

Insert Trust name here

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: Bernadette Bluhm Trust Director- lead for Winter	Contact details: <ul style="list-style-type: none">• Daytime telephone number – 07824 625614• Mobile number - 07824 625614• E-mail address – bernadette.bluhm@whht.nhs.uk
Name: Sally Tucker Trust Winter Operational lead (s)	Contact details: <ul style="list-style-type: none">• Daytime telephone number - 07990551583• Mobile number – 07990 551583• E-mail address – sally.tucker@whht.nhs.uk

Assurance template in a glance – key domains



Signatories

Name: Trust Chair	Signature Date:
Name: Trust Chief Executive	Signature Date:



Demand & Capacity



Demand & Capacity

- ❑ Inpatient beds modelled at 95% occupancy across the hospital bed base. The model uses historical data to ensure seasonal length of stay fluctuations have been taken into account. The forecast activity is based on the actual percentage growth.
- ❑ Embedded is the summary output at trust level for the main bed holding Divisions (Medicine & Surgery) covering both NEL and EL activity, but does not account for outlying patients between wards.
- ❑ Whilst the forecast demonstrates an under provision in the bed stock for some months Escalation beds available have not been included in this calculation. WHHT will flex this capacity as demand requires.
- ❑ The model is built on actual bed days used over 2012/13.
- ❑ The capacity modelled assumes continued 2012/13 trend and does not reflect the work being undertaken by partners to manage unscheduled care demand and attendance at ED.
- ❑ The model does not reflect the predicted reduction in in patient spells as a result of the planned expansion of the trust's ambulatory model.

		Bed Forecast (NEL & ELEC) Medicine and Surgery											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Medical	Demand	466	517	471	503	504	472	550	531	490	555	547	522
	Availabilit	508	508	508	508	508	508	508	508	508	508	508	508
	Variance	42	-9	37	5	4	36	-42	-23	18	-47	-39	-14
Surgical	Demand	170	186	171	179	163	194	184	174	169	178	194	159
	Availabilit	203	203	203	203	203	203	203	203	203	203	203	203
	Variance	33	17	32	24	40	9	19	29	34	25	9	44
Total	Demand	636	703	642	682	667	666	734	705	659	733	741	681
	Availabilit	711	711	711	711	711	711	711	711	711	711	711	711
	Variance	75	8	69	29	44	45	-23	6	52	-22	-30	30



Demand & Capacity (2)

Additional Capacity

Ambulatory Care Capacity:

- WHHT will be establishing a dedicated ambulatory care facility; this will be in place by 25 December 2013.
- This will improve patient care pathways, by ensuring that there are both dedicated staff and an appropriate clinical area for the care of patients requiring acute care, but who do not need to be admitted overnight.
- The ambulatory care unit will also care for some patients requiring day-case / diagnostic procedures.
- This new ambulatory care facility will be open from 8am – 10pm every day of the week.
- There will also be a specialist ambulatory service for frail elderly patients 5 days a week.
- The unit will consist of 6 consulting rooms, 8 trolley spaces, 2 bed spaces, 4 recliners and a dedicated waiting area.
- It is estimated that approximately 5 to 10 extra patients will be seen in the unit each day . These patients would normally have been admitted. This will considerably reduce the pressure on the bed stock.

Bank Holiday Capacity:

- In line with usual practice, WHHT will be ensuring that additional staff are available during Bank Holidays, so that care continuity is maintained during these periods.

Working with Partners:

- There is a joint bid to establish early supported discharge for stroke patients during the coming winter. We are awaiting the outcome of this process.

Staffing:

- The number of nurses on all ward areas has been up-lifted this financial year and the Trust is undertaking a major recruitment programme to ensure as many of these posts as possible are covered by substantive staff.

Demand & Capacity (3)

Workforce

- International (qualified) recruitment campaign in Spain and Ireland from October to reach increased substantive establishment and reduce ongoing use of bank and agency (staff support programme)
- Local enhance recruitment initiatives and assessment days
- Training programme developed in line with Cavendish recommendations
- Additional funding for 30 nurses agreed to support winter pressures
- NHSP recruitment campaign to supply pool of flexible nurses to cover sickness, surge etc
- Flu vaccination programme in place from October
- Daily meetings to check staffing levels
- Weekly executive (HR/Chief Nurse) led meeting to review deployment of staff
- E-rostering daily reporting on staff shortages

Delivery



Delivery (1)

Effective models of Care.

- ❑ Emergency Department – Provides a 24/7 service for all emergency attendances. The service has a dedicated minor injuries service and a nurse practitioner service to support. The service is led by consultants from 08.00 – 0.00 (midnight) seven days per week. From midnight till 08.00 the service is led by senior staff grade doctors. Accident and Emergency is part of the trauma network and provides a full trauma service 24/7 with links to Imperial for trauma transfers. The emergency department has a 6 bedded clinical decisions unit for patients requiring a longer stay in emergency care. This service is also provided in the Emergency Paediatric Department as well
- ❑ Acute Medicine – The Directorate of Acute Medicine has 7.7 whole time equivalent Acute Physicians providing a seven day service to the Acute Admissions Unit. All patients admitted under the care of Acute medicine are seen by a consultant within 4 hours of admission in hours and within 12 hours in the out of hours period. Patient receive a consultant review at least every 24 hours.
- ❑ Inpatient bed base –Daily board and ward rounds are carried out by a senior decision maker. Triage is undertaken in AMU to stream patients into the correct speciality bed base. Medical Short Stay spells are identified in AMU and remain under the care of Acute Physicians.
- ❑ Confirmation of provision of Ambulatory Emergency Care - the Trust provides a medical ambulatory care service seven days per week. The service is consultant led and all patients receive rapid access to diagnostics and consultant review. Patients are discharged home the day of admission with some patients having follow up in the ambulatory care service. There are a range of patient pathways that have been developed in line with best practice ambulatory care standards. The division of surgery provides a surgical review for all patients arriving into the Acute Admissions Unit.
- ❑ Access to diagnostics / Pathology – The Trust provides diagnostic services for all patients 24/7. Within working hours a complete range of diagnostics are available for all inpatients and emergency patients. Out of hours diagnostics and pathology are available for emergencies only (excludes routine work)

Delivery (2)

Seasonal Flu/ Pandemic Flu and Norovirus

- The Trust has an Outbreaks Policy, updated July 2012 and due for review in 2015. The Pandemic Influenza Policy was reviewed November 2011, with the next review due 2014. We are awaiting the Regional Pan Flu plan from PHE, due at the end of September.
- The Outbreak Policy sits alongside the Diarrhoea and vomiting policy, and the Corporate Business Continuity Plan, and follows these principles:
 - Establishment of a control structure at an organisational, managerial and ward level
 - Roles and responsibilities of the Microbiology Department and the Infection Control team
 - Definition and management of minor and major outbreaks
 - Recovery to normal working practices.
- Control Measures
 - Special infection control measures
 - Special clean and disinfection measures
 - Distribution of prophylactic medication or immunisation
- Outbreak Investigation
 - Epidemiology
 - Screening
- Post Outbreak
 - Review, Revise and Recommend alterations to the plans and Policy
 - Reports commissioned by DIPC to Trust IPCC, TLEC and Executive Board
- Flu vaccination program includes
 - Uptake monitoring
 - Flu champions across the Trust to improve uptake of vaccine with frontline staff
 - Communications Campaign – with campaigns to demonstrate the importance of immunisation demonstrated by Trust Executives and Senior Clinical Management.
 - Occupational Health to take vaccine to clinical areas
 - Quarterly surveillance reporting into the EPG which in turn reports to the TLEC and the Executive Board

Delivery (2)

Seasonal Flu/ Pandemic Flu and Norovirus (cont.)

- ❑ 'Flu management plans sit along side existing corporate Business continuity plans and Infection Control plans. The BCP reflects the need for maintaining core key critical services in the organisation – to include access to emergency care, emergency surgery, acute maternity services, and essential clinical support and infrastructure to maintain safe levels of care. It details the redeployment of staff from non essential services into areas providing those critical services.
- ❑ Flu vaccine uptake at 40.5% last year
- ❑ The Pandemic 'Flu plan echoes the principles for maintaining key critical services as per the BCP, but also details specific command and control structures and their links with other agency partners.
- ❑ There is further detail around the movement of staff and patients around the hospital, and cleaning protocols and practices during an outbreak of pandemic 'flu.
- ❑ The Trusts Flu vaccine uptake was at 40.5% last year. It is recognised that vaccination of staff with direct patient contact can minimise the risk of those staff picking up the virus and passing it on to vulnerable patients and that we need to aim for 75% compliance. The vaccination campaign program has been detailed in the last slide, and we are keen to learn from other organisations the methodology to be used to reach the 75% target set for them for this year.

Delivery (3)

2013/14 Christmas/ New Year arrangements

- 19th Dec – 5th Jan – emergency theatre session each day
- Extra surgical team on at key points e.g. 27th to 29th Dec, 2nd to 3rd Jan
- Planning currently in progress to maintain elective programme over Christmas/ New Year, ensure 18 weeks and Urgent or Cancer Patients are still seen.
- Increased medical doctor provision over weekend/ bank holiday
- Wards to work with reduced levels of annual leave
- Radiology – continuation of usual 7 day working during winter,
- Pathology – usual service provision
- Health records – service to run as usual, but will flex depending on demand
- Pharmacy – usual working hours during winter
- Midwifery / Maternity – normal service provision
- Senior management on-call system will provide both an on-site senior management presence for in and out of hours and on call director out of hour
- Ambulatory care and discharge lounge to open 7 days a week

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.

- Winter resilience plans will include: influenza, infection control outbreaks (such as noro –virus) adverse weather plans and the trusts' Christmas and New year operational plans.
- The executive lead for operational performance delivery and winter planning is the Chief Operating Officer.
- Winter plans will be signed by the executive team before being presented to the Operational Management Group and Trust Leadership Executive Committee in October.
- Winter plans will be presented to the Trust Board in November.
- The Board will receive details of performance in an integrated quality and performance report. The board will also be provided with progress against KPI delivery within the unscheduled care improvement plan.

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?

- Patient capacity reviewed and communicated 5 times daily
- Executive led daily operational site meeting that reviews:
 - ED performance in the previous 24 hours/week to date/month to date
 - Predicted admissions for the day (Medicine & Surgery)
 - Admissions against predictor (Medicine & Surgery)
 - Balance of expected admissions (Medicine & Surgery)
 - Live bed position (Medicine & Surgery)
 - Confirmed & possible discharges
 - 4 hour breach position & DTAs
 - Position with planned electives for the day
 - Departmental waiting times for A&E and UCC
 - Departmental status – Resus/Majors/Minors/CDU/CED
 - Waiting time for Ambulance off loads
 - Ambulances inbound for A&E
 - Ambulances inbound for AAU
 - DTAs anticipated in the next 2 hours – A&E and AAU
 - # NoF performance
 - Stroke Performance
 - Infection control isolation performance
 - Community capacity – IMC/Social Care/Medihome (Social Care and Medihome in attendance at the meeting)

Governance (2)

Daily management and escalation (Cont'd)

☐ Organisation Escalation:-

- The Trust works to an internal escalation process that is scored – Red/Amber/Green with internally agreed triggers points that result in specific actions/interventions.
- The escalation policy incorporates use of additional capacity , decisions regarding planned activity and flexible use of existing bed stock i.e. use of surgical beds for medical patients
- Escalation to external partners is triggered at the Amber stage
- Formal communication instigated with CCG in the event that the Trust is unable to admit a patient within 8 hours of a decision to admit.

Escalation Triggers

- Level 1 Amber – 5 patients in A&E with a DTA but no identified bed to place the patient in
- Level 2 Red – Level 1 escalation measures have created insufficient capacity to meet demand, 1st stage of surge implemented
- Level 3 Black – Level 1 & Level 2 escalation measures insufficient, inability to achieve 10 hrs DTAs, ambulance off load difficulties and prediction of 12 hour breaches without further actions and 2nd stages of surge

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, HCAs.

- As from October a strengthened monthly governance process in place from ward to Board
- Patient safety and quality committee (PSQC) (Board sub committee).
- Working groups providing assurance of operational delivery from ward to Board
- Matrons and senior nurse attendance at daily site operational forum, key quality and performance indicators are discussed and actions assigned to respond to concerns raised. Standing agenda items are (infection prevention and control, fracture neck of femur pathway, stroke pathway, isolation capacity, single sex accommodation, care of patients in outlying ward s
- Newly formed PTL chaired weekly by the Chief Operating Officer
- Additional support to the Trusts RTT performance delivery. Senior program manager appointed for a 4 month secondment from NHS IMAS 18 week team.
- Populating capacity and demand model to improve 18 week management at speciality level
- 2 hourly board rounds undertaken in ED
- Unscheduled care improvement plan (endorsed by NHS ECIST) is in place with established steering group lead by COO
- KPI's for unscheduled care improvement plan will be monitored bi-weekly at the unscheduled care improvement steering group.
- Daily operational meetings chaired at executive level.

Governance (4)

Additional Investment

Ambulatory Care Facility

The standalone ambulatory module will have the capacity to receive more patients as the environment will be entirely independent from the bed base. The existing medical and nursing and administrative workforce will transfer to the module.

The care of the elderly consultant team will provide an ambulatory service for all care of the elderly patients from the medical take and this opportunity will enable an alternative to admission for our over 80 year old patients. A robust model has been developed to support this.

Creating an ambulatory care facility is preferable to establishing an in-patient area as previous increases in beds have stretched resources and led to inefficiencies and have not promoted more efficient ways of working. The cost of delivery this service is £1.4m

Ambulatory Care ESACS Pilot Extension to March 2014 7 day Working

Extension of the Ambulatory Care service at WHHT to Pilot a surgical ambulatory care, i.e Emergency Ambulatory Care Service (ESACS). Using ambulatory care as an alternative to admission shows significant benefit in taking the pressure away from AAU and base wards within the hospital. The service cost will be £350,000.

Governance (4)

Additional Investment (cont.)

Enhanced Out of Hours and In Hours Visiting Support

This service will enhance both out of hours medical capacity and in hours visiting volumes to enable patients to be actively treated and managed at home. This service will avoid both calls for emergency ambulances and A&E/AAU attendances. The cost of this service will be £350,000.

13 weeks additional Homecare Capacity

This service is designed to provide additional targeted community based support seven days a week to expedite discharge from acute beds, and improve flow through the acute hospitals. The service will be available from September 2013 through to the end of March 2014 and will minimise the risk of potential re-admission to either acute or community beds throughout winter. The cost of the scheme is £86,000

Medical Outreach into Nursing and Residential Homes

The Outreach service will provide direct senior medical resource into both Nursing and Residential Homes over the winter period. It will work with homes to manage risk averse behaviour and prevent admissions to acute hospital beds and A&E attendances and reduce demand on emergency ambulance services. The cost of this service is £120,000

Pharmacy / Therapy Support at Weekends

Seven day extended Pharmacy and Therapy support at the hospital to enable timely discharge. The cost of this service is £300,000

Governance (5)

Stress testing the plans

- ❑ Plans have been tested in the following formats:
 - ❑ Business Continuity and Incident Management exercising program
 - ❑ Staffing Plan developed and used to plan for previous Bank Holidays this year, template model tried and tested with recommendations adopted in preparedness for the Christmas period 2013/14
 - ❑ Staff training program in place to ensure on call senior management are capable of managing internal and external emergency incidents. training is competency based and includes testing and exercising of candidates knowledge base. Training has multi agency input to facilitate network and improve understanding of partners roles and responsibilities.
 - ❑ Review of last winter's experience across the LHE resulted in an Escalation and System Management Group with our Health Partners to take forward and embed recommendations in advance of this winter. Whole system escalation plan tested and exercised, with changes incorporated before final sign off at beginning of October.

Governance (6)

Risk management

Key risks/challenges

- Risk of not receiving winter pressures funding
- Risk of additional winter capacity not available in the community
- Impact on capacity in acute and community sites, e.g. due to norovirus outbreak
- The Trust relies on other organisations providing normal levels of service during the Christmas and New Year period. If this does not happen, it will have a significant impact on the Trust
- Availability of temporary staffing workforce, in particular during the 2 week Christmas and New Year holiday period.
- Adverse weather risks causing disruption to public transport and preventing staff getting to work

The identified risks and challenges:

- Are reflected in the Board Assurance Framework – strategic risk relating to performance targets and external monitoring
- Each specific risk is recorded on the Trust's electronic risk register – datix. These are reviewed at Speciality and Divisional level and the risks rated 20 and above are escalated onto the Corporate Risk Register.

Partnership



Partnership

Partnership Working

- ❑ The UCB is responsible for ensuring that Winter Preparedness actions are achieved and any risks identified and outlined in good time across the wider partnership; working via the UCB and feeding into the SPG to which the UCB is accountable, all identified progress, slippage, newly identified risk and opportunity, flows.
- ❑ UCB meets monthly, is attended by GPs, Commissioning Managers, Patient – representatives, EEAST, HCT, HCC, clinicians working on key pathways associated with Winter related issues, and is chaired by a senior GP - Clinician who works to challenge assumption or slippage towards agreed targets. The Emergency and Urgent Care Turnaround Director also attends, with the brief to hold the UCB to account and to help bridge any gaps in delivery or agreed actions.
- ❑ SPG meets monthly and inter – meeting working groups are being established as a means of supporting speedy delivery of agreed action plans given the challenges represented by Winter. SPG is formed of the key (four) health economy partners - WHHT, HVCCG, HCT, HCC. Each of the health economy partners is responsible for assuring the delivery of actions taken away from the SPG – the Emergency and Urgent Care Turnaround Director is responsible for keeping SPG up to date with progress of the agreed Winter Project Plan and for supporting SPG members in their own individual and group based targets.
- ❑ An Integrated Discharge Team with a single point of access to community services and or beds has been developed between partners and will commence in October.
- ❑ Commitment to provide MDT clinical navigator service at the front of the hospital to facilitate early supportive discharge and admission avoidance.