health systems of activity surge. This will enable the health system to prepare for an increase in activity. Work is underway with the SystmOne Bureau to implement this reporting.

A winter planning task group has been established, consisting of Primary Care locality team colleagues and the CCG, to support the operational aspects of delivering the winter plan in locality settings and to ensure that Primary Care colleagues will be fully informed about winter plan requirements.

Essex Partnership University Trust (EPUT)

Community Bed Flow Manager

To ensure that patient flow into and out of community beds is optimised and discharges are not unnecessarily being delayed, the role of a community flow manager has been established. EPUT recruited a senior person into this role with the focus to manage the current and future commissioned bed capacity as a virtual ward working closely with care providers, therapy staff and social care services. This role is crucial especially during the winter period when pressure on the system increases and responsive actions to the demands are needed.

Medically optimised patients who require further care support which cannot be provided at home, will be referred by the Discharge Planners through the Single Point of Access (SPoA) to the Integrated Discharge Team which is supported by the Community Flow Manager who will focus on service and staffing capacity and patient flow.

Community Beds
Nationally and locally acute trusts are under unprecedented pressure which will only increase throughout winter. Locally, community beds provision has been redesigned taking this pressure into consideration and will provide a suitable community bed base which will meet identified gaps in the pathway, along with the 'step down' care provision from the hospital. The current bed base of 43 will be increased to 57 for patients with non-neurological conditions. The increased bed base will allow for discharge to assess (checklists) to take place in a community bed by November 2017. This will support the Managing Transfers of Care between Hospital and Supporting Care Outside of Hospital QIPP work streams.

Another element of the community beds redesign is that the Archer Unit will be the main rehabilitation centre for patients with neuro rehab needs. This will allow for patients to receive rehabilitation in a dedicated rehab unit with neuro rehab skills and reduce the level of rehabilitation in an acute setting.

Staffing
EPUT has increased Rapid Intervention Team capacity to support Local Authority care packages.

In order to ensure detailed oversight of capacity and staffing the Trusts has twice daily service capacity reporting (including LA delays) across all therapy and nursing services. There are also daily staffing capacity reviews across the Trust and when required capacity is shared across the services to ensure full service is provided at all times.

Individual service resilience plans have been updated and in place with internal trigger points and escalation systems in place.

Discharge planning
There is staffing cover 7 days per week at Bedford Hospital in place and working in a more integrated manner as part of a wider integrated team. There is an escalation (capacity) process in place to inform managers of lack of community capacity with a position statement being sent daily to senior team identifying potential discharges

Inpatient Beds
The Trust has a discharge planner on the Archer unit who is responsible for

- Maintaining a comprehensive patient database which assists in the identification of any discharge blocks
- Co-ordinates patient discharges to ensure a smooth process
- Escalating issues to Matron/Local Authorities/Senior managers as required
- Organising discharge meetings between patients, relative and staff
- Attending weekly ward consultant led MDT's

Where the system is under pressure and if there is capacity in community teams and it is clinically appropriate therapy input is increased for patients to facilitate a more rapid discharge.

Staffing/Operational Teams
EPUT conducts daily capacity telephone calls in place (all team leaders, unit matron and 8a managers) to understand service gaps and service capacity to ensure that staff are moved to support pressure areas/improve staffing in areas with lower capacity

OPEL3 or 4 reported by any local stakeholders will result in;

- Review of all caseloads (R&E/DN/inpatient beds for discharge if appropriate
- RAG rate applied to caseloads to free up capacity
- Medical and therapy review of inpatient caseload for potential early discharges

East London Foundation Trust (ELFT)

ELFT have extended their Psychiatric Liaison Service at Bedford Hospital from the 4th Sept 2017. The extended service is now operating 09:00am to midnight seven days a week covering all wards from the acute hospital for those patients 18yrs and over.

Planned reduction in Activity (via A&E) where Mental Health is the primary and/or secondary diagnosis:

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Inpatient admissions	13	13	13	13	13	13	13	91

There is further work to expand the provision of Mental Health Primary Care Liaison. The commencement of this service is yet to be announced. This will see a specific team supporting GP Practices across Bedfordshire.

The Bedfordshire and Luton services operate throughout the winter months to the trusts severe weather plan. This policy includes a detailed account of the communication plan how the trust will communicate externally and internally at periods of above high capacity during the winter months.

Business continuity plans are in place and presently being updated to integrate the OPEL trigger points / escalation process across the services. The update will include the systems in place to identify by team our vulnerable people. The Trust duty system is comprehensive and robust. On call information is available to support staff in the event of any major capacity issue.

A preventive programme of vaccination against seasonal flu uptake for key Clinical and operational staff.

East of England Ambulance Service Trust (EEAST)

EEAST are taking consideration of multiple factors, such as demand, capacity, system pressures, issues and risks and will build in contingency and mitigation in so far as they reasonably can. EEAST also recognise that they have an existing substantial capacity gap and no confirmation of any additional financial support for winter.

One of the most significant factors that needs to be considered relates to the combined implementation of the NHS England led Ambulance Response Programme ahead of winter and the lost capacity at Emergency Department related to handover queuing and the subsequent lost ambulance capacity that this leads to. The ARPs model will see a significant reduction in the use of solo responders and an increase in the number of ambulances. This is excellent news for patients in getting a better and more appropriate response but only if those ambulances are free to respond. EEAST is presently modelling the implementation of this revised ARP. Feedback to follow with outcome of modelling.

EEAST will need assurance from the A&E Delivery Board that provider plans limit handover delays and do not have a default for patients to call 999 due to the lack of provision elsewhere. EEAST will also be seeking assurance that the significant variation in 111 to 999 conversion rates across the region are considered and in particular, the loss of clinical triage capability we saw last Christmas in 111 is mitigated against ahead of time.

No additional resource has been allocated by or to EEAST relating to Winter Planning. However, there is additional emphasis on Hear & Treat, See & Treat as well as paramedic wound closure which should further reduce unnecessary A&E conveyances.

The Hospital Ambulance Liaison Officer was commissioned by BCCG as an additional service in place at Bedford Hospital last winter in order to support the Trusts achievement of the national requirement to reduce ambulance handover times to the same level as 2014/15. This service ceased 1st May 2017 and there is concern that with the increase in demand at A&E of high acuity patients, there is a potential for delays in the handover of care from EEAST to BHT. This could result in significant delays in the overall system and therefore alternative processes are currently being explored by Bedford Hospitals A&E Delivery Board

The CCG's contract with EEAST is a block contract for 2017/18 therefore payment is not made against activity. In line with the National CQUIN to reduce A&E attendance through increasing the numbers of patients treated through the Trusts Clinical Support Desk (Hear and Treat), the CCG is expecting A&E ambulance activity to reduce. The CCG is also expecting the national push through the ARP to increase the numbers of patients being treated at scene by paramedic crews rather than being conveyed to hospital (See and Treat) to have a local impact. The total modelled activity impact for Hear and Treat and See and Treat at Bedford Hospital for the winter period is as follows

Activity Reduction	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
H&T and S&T	205	205	205	274	274	274

Christmas & New Year and Easter Workforce Arrangements

All Bedfordshire system providers has on-call arrangements in place. For the Christmas and New Year holidays each organisation will ensure appropriate cover is in place and copies of these arrangements will be provided to the A&E Delivery Board for assurance.

System Resilience and Escalation Plans

Operational Pressures Escalation Levels (OPEL) Framework

The Bedfordshire Health and Social Care system has an OPEL framework in place which is based on the NHS England Central Midlands & East Escalation Framework (Sept 2016) and align with the NHSE Operational Pressures Escalation Levels (OPEL) Framework (Oct 2016).

To support the framework Bedfordshire has an OPEL Plan in place which sets out the procedures across the Bedfordshire system to manage variations in demand across the health and social care system. (Appendix 3)

This plan provides a coordinated approach to the management of pressures across the whole Health and Social Care system, where local escalation triggers have already been applied and yet the pressure on capacity and the need to mitigate against the possibility of compromising patient care require additional support from other service providers.

This Plan is designed for managers and clinicians involved in managing capacity and patient flow at times of excess demand.

Senior Managers On-call (SMOC)

Under the civil contingency act 2004 all providers are required to ensure they have in place robust on call arrangements. CCG on call is a shared resource between Luton and Bedfordshire CCG, the on call answering service is commissioned through Medicom.

Winter communications tests will be scheduled from the 1st November to assure on call processes are in place and robust.

As part of the OPEL framework for the Bedfordshire Health and Social Care system escalation arrangements have been clearly defined.

The CCG continually monitors system wide capacity challenges and performance across the Bedfordshire Health and Social Care system; therefore the Capacity management plan which compliments the OPEL framework, requires no formal activation. The plan has been approved at executive level and performance managers have the autonomy to provide strategic direction in managing and progressing performance and capacity issues, in addition to providing an escalation route.

NHS England Midlands & East SITREP reporting

During the winter, Health and Social Care systems are expected to report by exception on a daily basis to NHSE should the system reach OPEL 2, 3 or 4. Contact with NHSE will be initiated and maintained by the CCG Regional teams in NHSE and NHSI will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system.

Cold & Severe Weather Alerts

Adverse weather forecasts are available from the Met office via the National Severe Weather Warning Service and the Environment Agency provide Flood Alerts. It is the responsibility of the Emergency Preparedness Resilience and Response (EPRR) leads in each organisation to ensure that these alerts / warnings are made available to appropriate personnel within their organisation and that appropriate plans are initiated.

Business Continuity Plans

All NHS organisations are required to have robust business continuity plans in place in order to maintain their services to the public and patients and as part of their contractual arrangements as a provider of NHS funded care. Each plan provides details for business continuity incidents, critical incidents and major incidents along with Major Incident Response and responses to severe weather.

Major Incident Response

From an NHS perspective, it is any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations.

In a wider context as demonstrated by recent events on both London and Manchester , a severe event or situation, with a range of significant impacts, which requires special arrangements to be implemented by one or more emergency responder organization, would necessitate a multi-agency major incident response.

Partners will at this point work collaboratively to support and help resolve the major incident, in a supportive and inclusive approach.

Winter Plan Documentation Appendices

Appendix 1: Winter Communication Plan

Winter Communications Pla

Appendix 2: Seasonal Flu Joint Communication Plan

2017-18 Joint Seasonal Flu Comm

Appendix 3: Bedfordshire CCG

Bedfordshire and Luton System Escala

Bedfordshire and Luton Operational F

Appendix: EEAST

EEAST Winter Plan.docx

Appendix: ELFT

ELFT Severe Weather Plan v1.3.d

References:

Next Steps on the NHS Five Year Forward View – March 2017

Urgent and Emergency Care Delivery Plan – April 2017

17-18 Winter Planning Letter – Pauline Philips (National Urgent & Emergency Care Director) – July 2017

National priorities for acute hospitals 2017 / Good practice guide: Focus on improving patient flow – July 2017

Bedfordshire Urgent & Emergency Care Strategy – July 2017

Keogh Review's Safer, Faster, Better (2015)

Bedfordshire & Luton Operational Pressure Escalation Level Framework – December 2016

What's going on in A&E? The key questions answered – Kings Fund – March 2017

The Cold Weather Plan for England Protecting health and reducing harm from cold weather – NHS England / Public Health England - October 2015