The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	23rd September 2013
Title:	Winter Operational Plan
Executive Summary:	This report provides the Board with the Winter Operational Plan. The purpose of the plan is to provide assurance that the Trust has planned to deliver sufficient capacity based on a comprehensive assessment of activity. The appendix details the actions the Trust has put in place, including the bed capacity, workforce modelling and management escalation plans.
Action Requested:	To approve: The Winter Operational Plan.
Report of:	Chief Operating Officer
Author: **Contact Details:**	Head of Performance & Compliance Tel: 01902 694366 Email: simon.evans8@nhs.net
Resource Implications:	None
Public or Private: **(with reasons if private)**	Public Session
References: **(e.g. from/to other committees)**	Appendix 1 – Winter Planning Assurance Template
Appendices/ **References/** **Background Reading**	
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

The Royal Wolverhampton NHS Trust

Winter Planning 2013/14
Assurance Template

Guidance

- **In addition to your Board approved winter operational plan, Trusts are also required to complete and submit this assurance template (signed by Trust Chair, Chief Executive and lead commissioner) by the 30th September.**

- **It is important to note:**
  - The winter operational plan and assurance template should relate to the winter period defined as 1st December 2013 to March 31st 2014.
  - The Trust winter operational plan is distinct from the system winter plan being developed by your local commissioners.
  - The TDA will be using the submitted winter operational plan and completed template to gain assurance that you have planned to deliver sufficient capacity based on your assessed activity. In particular looking at the key domains outlined on page 4.
  - The operational plan should be focused on the modelling of winter demand and therefore what additional measures will be required to sustain safe and effective care during this period.
  - A separate focus is required for the Christmas and new year period 21st December – 5th January due to the way the banks holidays fall. The assurance template asks for assurances that this particular period has robust arrangements in place.

- Could you also provide the names and contact details in the spaces below for the Trust Director-lead and operational leads for winter, so that any specific queries regarding the plan can be directed accordingly.

Name: Trust Director- lead for Winter Gwen Nuttall	Contact details: • Daytime telephone number use mobile number below • Mobile number 07788 308053 • E-mail address gwen.nuttall@nhs.net

Name: Trust Winter Operational lead (s) Tim Powell (operational) Simon Evans (planning)	Contact details: • Daytime telephone number use mobile number below • Mobile number Tim – 07794 334838. Simon – 07768 835168 • E-mail address tim.powell@nhs.net simon.evans8@nhs.net

Assurance template in a glance – key domains

Sign off

- The winter assurance template requires sign off from Trust Chair/ Chief Executive

Demand & Capacity

Trust will need to demonstrate it has undertaken a demand and capacity review for :

- ED with regard to staffing numbers and skill mix to manage predicted demand.
- Assessment Areas for numbers of assessment / short stay spaces in addition to staffing to manage the 85th centile of admissions.
- The Trust must set out the additional capacity (beds, support services and staff) it intends to deploy during the winter period.

Delivery

The Trust demonstrates it has effective models of care , this would include:

- Senior review on attendance / admission to ED / AMU as early as possible following presentation.
- Ambulatory Emergency Care
- Daily senior review of all patients every day
- Same day access to diagnostics for inpatients
- EDD and Clinical Criteria for discharge set at the point of admission and reviewed every day via board / ward rounds

Governance

The Trust needs to demonstrate the following

- An approach to daily / weekly performance management / service improvement
- A clear structure of accountability with an executive lead
- Board reporting in place with the winter operational plan signed off by the board.
- That the Trust is clear on Risks and associated mitigating actions
- Assurances that plans have been stress tested
- The Trust will need to give a clear outline of the areas where additional resources would be targeted. The investments need to evidence the contribution to the Trusts capacity to deliver and sustain quality care.

Partnership

- The Trust demonstrates it is working with all parts of the system to reduce urgent care demand and improve internal flow.

Best practice
(See attached documents)

- In order to support Trusts in the development of their winter operational plans. We have attached a winter plan checklist and best practice guidance developed by ECIST for information and consideration.

Signatories

Name: Richard Harris Trust Chair	Signature Date:

Name: David Loughton Trust Chief Executive	Signature Date:

Demand & Capacity

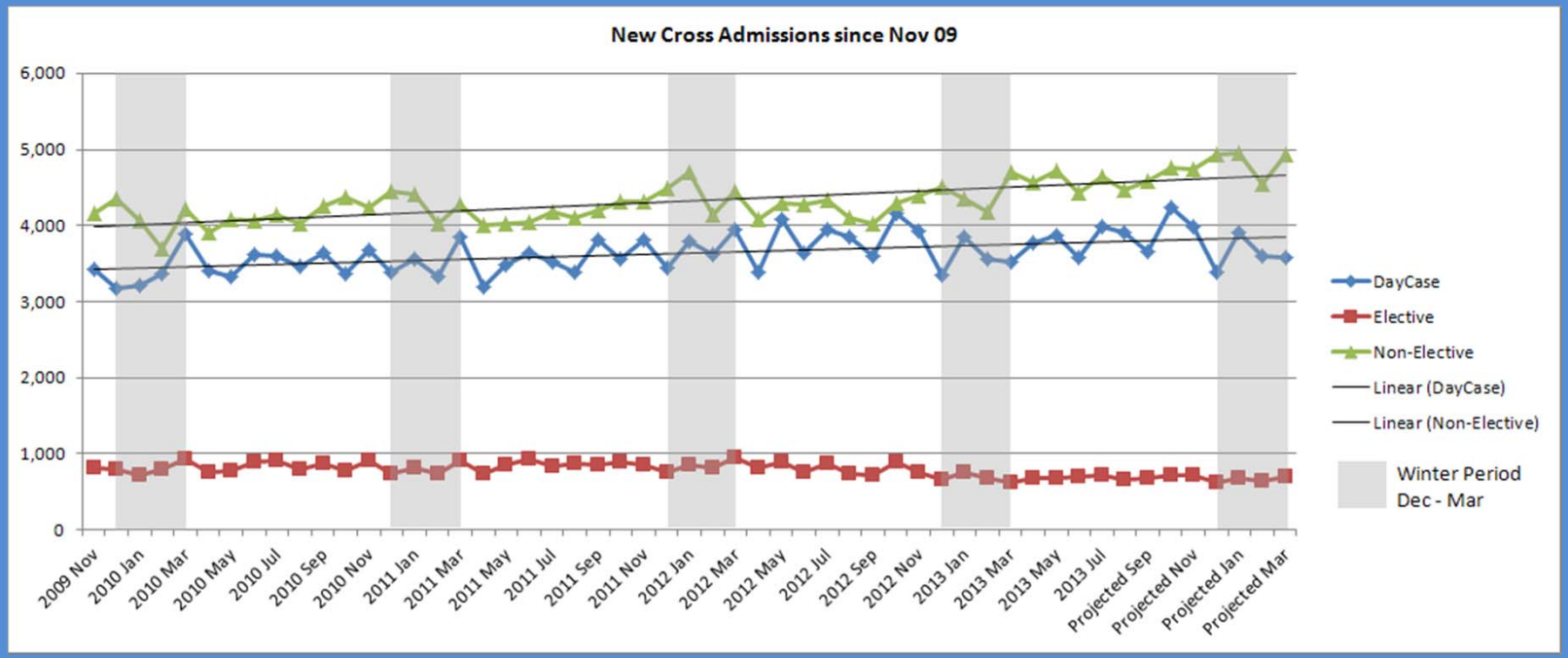
Demand & Capacity (1)

Bed Modelling

Please provide details in the space provided below to the following question (if necessary continue on an additional slide):

- Could the Trust provide the model for bed requirements for assessment units, inpatient beds, Critical Care and any re-ablement capacity for the 2013/14 winter period? Best practice would suggest the following assumptions should be considered:
  - Predicted admissions modelled at the 85th centile levels
  - Length of stay increase during winter for non elective admissions.
  - Bed Occupancy modelled at 92% across the inpatient hospital bed base

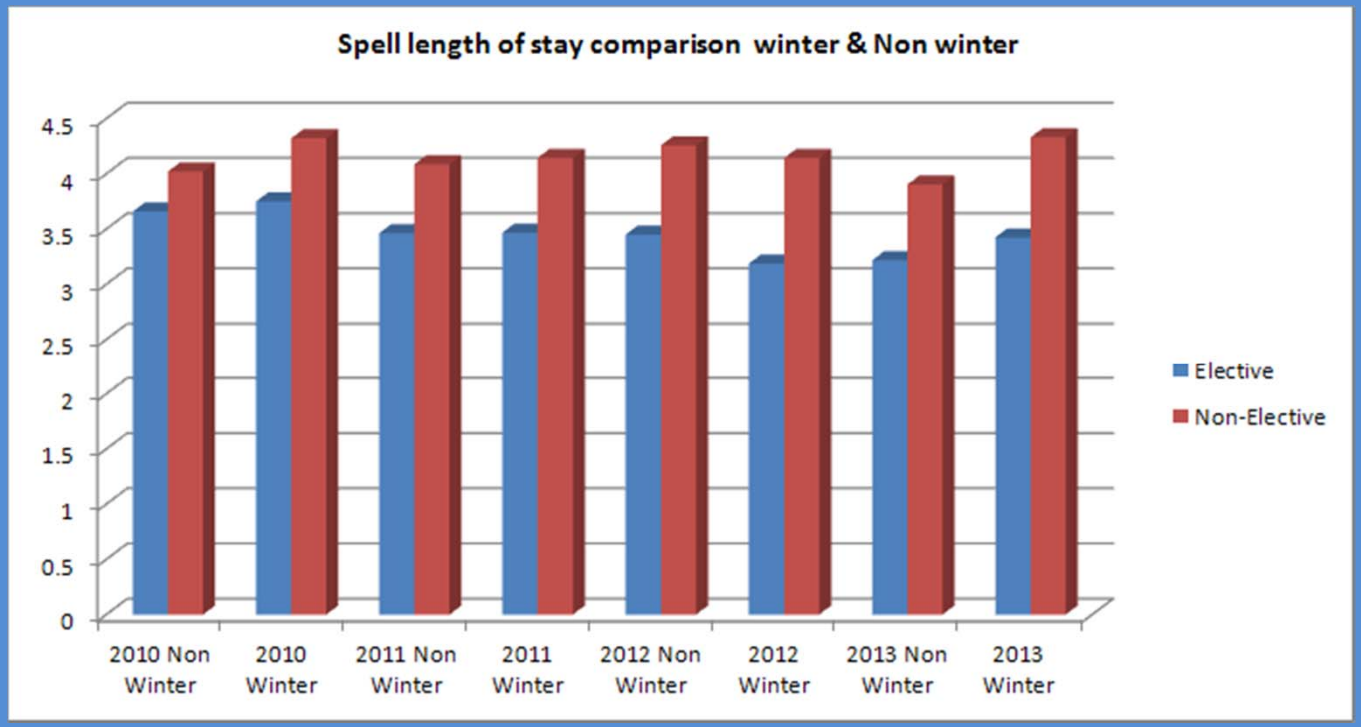
❑ Looking at historical activity , the graph below shows Non elective activity peak during the winter periods (Dec – Mar). The forecast for the 13/14 winter period below shows a continuing increase on already high levels of Non elective admissions.



Demand & Capacity (1)

Bed Modelling

- Not only is there an increase in the number of non elective admissions, the length of stay in winter periods is overall longer than in non winter periods as the graph below shows. For example during Jan – Mar 13, non elective stay was nearly ½ day longer than Apr – Jul 13.



Demand & Capacity (1)

Bed Modelling

- Based upon the over performance of activity in the last winter period, it is forecasted an additional bed requirement of at least inpatient 30 beds is required. This is based upon factoring a higher length of stay for winter and also applying a 92% bed occupancy rate.
- It is anticipated that 13/14 winter bed requirements are:

Bed Requirements	
Type	**No of Beds**
Assessment Units SAU / AMU / PAU	83
Inpatient Beds	635
Critical Care	28
Winter additional inpatient beds	30
Total	**776**

NB: A detail bed model by speciality has been developed to arrive at the figure of 30.27 beds.

Demand & Capacity (2)

Additional Capacity

Please provide details in the space provided below to the following question (if necessary continue on an additional slide):

- Based on the modelling exercise what additional capacity are you planning to put in place? This should include additional beds of any type, staffing both clinical and non clinical and any other support services.

- ❑ Use of ward B7 – 20 medical beds
- ❑ Use of ward A10 - to provide additional surgical capacity linked to the expansion of SAU
- ❑ Use of Beynon short stay – weekends
- ❑ Use of additional beds at West Park

- ❑ Phased expansion of medical beds over the past 18months (2 wards)
- ❑ Day case unit providing extended opening hours and capacity to support elective workload
- ❑ Ring-fenced orthopaedic beds (22)

- ❑ A&E – see later slides
- ❑ CDU – open to 10- strict criteria for use
- ❑ Majors additional capacity - 9

- ❑ Use of step down beds – community

- ❑ Pharmacy extended opening weekends
- ❑ Additional Radiology support at weekends for reporting
- ❑ Discharge Reg/Consultants

Demand & Capacity (3)

Workforce

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Could the Trust provide details regarding your winter staffing plan and how this aligns to predicted demand for services?

- ❑ Recruitment of nursing staff to support additional winter capacity will be completed by 1st October 2013
- ❑ Additional Medical and support staff will be in post to support the opening of the additional capacity
- ❑ Additional A&E Consultants and Acute physicians have been recruited
- ❑ Embedded a strengthened medical take rota
- ❑ Extended roles in Therapy and Pharmacy have been developed

- ❑ There will be 7 day on-site consultant presence in the following specialties:
  - gastroenterology
  - diabetes
  - respiratory medicine
  - renal
  - care of the elderly
  - acute medicine

- ❑ Strengthened the A&E consultant rota
- ❑ Enhanced the out of hours management of the hospital by recruiting more night nurse managers
- ❑ Ability to strengthen the management on call rota
- ❑ Management on-call presence 7 day per week
- ❑ Close working with West Midlands Ambulance Service local HALO.
- ❑ Inpatient Ward Senior Sisters will have a supervisory status to enable the support of patient flow

Delivery

Delivery (1)

Effective models of Care.

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Could the Trust describe its models of care / access standards in the following areas:
  - ED
  - Acute Medicine
  - Inpatient bed base
  - Confirmation of provision of Ambulatory Emergency Care
  - Access to diagnostics / pathology

- Emergency Department (ED)
  - 24/7 CDU will open September
  - Additional 9 major cubicles will open November
  - Streaming of patients will include paediatrics and see and treat
  - RAT process for all majors patients
  - Utilisation of clinical pathways aligned with Acute Medical Unit and other Trust specialities
  - Senior Decision maker and Senior nurse in all areas of ED to improve flow and co-ordination
  - Senior Clinical nurse in ED 7 days a week
  - Increased ACP recruitment

  Acute Medicine
  - Consultant Acute Physician 6 day working
  - Band 7 Supervisory Senior Sister 7 day working
  - Junior sister co-ordinators 24/7
  - Utilisation of clinical pathways
  - Links with medicine to improve flow to relevant specialities
  - In reach services –Gastroenterology, Respiratory, Cardiac etc.
  - Increased therapy service support
  - Trigger process for those patients with a longer than 72 hour length of stay

Delivery (1)

Effective models of Care.

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  - ED
  - Acute Medicine
  - Inpatient bed base
  - Confirmation of provision of Ambulatory Emergency Care
  - Access to diagnostics / pathology

Confirmation of provision of Ambulatory Emergency Care

- 24/7 CDU based in ED from September 2013 – criteria and pathway based
- Lead Consultant and Nurse accountable for area
- Ambulatory Assessment Area (AAA) re-processed with the implementation of MSS opening hours 09.00-24.00
- RAT principles utilised in AAA

Access to diagnostics / pathology

- The pathology department will provide a 24/7 service to the trust. This service will ensure that all tests generated in emergency portal departments meet the expected 1 hour turnaround time from receipt of sample. The ward areas and other clinics will meet the expected turnaround time of 4 hours. Phlebotomy support will be enhanced to ensure all samples are received into the laboratory promptly, including weekends.

Delivery (1)

Effective models of Care.

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Could the Trust describe its models of care / access standards in the following areas:
  - ED
  - Acute Medicine
  - Confirmation of provision of Ambulatory Emergency Care
  - Access to diagnostics / pathology

Radiology will provide 24/7 service for A&E radiography and CT scanning.

❑ Radiology will provide 24/7 service for A&E radiography and CT scanning.

A&E CT head scans will be performed within one hour.

In-patient CT scans will be performed within 48 hours (unless clinically more urgent).

MRI scans will be available 12 hours a day, 7 days a week with an expected turnaround for in-patients within 72 hours (unless clinical urgency dictates a more rapid turnaround)

The main x-ray department will be open for a walk in GP service between 9:00am and 4:00pm weekdays.

Ultrasound scans will be available 7 days a week. Surgical in-patients are scanned within 12 hours. Others are scanned according to clinical need.

Nuclear imaging scans are available weekdays with in-patients scanned within 48 hours. This service can be extended to cope with increased demand

Delivery (2)

Seasonal Flu/ Pandemic Flu and Norovirus

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Could the Trust provide an outline of the Trusts updated Flu, Norovirus and infection outbreak management plans, including when the plans were updated or are proposed to be updated? It would be appreciated if the Trust could provide copies of the above plans when submitting?
- Could the Trust set out its plans for staff flu vaccination including a trajectory?

- Norovirus
  - Trust Norovirus Policy updated June 2012 and currently undergoing updates based on last years learning (see attached) Revised version to Infection Prevention Group for Agreement in September 2013.
  - In-house norovirus testing, introduced in December 2012 to improve speed of identification of infectious cases and rule out negative cases to improve bed utilisation, to be funded in Winter 13/14
  - All communication material updated and ready for distribution
  - Norovirus communications planned for late September/early October 2013 Trust wide
  - Community surveillance observed to detect increasing cases in the local population.
  - Message to prevent sharing of equipment and prevention of transfer of any patient from affected wards reinforced through matron groups
  - Care homes outbreaks managed by the Trust's Integrated Infection Prevention Team with daily telephone communication, visits as necessary and standardised care plan and communication pack. Zero admissions secondary to norovirus from care home outbreaks managed by IP Team in winter 2011/12 and 2012/13.
  - 7 day outbreak control with formal on-call arrangements during norovirus outbreaks by infection prevention nurses (including care home outbreak management and communication)
  - Public Health & CCG are supportive in communication campaign and communications to GP's relating to admission avoidance, home rehydration using rehydration care pathway and on-going support with care home agreement
  - Strengthened communications with other community teams to reduce admissions secondary to norovirus from care homes outside Wolverhampton

Delivery (2)

Seasonal Flu/ Pandemic Flu and Norovirus

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Could the Trust provide an outline of the Trusts updated Flu, Norovirus and infection outbreak management plans, including when the plans were updated or are proposed to be updated? It would be appreciated if the Trust could provide copies of the above plans when submitting?
- Could the Trust set out its plans for staff flu vaccination including a trajectory?

- Flu Vaccination
  - 5000 flu vaccines ordered, delivery expected 7th October 2013, can obtain further stock if required.
  - Will be offered to all staff & will produce 2 statistical reports, 1 reporting percentage Trust staff uptake and 1 reporting to *immform* detailing percentage uptake for frontline health care workers.
  - Campaign materials ordered from NHS employers, delivery imminent, aiming for flyers on September payslips.
  - Delivery format ad hoc visits to wards/departments, drop ins at both acute & community West Park satellite clinic, visits to wards/departments for groups of staff on request, attendance to key Trust meetings.
  - Out of hours clinics will be offered evenings & weekends.
  - Risk stratified approach targeting groups of staff in 1st wave in emergency department, Acute Medical Unit, critical care, paeds, Maternity & Respiratory Wards.

Delivery (3)

2013/14 Christmas/ New Year arrangements

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Given the way Christmas and New Year Bank holidays will fall in 2013/14. Could the Trust provide assurances that robust arrangements are in place to cover the Christmas/ New Year period, including specifically a workforce plan for this period covering 21st December 2013 through to 5th January 2014.

The Trust has put a number of measures in place to ensure operational delivery over the Christmas and new year period, this includes:

- ❑ Restricted annual leave allowance
- ❑ Enhanced Manager on call arrangements
- ❑ Wolverhampton Social Worker will be on site over the Christmas and new Year period
- ❑ Opening hours of support Services will match demand

- ❑ During Bank Holidays additional medical staff will be available to support discharges
- ❑ Junior Medical Staff rotas to be enhanced

Governance

Governance (1)

Governance Structure

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- How the board will review and formally approve the winter resilience and influenza plans?
- Can the Trust describe the accountability framework in place to manage winter performance and how the Board will hold the Executive team to account.

- ❑ The influenza plans are signed off by the Trust infection prevention committee. This committee reports to the Trust Management Committee and Quality and Assurance Committee – both of which are sub-committees of the Trust Board.
- ❑ The internal A&E recovery plan reports on a quarterly basis to the Trust Board – and more frequently if significantly off trajectory . The winter plan will be incorporated into this plan.
- ❑ This winter plan will be submitted to the Trust Board for sign off in September.
- ❑ The Health economy surge plan has been signed off by the system wide Urgent and Emergency Care Board and has been circulated to the Board via email in August (there is no formal Board Meeting in August).
- ❑ There will be a regular teleconference held with local CCG and other service providers over the winter period, using the winter pro-forma as already established
- ❑ Winter performance is reviewed by operational leads on a daily basis Mon-Fri, with internal Gold on call support, out of hours and weekends. Overall performance is reviewed by the Chief Operating Officer at a weekly performance meeting. This meeting provides oversight on all operational standards, not just winter – e.g. RTT, Cancelled Ops.
- ❑ Operational performance will be overseen via the Trust Management Committee and the newly established Finance and Performance Committee. Both are subcommittees of the Board. The Finance and Performance Committee include NEDS for overall Board accountability and assurance.

Governance (2)

Daily management and escalation

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Can you set out the process of daily / weekly performance and capacity management and your escalation process? this should also include the metrics you use to support this?
- Can you describe the process for engaging external partners in the escalation process?

Use of local and regional capacity management tool is in place to predict admissions.

The Trust has established 'protected streaming' – creating separate streams for paediatrics, minors and majors, with dedicated staff, processes and co-ordination.

Process is in place to ensure that the majors stream is not halted by a full resuscitation room

In order to manage flow of patients requiring admission, AMU takes patients with a LOS of 72 hours or less at which point patients are transferred to specialist beds. This is supported by a range of specialty specific SOP's.

A well established internal and external escalation processes is in place. Daily capacity management processes are established with robust escalation – live bed state to be established ahead of Winter 2013/14.

There are a suite of pathway protocols to ensure patients with complex discharge needs are managed appropriately.

C of E Outreach into Community Pilot extended through Winter 2014. Frail elderly patients streamed to appropriate ward.

Integrated Health and Social Care Patient Flow team will be well established for Winter 2013/14. 7 day working – Pharmacy Specialist. Diagnostics social services, extended transport

Governance (3)

Quality & Patient Safety

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):
Ensuring patient outcomes and experience do not deteriorate during winter pressures is a key challenge:

- What governance arrangements are in place to ensure Quality & Patient Safety is not compromised during winter period? Could the Trust outline these arrangements? Could the Trust describe what plans are in place to ensure operational standards are maintained consistently throughout the year e.g. A&E and Acute Medicine Clinical Quality Indicators, referral to treatment times, cancer operational standards, HCAIs.

- ❑ All additional capacity areas will have individual risk assessments completed with control and assurance measures
- ❑ Daily quality and safety meetings will be chaired by Heads of Nursing
- ❑ List of possible patients suitable to outlie from base wards will be identified by Matrons or Clinical Night Managers

Delivery of the key operational standards remains the Trusts priority throughout the year. Progress against the performance standards is monitored by the performance management team on a daily, weekly, monthly or quarterly basis, depending upon data refresh frequency intervals. Business rules are applied to each objective and performance against these rules is monitored and managed with the Accountable or Responsible Officer at appropriate intervals. As part of this activity, each indicator is RAG (Red, Amber or Green) rated to determine the level of actual performance against planned activity.

A performance meeting, attended by the Divisional Heads of Department and Deputy COOs is held weekly which is chaired by the COO. This meeting reviews progress against the key operational standards, highlights any areas for concern or pressure points and identifies remedial actions where required.

Governance (3)

Quality & Patient Safety

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):
Ensuring patient outcomes and experience do not deteriorate during winter pressures is a key challenge:

- What governance arrangements are in place to ensure Quality & Patient Safety is not compromised during winter period? Could the Trust outline these arrangements? Could the Trust describe what plans are in place to ensure operational standards are maintained consistently throughout the year e.g. A&E and Acute Medicine Clinical Quality Indicators, referral to treatment times, cancer operational standards, HCAIs.

Daily information is sent to key managers across the Trust detailing the previous day's performance in the A&E department. This also includes the latest position on ambulance handover, emergency admissions, available bed stock, delayed discharges and cancelled operations.

To ensure operational effectiveness, three bed meetings are held daily to discuss ward pressures and the "flow" across the hospital. When operational issues arise, regular dialogue is held with Health Economy partners to discuss any potential blocks or operational concerns.

The Trust has developed a Performance Repository which captures over 300 performance metrics covering all areas of operational activity. This includes all measures within the contract, all of the risk assessment framework and a number of measures to assess the operational efficiency of the organisation.

The Trust Board are accountable for the delivery of the organisations objectives and it receives a monthly performance report covering all of the areas described.

Governance (4)

Additional Investment

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Could the Trust give a clear outline of the areas where additional resources would be targeted. The investments need to evidence the contribution to the Trusts capacity to deliver and sustain quality care.

- ❑ Cardiology In-reach to EAU - Increase availability of additional diagnostic support at weekends to assist with discharge planning .£180,000.
- ❑ Additional Support for resolving Step Down Pressures -To enhance the social work capacity within step down facilities to assist with the planning of care for discharges and reducing delayed discharges. Joint development with Social Workers support to reduce the number of step down beds .£150,000.
- ❑ Weekend pharmacy cover -Additional opening hours and pharmacy provision at weekends to ensure all discharges can be completed in a timely manner. £64,000.
- ❑ Ambulance nurse triage -Additional nursing support to ensure that ambulance handover can take place as soon as possible on arrival to the A&E department. Prevents delays to ambulance handover. £200,000,
- ❑ Wolverhampton GP in a car -A reduction of ambulance dispatches for associated activity (Primary Care/low priority calls). Review the project impact against emergency attendances .£300,000.
- ❑ Therapy services Rapid Response Plus- Therapy services in-reach into A&E for extended hours: Therapy services in-reach into EAU: Therapy services support in step down provision .£282,000.
- ❑ Community Geriatrician - Actively responding to patients admitted from Nursing Homes to facilitate speedy discharge .£150,000.

Governance (4)

Additional Investment

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Could the Trust give a clear outline of the areas where additional resources would be targeted. The investments need to evidence the contribution to the Trusts capacity to deliver and sustain quality care.

- ❑ Mental health practitioner presence in A&E along with additional clinical staffing in the RAS team -This is to provide additional support at weekends and after 5pm weekdays to reduce the numbers of patients whom could breach whilst waiting for a psychiatric assessment. We will be commissioning this service from one of our local mental health Trust providers who already operate an established 'in-reach' service into A&E. this initiative will build additional capacity on this pressured service. £150,000.

- ❑ Senior medic in A&E 24/7- Additional senior decision maker in A&E department to ensure appropriate treatment of very ill patients and ensure that the department has senior leadership, not just on call cover out of hours. £200,000.

- ❑ Additional portering capacity- The additional costs of portering are due to increased volumes of A&E attendances and resultant admissions with ambulance transfers up to 20% higher than last year. The additional porters will ensure the timely transfer of patients from A&E to wards. £90,000.

- ❑ Locum Radiologist- To increase the weekend availability of radiologists .£82,000.

- ❑ WUCTAS v2- Extend current service to include Social, Surgical and urgent outpatient appointments. £25,000.

- ❑ Primary Care alongside A&E including support to nursing homes- Learning from GP in A&E scheme in 12/13 has helped frame the model in 13/14. Primary Care function alongside A&E 24/7 incorporating the OOH provision and urgent visits to nursing homes. £317,000.

Governance (4)

Additional Investment

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Could the Trust give a clear outline of the areas where additional resources would be targeted. The investments need to evidence the contribution to the Trusts capacity to deliver and sustain quality care.

- ICCU Capacity -Increase transport availability from current (non-emergency) transport provider to reduce delayed discharges and increase acute bed capacity. £20,000.
- Dr First scheme -Widely published scheme available to redesign/reconfigure appointment systems in GP surgeries (based on10 GP practices signing up to the scheme). £80,000.
- Paediatric Hot Clinic - Rapid access to both a telephone advice service between GP and Paediatric consultant with access to a hot clinic for common conditions (upper respiratory/Gastro) . £225,000.
- Walk-in centre additional capacity -To fund the increase in walk-in activity. £150,000.
- Community Equipment to facilitate discharge -Additional equipment required to facilitate speedy discharge . £125,000.
- Patient Communication -To enable the health economy to communicate with patients at times of pressure, these funds will purchase radio advertising and patient leaflets for heatwave/cold weather. £50,000.
- Opening of additional wards – two wards will be open all year to accommodate the increase in activity – £2.3m. An additional ward will be open for part of the year with forecasted expenditure of £915,000 which is currently unfunded.

Governance (5)

Stress testing the plans

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- Could the Trust explain the process to stress test the plans and how will lessons from this testing be including in the winter plan?

- ❑ The Trust began stress testing the Winter Plan following the 2012/13 Winter de-brief that was held across the Health economy.
- ❑ Last years data has been modelled to understand the capacity requirements across all areas of the Trust and to determine peak flow and throughput by area by date.
- ❑ Whilst robust analysis has identified the requirement for an additional 30 beds for this coming Winter, the Trust has built a further contingency that would see a further 7 beds become available.
- ❑ The Trust contributes to a Health economy wide surge plan which details how the system will look to cope through the surge period, this has enabled much closer partnership working with commissioners, primary care and social care.
- ❑ Monthly surge planning meetings are held to monitor progress
- ❑ An agreed set of performance data is reviewed daily, weekly etc. to ensure the plan is effectively being monitored and that outliers are appropriately identified and managed.
- ❑ The Trust has major incident type levels of escalation available to use.

Governance (6)

Risk management

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- What are the key risks / challenges currently regarding winter planning?
- Have they been placed on the corporate risk register?

- ❑ A greater than forecast increase in demand could severely compromise Trust wide capacity to meet demand.
- ❑ Failure to achieve operational standards
- ❑ Failure of external agencies to respond in appropriate timeframes for discharge planning, health care assessments
- ❑ Increase in length of stay due to complex nature of patients results in cancelled operations, reduce income, increase in patient complaints and reduction in patient satisfaction
- ❑ Significant outbreak of norovirus could affect bed availability

All of these are on the Trust Risk Register and have been all year – they are reviewed on a Monthly basis and signed off by the COO before presentation to the Trust Management Committee and ultimately Trust Board.

Partnership

Partnership

Partnership Working

Please provide details in the space provided below to the following questions (if necessary continue on an additional slide):

- What arrangements are in place with the Urgent Care Board and key health economy partners?

- ❑ The Urgent Care Board is system wide multi disciplinary group. It is chaired by the Trust Medical Director. The Terms of reference and membership of the group are attached. This group meets on a Monthly basis.
- ❑ There is also an operational surge group, chaired by the CCG that feeds into the Urgent Care Board.
- ❑ There are regular Black Country Urgent Care meetings, at which RWT always ensures it has Trust representation, at either Director of Associate Director Level.
- ❑ There is regular meetings with partners in Social Care, informally with Operational Leads (at Director Level) Quarterly for strategic planning.
- ❑ Regular engagement and discussion with partners from Mental Health Partnership, with clear escalation process to operational teams.
- ❑ Regular contact and meetings with the Ambulance service (WMAS)
- ❑ All the above partners are members of the Urgent Care Group.