Health Scrutiny Committee

14 October 2015

Planning for winter pressures in 2015/16

Introduction

Both West Suffolk Clinical Commissioning Group and Ipswich and East Suffolk Clinical Commissioning Group have led on planning for winter this year.

In this joint paper, the two CCGs set out what has been learned in each of the systems during evaluation of 2014/15 schemes and what has informed 2015/16 schemes. Part One refers to the West Suffolk system and Part Two to the Ipswich and East Suffolk System.

Parts Three and Four relate to voluntary sector involvement and partnership working respectively.

Part One

1.0 West Suffolk System Forum Winter Review 2014/15

The Forum commissioned this review after a difficult winter in 2014 and it concluded that the West Suffolk Health and Care system had been challenged by the complexity of care need rather than a specific standalone singular cause. A significant proportion of the admissions were underpinned by frailty with respiratory, urinary tract infections and falls being a trigger.

The review made a number of recommendations which included:

a) Preparations for the flu campaign this year may benefit from a particular focus to raise confidence levels following last winter's low efficacy of the vaccine.

b) The local system may wish to consider how surveillance of respiratory illness and other infections circulating in the population undertaken by Public Health England at both a local and national level could be factored into monitoring as part of an early warning system.

c) The reduced referral activity to the Chronic Obstructive Pulmonary Disorder (COPD) and Pulmonary Rehabilitation Services over the winter period needs further examination to understand the underlying reasons.

d) Access to early warning signals, real time information from all sections of the health and care system and early escalation are key in supporting the system in preparing and managing demand safely and effectively.

e) Ensuring full sign up to a system-wide escalation plan where all parties recognise the early warning triggers.

f) Real time system monitoring using an urgent care dashboard developed by the CCG escalation managers. The system may need to consider how primary care can be part of this and how pressure in practices is escalated and supported by the system.

g) An urgent review of capacity in West Suffolk is needed. The variation in delays and declines in referrals across East and West Suffolk may need to be

considered as part of this review to better understand the distribution of resources.

The above recommendations form part of the local system action plan and have informed the allocation of resilience funding in 2015.

The reports led to the West Suffolk System Forum agreeing a number of priority areas which have informed the Winter Plan 2015/16:

West Suffolk Forum projects for 2015/16

1.1 COPD service

The winter 2014/15 review highlighted that the COPD and pulmonary rehabilitation service experienced a decrease in referrals which did not reflect the increased levels of respiratory illness in the population or the rise in COPD emergency admissions. The COPD service, as did many of the community services, experienced an increase in the number of interventions per patient indicating that acuity may have been driving most of their activity. The CCG has worked with the service provider to undertake a deeper analysis of the service model and has since made a number of pathway changes which will produce an improved proactive response to case management and a reactive response as part of an integrated admission prevention service. Work is in progress and the revised operational pathway is planned to be launched in late September 2015.

1.2 Pneumonia

The level of demand last winter was unprecedented across the system. The SRG agreed that the efficacy of the flu vaccination was most likely to be an underlying cause and agreed that the local plan for 2015/16 would require additional focus to ensure confidence does not affect uptake this winter. It was felt the management of frailty was also key in managing respiratory related emergency admissions and this is a major focus of this year's plan.

1.3 Frailty

The number of frail elderly emergency admissions had risen exponentially over winter 2014 with respiratory and other infections such as Urinary Tract Infections presenting as the tipping point and the primary diagnosis for admission but with underpinning multiple co-morbidities. The priority areas of action have included:

- Identifying the very highly complex frequent service users – through case note review of frequent service users we have identified the top 100 cases which are now being proactively case managed in the community. For the frail cohort of service users the Interface Geriatrician takes a lead role in supporting the community case manager and patients' GP to develop a shared care plan and supports the multi disciplinary team review. The system has developed a pull-based discharge pathway for individuals whose plan at home has failed and they have subsequently been admitted into hospital.
- Frailty assessment – as part of CQUIN (Commissioning for Quality and Innovation) we have co-developed a frailty pathway for all over 75 year olds who are admitted as an emergency

Evidence Set 2

1.4 Care Homes

The work with care homes has expanded in 2015/16 following a successful launch in 2014 and is a key part of the system plan. Supported by the Interface Geriatrician, End of Life Consultant at WSFT, sessional pharmacists and the GPs, the Care Home Clinical Team work closely with care home staff, residents and families to undertake clinical reviews and develop shared care plans. This year we expect to completely roll out the approach to all 47 of the care homes in West Suffolk and evaluate the impact of the Recognizing the Deteriorating Patient toolkit. The impact of this care home approach is already demonstrating a 50% reduction in care home emergency admissions from those care homes already worked with.

1.5 Integrated Admission Prevention: The Early Intervention Team

The successful implementation of the Early Intervention Team at WSFT in 2014/15 on reducing emergency admissions has informed the decision by the West Suffolk System Forum to utilize most of the Operational Resilience Funding to extend the model of working out into the community as part of an integrated community facing enhanced admission prevention service. The new Team will operate under a single management structure but includes services from the acute trust, community services, social care, Age UK Suffolk and mental health services. The full model is expected to be launched on 12th October.

The existing community admission prevention service is being re-engineered in a number of ways including: pathway changes to separate planned and unplanned demand, increased training for core teams, changed alignment of core/aps team interfaces, reduction in existing pathway duplication/delays and workforce/skills re-profiling. This work is supported by new operational policies and procedures. The impact of the work will improve urgent response capacity, benefit recruitment and retention and ensure core community functions are not compromised.

The team will also have direct access to a number of existing community beds which will be designated for admission avoidance purposes. This will enhance the integrated model described above and will be a critical part of its success. The team will 'pull' together the interface geriatricians, and other services/organizations to develop and agree the management plan for patients so that they receive a safe and viable alternative to acute admission.

1.6 Additional step down and step up community beds

The operational resilience funding has supported the commissioning of up to 7 additional community beds which will be used for step up purposes accessed via the Early Intervention Team and step down reablement or rehabilitation from WSFT. These beds will be operational from 1 October 2015 to 31 March 2016.

1.7 Enhanced Hospital Ambulance Liaison Officer (HALO)

The HALO role played an important part at WSFT last winter in supporting delivery of ambulance handover. The CCG has supported use of the resilience funding again this year to reintroduce this role at WSFT and we are enhancing the role to work alongside the Early Intervention Team in supporting crews to refer to the community team. Utilisation by the East of England Ambulance Service Trust of community alternatives to conveyance has been inconsistent

and it is planned that this critical role will provide education and challenge to crews where a conveyance could have been avoided. The role will promote the admission prevention response and provide feedback to crews on referral activity.

2.0 Funding

West Suffolk Clinical Commissioning Group has been allocated £1,457,000 to fund winter schemes.

Part Two

3.0 Ipswich and East Suffolk System Review 2014/15

Public Health, commissioned by the System Urgent Care Group (SUCG), conducted a review of winter 2014/15 looking at system levels and patterns of activity. Key messages from that review included:

3.1 *Trends in health service needs*

- National and local surveillance data covering primary and emergency care clearly showed **increased levels of respiratory illness** circulating in the population this winter compared to the previous year. This would have contributed towards the pressures on the local system.
- **Flu vaccine uptake** for key population groups in 2014/15 was **higher or similar** to that in 2013/14. However the change in flu strain and subsequent **low efficacy of the vaccine** may have been a contributory factor for increased levels of flu.
- The increase in deaths (especially among over 75s) may also reflect a cohort of older, more acutely ill patients.

3.2 *Trends in people contacting health services*

- **13% increase in 111 calls** demonstrated increased demand within the health care system. An even greater increase at 25% in activity was observed in the two week period between Christmas and the New Year.
- Most of the **increase in ambulance activity was for patients 'seen and treated'** indicating the need of patients in 2014/15 may have been less acute compared to previous years. It might also suggest that admission prevention services were more effective at providing support within the community, hence reducing the need for conveyance to hospital.
- The **relatively small increase in A&E attendances at 1%** is unlikely to have caused the unprecedented pressure. However, variation during this period may have contributed to this e.g. a 5% increase in attendances in the weeks between Christmas and the New Year.
- **Increase in A&E 'minors' (10%) and decrease in 'majors' (down 3%)** suggests the needs of patients may have been less acute. However the large increase in patients over the age of 65 year (up 3% and over 75s up 10%) indicates the presence of a cohort of patients with potentially more complex acute needs.
- The increase in **emergency admissions** may have placed an additional pressure on the system. However, during the period **between Christmas**

and the New Year there was only a 1% increase admissions compared to the previous year

- 438 more (5% more) emergency admissions in Sept-Dec 2014 compared Sept-Dec 2013:
  - The largest increase in admissions was among 65 to 74 year olds (increase of 15% or 180 admissions) and over 75s (8% increase or 280 admissions)
  - The length of stay reduced from 5.0 to 4.7 days
  - During the two weeks between Christmas and New Year the number of emergency admissions increased by 1% or 16 admissions
- Increase in referrals to community health services, Home First, new home care packages
- Effect of readmissions on pressures was limited
- Delayed Transfers of Care (DToC):
  - At Ipswich Hospital the number of DToCs (based on number of DToC on the last Thursday of each month) increased by 96% (from 53 in the period between Sept 2013-Jan 2014 to 104 in the Sept 2014-Jan 2015).
  - The NHS was responsible for 55% of DToCs (Social Care 45%) in 2013 similar (54%) in 2014.

3.3 *Overall findings*

- Experienced increased demand for urgent and emergency care which could have put additional pressure on the system however the magnitude of the increase differed by service and time period.
- The increase in activity was attributable to patients at both ends of the spectrum of need - from patients with less acute problems (e.g. minors in A&E) to frail elderly patients with potentially complex need.

4 2014/15 Winter Schemes Summary

4.1 Post-Acute Care Enablement (PACE)

This service was led by Suffolk Community Healthcare, in partnership with Adult Community Services, Age UK Suffolk and Suffolk Family Carers with support from Ipswich Hospital NHS Trust. PACE identified patients in IHT suitable for early supported discharge. The PACE team then provided an assessment, care planning and up to 5 days support within the patient's home. The service was delivered by nurses, therapists and carers; based with the Waveney Unit alongside the community winter beds at Ipswich Hospital.

In total, the PACE scheme cost £560,762 (which included the extension of the PACE scheme for an additional month in April upon request of NHS England to support pressures during the 2015 Easter period) and achieved a total of 289 patients discharged with an average bed saving of 2.3 days per patient.

The learning from the PACE scheme evaluation has supported development of the Crisis Action Team (CAT) pilot for 2015/16 (see below for further details).

4.2 Winter Nursing and Therapy Beds

The 24 winter nursing and therapy led beds on the Waveney Unit. This scheme was led by Ipswich Hospital NHS Trust in partnership with Suffolk Community Healthcare. The criteria for using these additional beds was based on the successful community beds model used during 2013/14 winter where patients had an average length of stay of 9 days. The community winter bed scheme worked with the PACE scheme.

In total, the 24 winter nursing and therapy beds cost £662,119 (which included the extension of the bed scheme for an additional month whereby Woodbridge Ward was used in April 2015 upon request of NHS England to support pressures during the 2015 Easter period). This figure does not include the four spot purchased beds at Monmouth Court at a cost of £37,136 that were also used for winter to step down patients primarily for reablement or Delayed Transfers of Care (DToC).

Bed use was 94.8% and the average length of stay was 7.2 days. However, the average percentage of emergency readmissions following discharge from the Waveney Ward was 19.42%.

During the winter months 650 patients were discharged from either the Waveney ward (1st November to 18th March) and Woodbridge ward (19th March to 30th April).

The agreed approach for commissioning up to 24 community reablement beds for 2015/16 will focus on supporting keeping patients safe and out of an acute hospital where possible, maintaining their own independence through a step up, step across and step down model of care.

4.3 GP Streaming Service

The service was led by Care UK. A nurse was based in the Emergency Department at Ipswich Hospital (IHT) and identified patients suitable to be managed by Primary Care Out of Hours (OOH). These patients were referred to a designated GP in OOH service based in the Rheumatology Clinic on site. The service was active at weekends between the hours of 10am to 11pm with minimum capacity to see 26 patients (2 per hour) per day, a total of 52 patients per weekend. Patients were identified by a Care UK streaming nurse prior to being recorded onto IHTs system and therefore no tariff or charge was incurred for these patients.

In total, the GP Streaming Service cost was £62,962 whereby 859 patients were streamed from November to end of March. The target for this period of time was 1,114 patients based on 26 patients per shift, this was a shortfall of 255 patients. During the five months 52 hours of Nurse Streaming shifts were not covered.

The Prime Minister's Challenge commenced on 7 September which will provide additional primary care planned and urgent care capacity for patients in the Ipswich area.

4.4 Integrated Community Respiratory Service

An integrated community respiratory service led by the Suffolk GP Federation in partnership with Suffolk Community Healthcare (SCH) which provided

proactive management of patients with Chronic Obstructive Pulmonary Disease (COPD). GPs and community healthcare teams identified patients who are not managed well and improved management of their condition. The service included a development and enhancement of the successful COPD scheme run in 2013/14. It included case finding, identification of patients and partnerships with the pulmonary rehab team at SCH which provided education and preventative interventions for the newly diagnosed.

In total, the Integrated Community Respiratory Service cost was £99,995. During November to February, 492 spirometry tests were performed with 125 new patients being diagnosed with COPD. The number of newly diagnosed patients offered pulmonary rehab was 27 with 11 of these patients referred to a pulmonary rehabilitation service. 2,216 patients with COPD were sent a standby prescription. In total 2,596 patients were identified from the searches.

Further developments to support respiratory patients are being taken forward collaboratively with all providers all year round through a Respiratory Clinical Transformation Group.

4.5 Moving and Handling Scheme

The scheme provided Moving and Handling Tuition for family carers including a falls prevention focus with notification to GP practices regarding identification of potential fallers. Family carers had tuition around how to safely move the person they look after, ensuring they do not put themselves or their loved one at risk of injury. The scheme was led by Suffolk Family Carers which were also able to identify potential fallers and signpost them to services that could offer further support. The Moving and Handling Tuition included teaching a family carer how to get someone safely up from the floor. This was designed to reduce the need to call for the emergency services. The scheme also sought to help patients become more independent.

In total, the moving and handling scheme cost £5,150. During the scheme 45 referrals were made in total to the Moving and Handling service and 34 carers were trained. 87% (30 out of 34) of visits (which incorporate the training) were completed within 20 days. There were 4 likely fallers identified during the 5 months.

This scheme has been funded all year round and will support the 2015/16 winter plans.

4.6 Town Pastors

Town Pastors provided a watchful and caring presence on the streets of Ipswich when the night time economy is at its busiest. They provided appropriate support and assistance to those in need of assistance.

In total, the Town Pastors Ipswich scheme ran for six months and cost £6,000. There were 2,658 interventions during November to April with an estimated 85 Emergency Department attendances avoided, saving about £6,545.

This scheme has been funded all year round and will support the 2015/16 winter plans.

Evidence Set 2

5 Winter Schemes 2015/16

There are a total of eight winter schemes developed for 2015/16 which will complement the existing Admission Prevention Services for Ipswich and East Suffolk. The schemes are detailed below:

5.1 Winter Scheme 1 - Town Pastors

Ipswich Town Pastors scheme is part of the 'proactive' core element within the Health and Independence Model. It is provided by a Voluntary Care Sector (VCS) organisation that takes a proactive approach to help reduce conveyances, A&E attendances and, on some occasions, admissions.

Ipswich Town Pastors are continuing their work from 2014/15 by providing practical support for individuals who are intoxicated and other vulnerable people who otherwise may end up needing NHS care via ambulance, paramedic or A&E services. Their focus continues to be the Ipswich town centre area on Friday and Saturday nights between 10pm to 4am.

5.2 Winter Scheme 2 - Suffolk Family Carers Moving and Handling

Suffolk Family Carers has successfully provided Moving and Handling tuition to family carers in their own home since 2004 and in its current version since October 2011.

The scheme for 2015/16 will provide Moving and Handling tuition for up to 100 family carers, including a falls prevention focus, with notification to GP practices regarding identification of potential fallers they are caring for. Family carers receive tuition around how to safely move the person they look after, ensuring they do not put themselves or their loved ones at risk of injury. The scheme can also identify potential fallers and signpost them to services that could offer further support and to help patients become more independent.

5.3 Winter Scheme 3 - Suffolk Family Carers Respite on Prescription

The Respite on Prescription scheme originated from Ipswich and East Suffolk CCG Voluntary Sector winter project funding in December 2012. Suffolk Family Carers successfully bid for funding to provide respite care for carers who required either a hospital appointment or a planned hospital admission for a condition.

The scheme for 2015/16 continues to provide support to carers to maintain good health and be less likely to suffer an emergency admission by providing a service whereby a GP can prescribe respite to a family carer providing care to a person 18 years and over, to enable them to attend a health appointment.

5.4 Winter Scheme 4 - Community Reablement Beds

In April 2015, IESCCG completed an analysis of community beds utilisation (2015 Community Beds Utilisation Review), both within community hospitals and care homes, to compare with benchmarking activity data from a previous review in 2014. This review was undertaken to inform the system about capacity and potential future community bed needs for Ipswich and East Suffolk. The Integrated Care Network System Forum on 12 May 2015

agreed a number of recommendations from the review which included supporting additional winter capacity for 2015/16.

IESCCG is commissioning up to 24 community reablement beds for the purpose of meeting the increased demands placed on the system specifically during November to March and based on the findings from the previous winter evaluations 2013/14 and 2014/15. The system has confirmed it will be able to support the recruitment and possibly hosting of the roles but not support the funding contribution so the entire funding for community reablement beds for 2015/16 (including staffing costs) will need to be borne by the CCG.

Given the procurement timelines of a wider CCG Care Homes procurement plan, it was agreed that the community reablement beds would be progressed as a six month pilot from October 2015 to March 2016 with the beds going live from 1 November 2015 following a period of mobilisation taking place in October 2015.

Patients placed in the community reablement winter beds will be deemed 'medically fit' with a low level reablement need or awaiting a care package. The activity for the community reablement beds is based as follows:

- 25% of step up patients (step up from primary care to avoid an admission to the hospital)
- 50% of step across patients (step across from A&E or via emergency assessment unit triage, thus avoiding an admission at hospital)
- 25% of step down patients (step down from acute beds)
- This is a guide only and would be flexed depending on need within the system, in particular when IHT is on Black escalation.

Following a mini competition procurement process, the CCG is commissioning 10 beds from the Stowmarket area. Further discussions are progressing with additional care providers for another 8 spot purchased beds in Ipswich and 6 'virtual' beds in Felixstowe.

5.5 **Winter Scheme 5 - Crisis Action Team (CAT)**

The six month pilot will commence on 1 October 2015. The Crisis Action Team (CAT) will provide a 24/7 service to support adults experiencing a crisis situation to remain in their own homes and/or enable rapid discharge from front door services in order to prevent an emergency admission. The service will be via a single point of access (discussions have taken place to use the Care Co-ordination Centre) which will offer a clinician to clinician referral/handover process to enable assurance to be provided to the referrer that a suitable and timely solution will be provided that meets their patient's needs.

The scheme will be a multi-agency service consisting of Adult Community Services (ACS), Ipswich Hospital Trust (IHT), Suffolk Community Healthcare (SCH), Age UK Suffolk, British Red Cross, Suffolk Family Carers and Norfolk Suffolk Foundation Trust (NSFT), with the contract held by IHT and sub-contracted out to other agencies. The scheme is based on learning from the 2014/15 winter Post-Acute Care Enablement (PACE) scheme and from successful admission avoidance schemes elsewhere in the country.

Current Admission Prevention Services, Dementia Intensive Support Team, Flexible Dementia Service and Crisis Response Service will come under the banner of the CAT service and be enhanced to include occupational therapists, physiotherapists, social workers, generic workers and voluntary care sector support workers to provide interagency, interdisciplinary assessment, care and interventions day or night to return the person to independence or to enable a reablement package to be established for them.

A focus on self-care will support the patient and carer to avoid (where possible) future crisis situations from occurring or at a minimum assist them to recognise the signs of deterioration and signpost to the most suitable place to receive the right level of care for their needs. It is proposed that a conservative activity figure of 3.5 admissions will be avoided per day by the scheme (this equates to 616 avoided admissions over the six month period of the pilot).

5.6 **Winter Scheme 6 - Frailty Assessment Base (FAB)**

This new service model has a focus on frail people and their needs with a key component of the scheme being continuity and co-ordination of care for frail patients with complex frailty syndrome. FAB will enable this cohort of patients to have a comprehensive assessment of need. The aim is to avoid lengthy hospital admissions and reduce the risk of readmission by providing comprehensive geriatric assessment (CGA) with signposting and support with an appropriate package of care to ensure the patient can be fully supported in primary care.

This six month pilot due to commence on 1 October 2015 will take place in the newly created Frailty Assessment Base at Ipswich Hospital, whilst the use of diagnostics is fully evaluated with the long term aim of moving this service to a community service.

The service will be consultant led and will see a minimum 15 patients per week and will provide nursing, therapy, dietetic and medical assessment and planned intervention in keeping with the key domains of CGA which has been shown to reduce disability, death, and admission to acute hospital beds and care homes. The service will initially be provided Monday to Friday 7.5 hours per day. Following initial evaluation after the first two months, the aim is to extend to a 7 day service.

Following assessment, the Frailty Unit Team will develop a clear management plan with expected outcomes which will be communicated to both GP and community teams. The scheme is based on a key outcome of avoiding 260 admissions over the six month period.

5.7 **Winter Scheme 7 - Admission Readmissions Avoidance Scheme (ARAS)**

The ARAS scheme, run by the British Red Cross (linked with Suffolk GP Federation), was in place for winter 2014/15. The service focused on two elements – a preadmission element at the front door aimed at avoiding admissions and a second element focused on patient discharge supporting patients deemed vulnerable for readmission. Learning from the 2014/15 scheme highlighted that the discharge element of the scheme proved to be

extremely successful. The pilot finished at the end of May 2015 and Ipswich Hospital had highlighted that the scheme was sorely missed. Initial statistics following the pilot, showed 579 hospital bed days were saved. Patient experience surveys also showed the scheme was an overwhelming success.

The winter scheme for 2015/16 is to re-run the 'discharge' element of the scheme and offer intensive support following Ipswich Hospital discharge for an intensive 72 hour window. This support includes:

- Settle the patient back at home, making sure they are safe and warm and have everything needed to hand
- Advise neighbours/relatives of their return (if appropriate)
- Confidence building
- Resilience and extreme weather preparation
- Help patient stock up on shopping and prepare a meal
- Provide emotional support
- Identify on-going or longer term needs and agree the way forward
- Supportive signpost and assistance facilitating private, statutory or third sector support to help with support needs
- If necessary provide numerous welfare checks to make sure that they are safe
- Prompt person to take medication
- Notify the GP practice

5.8 **Winter Scheme 8 - Hospital Admission Liaison Officers (HALOs)**

IESCCG agreed to commit £187k of baseline winter funds for support to the ambulance service. £184k has been pre-committed to HALO schemes to support the reduction in handover and turnaround delays with £3k set aside for local contingencies. Ambulance turnaround delays are identified as a system priority for 2015/16 and the provision of HALOs located in the Emergency Department at IHT will support and tackle handover delays.

Part Three

Voluntary sector

Five of the eight 2015/16 winter schemes for Ipswich and East Suffolk CCG involve Suffolk Voluntary Care Sector (VCS) organisations as an integral and vital resource within the Suffolk health and social care system. These schemes are:

- Ipswich Town Pastors scheme supporting vulnerable and intoxicated persons in Ipswich town centre at the weekends (see Winter Scheme 1 above)
- Suffolk Family Carers scheme supporting Moving and Handling training of family carers in Suffolk (see Winter Scheme 2 above)
- Suffolk Family Carers scheme providing respite for patients in order that carers are able to attend hospital appointments (see Winter Scheme 3 above)
- Age UK Suffolk, British Red Cross and Suffolk Family Carers are part of a multi-agency service to support adults experiencing a crisis situation to remain in their own homes and/or enable rapid discharge from the Emergency Department (see Winter Scheme 5 above)

- British Red Cross/Ipswich Hospital scheme offering intensive support following discharge from Ipswich Hospital for an intensive 72-hour period (see Winter Scheme 7 above)

In west Suffolk, Age UK Suffolk and Suffolk Family Carers are represented on the West Suffolk System Forum. The main focus on the West Suffolk resilience plan this year has included funding the Early Intervention Team – a multi-agency admission prevention response – which includes the provision of the Welcome Home Service operated by Age UK Suffolk and GP family carer advisors operated by Suffolk Family Carers.

Part Four

Partnership working

The Ipswich and East Integrated Care Network (ICN) meets on a monthly basis, bringing together senior decision makers from across health and care partners to oversee the strategic direction and delivery of health across the CCG area. It is this group which has overall responsibility for Winter Planning.

Underneath the ICN there has been a System Urgent Care Group and now a fortnightly Delayed Transfers of Care senior management group which both involve key organisations represented on the ICN such as CCG, IHT, SCH and ACS members. A proposal is being taken to the next ICN meeting on the 13 October to combine these two groups into a Winter Resilience Group and for each partner organisation to identify one senior decision maker to represent their organisation and for the group to be accountable to the ICN for the ongoing development and delivery of the 2015/16 Winter Plan including processes to support early supported discharges to ensure that DTOC patients are progressed on a more timely basis.

The West Suffolk System Forum is a senior leadership group represented by the health and care system charged with accountability for delivery of the local winter plan. Reporting to the System Forum is a system operational delivery group which has day to day responsibility for the plan. Both groups are well represented and formally report into the Health and Wellbeing Board

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