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Review Lead: Deputy Chief Operating Officer

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Winter Plan 2019/20

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Ratifying Committee	
Board of Directors	

Consultation Committees		
Committee Name	**Committee Chair**	**Date**
A&E Delivery Board	Chief Officer, Calderdale CCG	September 2019

Does this document map to other Regulator requirements?	
Care Quality Commission	Outcomes 4B, 6D, 10E and 14A

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V1	Updated for Winter 2019/20
V2	Updated
V3	

Contents

1. Introduction

The winter plan describes the structure within which operational pressures during the winter period will be anticipated and managed. It provides the framework for managers and clinicians in the Trust to work together and with other organisations.

The winter period is normally defined as being from early November to late March with specific emphasis on the 'Critical Period' early December to the end of January. However, NHS England expectations of Trusts to implement improvements as described below do not and cannot be achieved if just focused on planning through the winter but must be the focus throughout the year. This has been a focus in CHFT where seasonal variation is less defined and the improvements implemented benefit patients therefore should be in place at all times, winter only additionality is focussed on management capacity to support patients and staff, testing of ideas and those interventions that are specifically prevalent in winter for example Flu. For winter only schemes these will remain in place until the end of April 2020 reflecting learning from the last 2 years.

A separate plan is being developed to manage the potential exit from the EU on 31st October; this will be closely monitored and changes to the winter plan may be required as a consequence.

2. Purpose

The objectives of the Plan are as follows:

- To support existing plans by increasing the operational focus on winter as an issue that challenges the resilience of the Trust.
- To provide a framework for the management of the winter response
- To provide a framework for the development of other plans
- To provide the basis for agreement and working with other partners & organisations
- To provide reference material for use in the Trust
- To set out the information systems to be used to manage the response.

NHS England has reiterated that trusts are expected to respond appropriately to the demands of winter through attention to the following areas:

- Reducing Delayed Transfer of Care
- Reducing variation in best practice (Improving patient flow and effective discharge planning)
- Demand and capacity planning
- Planning for Peaks in demand over weekends and Bank Holidays

3. Definitions

Import - the monthly report on take up of influenza vaccination in staff.

Organisational resilience - the ability to adapt and respond to disruptions to deliver organisationally-agreed critical activities.

Sitrep - a daily report to NHSE which highlights pressures in Trust's capacity. Sign off will be required by 11:00, Monday-Sunday from the beginning of November 2019 until the end of March 2020.

THIS will support the reporting of the Sitrep on a daily basis and the Deputy Chief Operating Officer or deputy will complete the sign off, a rota has been created.

4. Duties (roles and responsibilities)

Chief Operating Officer

- Reportable officer at Executive level for Winter Planning
- Will represent Trust on the A&E Delivery Board
- Chair of Urgent Care Board

Deputy Chief Operating Officer

- Chair the Winter Planning Group
- Represent the Trust on the Joint Surge and Escalation Teleconferences
- Compile a situation report for the Joint Surge and Escalation Teleconferences
- Cascade the situation report from the Joint Surge and Escalation Teleconferences / Update the winter planning group and divisional leads of the situation across the local healthcare system
- Respond to requests for assurance from the CCG and NHS England
- Benchmark and share good practice from partner organisations
- Ensure that winter plans are aligned with the Trust Emergency Management Arrangements and associated emergency plans
- Collate departmental plans for the Christmas and New Year period and ensure they are accessible to staff on-call and on-duty over the period
- Ensure that contingency plans that are in place for surge in emergency demand for inpatient capacity, severe winter weather and outbreaks of winter infectious diseases are appropriate and will deliver safe patient care and experience and organisational resilience.
- Ensure that the Trust Winter Plan aligns with those across the local health & social care system.
- Lead in partnership with the Deputy Chief Nurse and Clinical Director for Emergency Medicine CHFT's Winter Room

Divisional Directors

- Ensure each Division takes responsibility for securing sufficient capacity to meet out of hours demands on a daily basis
- Ensure collaboration across Divisions to ensure compliance with Patient First principles
- Ensure each Division has robust arrangements for escalation and any associate operational and tactical or Winter Room Meetings

Deputy Chief Nurse

- Lead in partnership the Winter Room

Divisional Director of Operations

- Ensure that appropriate plans are in place to manage an increase in activity through the winter period within the division
- Ensure that divisional plans are joined up across the organisation
- Ensure that contingency plans are in place for surge in emergency demand for inpatient capacity, severe winter weather and outbreaks of winter infectious diseases.
- Ensure that key staff groups are aware of the risks and response arrangements for winter

CHS, Clinical Site Commanders and Night Matrons

- Liaise with Local Council Highways departments to clear roads for urgent patient transport requirements
- Contact alternative transport providers if required

CHS

- Ensure that there is sufficient supplies of salt/grit for clearing car parks, pathways and roads on site and in community buildings where CHFT staff and patients are working/attending
- Liaise with contractors to arrange access to 4X4 vehicles for transport services if required
- Ensure that additional staff accommodation is available if required
- Cascade weather updates throughout the year including winter.

5. The Trust's Winter Strategy

The winter plan is based on the following strategic aims;

- To continue to provide high quality health and social care to the communities of Calderdale and Kirklees.
- To ensure that patients receive treatment in the most appropriate environment at the time most beneficial to their needs
- To work collaboratively with other health and social care providers to effectively manage capacity
- To assess risks to continued service provision and put plans in place to mitigate those risks
- To put in place a communications strategy that assists the public in gaining access to appropriate health and social care services.
- To ensure optimum occupancy and staffing levels over the winter period to minimise the risk of harm
- To ensure patients do not wait in any part of the system unless clinically appropriate
- To ensure learning from Winter 2018/19 is incorporated into 2019/20 Winter Plan.

6. Winter planning arrangements

The Trust Operational Lead for winter planning is the Deputy Chief Operating Officer in collaboration with the Divisional Senior Management Teams.

The local A&E Delivery Board has overall responsibility for ensuring that the health and social care service in Calderdale and Huddersfield is adequately prepared to manage an expected increase in activity and acuity over the winter period. The CHFT Winter Planning Group reports to the A&E Delivery Board and, in addition to internal escalation arrangements, is responsible for ensuring that the Trust has plans in place for severe winter weather, seasonal infectious disease outbreaks and Christmas and New Year bank holidays.

The Trust's internal Urgent Care Board with membership of all Clinical Director's, has contributed to planning by developing new innovative schemes providing increased resilience and clinical effectiveness for urgent and emergency care with the majority of developments commencing prior to the winter period but will be recurrent. All innovations are being monitored against clear aims and KPIs specific to the scheme. There is an overall aim of improving patient safety through early assessment, diagnosis and treatment as well as an improved patient and staff experience.

Recurrent Innovation Schemes			
Work Stream	Project Number	Description	KPIs
Enhanced Frailty Service To introduce a frailty on stop community clinic	1	The project is to open an ambulatory/admission area for Frailty patients To provide an environment/clinic that has an MDT approach for patients who are deemed frail in community to ensure they can be maintained in their own home.	• Reduction in admissions • Reduction in readmissions • Reduce LOS • Reduced occupancy levels • Increased discharge to usual place of residence
Enhanced Paediatric Admission Avoidance	2	To increase paediatric consultant cover in ED at CRH over 5/7 To provide a GP rapid access assessment/ambulatory clinic	• Reduce admissions • Reduce ED attendance for paediatrics • Improved patient experience
Stroke - Early Supported Discharge (ESD)	3	To increase capacity within the stroke ESD to enable an enhanced rehabilitation offer on discharge to patients who have had a stroke and to enable more patients on the ESD case load	• Reduce LOS for stroke patients • Improved patient outcomes
Expansion of Surgical Ambulatory Care	4	To provide dedicated nurse coordination on SAU	• To improve the patient experience • To prevent delays in the ambulatory pathway
Proactive Care for	5	To provide a dedicated elderly care senior medic to	• Reduced LLOS for

Older People (Surgical)		enable assessments for frail/elderly patients within surgery, to prevent complications and improve discharge	elderly/frail patients in surgical division • Reduce readmissions for this cohort of patients
Advance Care Planning	6	To improve the number of patients who have an advanced care plan at the end of life	• Increased number of patients with an advanced care plan • Increased number of patients who die in their preferred location • Improved completion of DNACPR forms
Acute Kidney Injury Nurse	7	To recruit a dedicated nurse to support patients with an AKI	• Reduction of LOS for patients with an AKI • Reduce readmissions
Acute Physician in ED	8	To provide an acute physician dedicated into ED to prevent avoidable admissions	• Reduce admissions • Improve patients experience
Pharmacy Prescribers- enhanced service	9	To provide pharmacy prescribers to prevent delayed discharge and risks associated with medications errors on discharge.	• Reduce delays due to TTOs not being prescribed timely. • Reduction in medication incidents/errors on discharge
Radiology Coordinators	10	To improve links with radiology, attend patient flow meetings, visit key areas e.g. ambulatory, ED, MAU, SAU as needed to help manage demand and improve flow and prevent delays for diagnostics. To pick up clinical calls/ queries and direct to the most appropriate person e.g. ensuring requesting clinicians (e.g. ED) access a radiologist quickly. They will also prevent unnecessary interruptions to radiologists during reporting sessions	• Improved access to diagnostics • Improved staff experience
DeepClean/HPV programme	11	To ensure all prioritised inpatients wards are fully deep cleaned and have HPV applied	• Reduce incidents of C Difficile • Reduction in closed wards due to IPC issues

Non-Recurrent Innovation Schemes			
Work Stream	Project Number	Description	KPIs
Home First Team	11	Develop senior nurse team to focus on patients with a LOS of 7 days and support ward staff to improve the discharge planning.	• Reduce the number of patients with a LOS over 7 days. • Reduce the number of incidents due to poor discharge planning
Point of care testing for Flu	12	Facilitate early diagnosis of patients presenting with flu like symptoms and ensure appropriate isolation	• Decreased number of patients with flu in open wards. Datix reduction • Available side room capacity
Point of care testing for Norovirus	13	Facilitate early diagnosis of patients and ensure appropriate isolation	• Decrease number of IPC related ward closures • Availability of side rooms

Pilot Innovation Schemes			
Work Stream	Project Number	Description	KPIs
Emergency Department Senior Nurse Triage & Steaming	12	To recruit senior nursing staff and develop an enhanced senior triage and streaming services. This scheme links to the Integrated Care System transformation scheme as agreed through the AEDB that will test the benefit of an Urgent Care Hub at both HRI & CRH working with Community Pharmacy, social care, the voluntary sector, GPs and Mental Health to refer patients from triage to other services more appropriate to their needs	• To reduce ED attendances • Reduces time to first assessment for patients presenting to Majors area • To prevent unnecessary delays for patients to be seen by the most appropriate service. • Reduce admissions • Improve patients experience

7. Command, control and co-ordination

During the period 1 November – 29 February, a daily SitRep (Mon-Fri) will be completed for submitting to NHS England by the Health Informatics Service. The Monday SitRep will include details from the preceding weekend. SitReps will be signed off by the Deputy Chief Operating Officer/Director of Operations/Deputy Chief Nurse after high level validation with fully validated data submitted daily. Arrangements have been confirmed to ensure that there is adequate cover in case of absence.

A **Winter Room** will be introduced from the beginning of December, led by the Deputy Chief Operating Officer, Deputy Chief Nurse and Clinical Director of Emergency Medicine. This will be a more robust coordination of the command and control of the operational sites, escalation and actions needed to provide assurance of increased resilience during surge and escalation.

8. The National Escalation Framework

4 Hour Emergency Care Standard Performance is one measure of a whole health and social care system experiencing pressure, but it is not the only one. An Emergency Department (ED) could be experiencing isolated difficulties but the rest of the system is coping well for example there are sufficient beds available and there is good flow through the system. Alternatively, an ED could be managing well whilst the rest of the hospital, and the wider system, community beds, community services and social care are experiencing high pressures due to a lack of capacity.

Escalation Triggers at Each Level

Local A&E Delivery Boards have aligned their existing systems to the escalation triggers and terminology used below, and adds to the triggers listed as appropriate. The escalation criteria detailed over the following pages are not an exhaustive list of triggers, nor do they constitute a rigid system where criteria must be met sequentially for escalation to take place. **Not all parts of the system need to meet all triggers in order to escalate – escalation can be service specific if agreed locally.**

Local A&E Delivery Boards are able to demonstrate that appropriate triggers have been met to warrant escalation. NHS England and NHS Improvement sub-regional and regional teams will also use the framework to moderate and challenge in discussions with local systems.

National terminology (OPEL) has now been adopted and has been used within the Trust throughout 2018.

To ascertain the OPEL status of acute hospitals within Yorkshire, YAS contacts each acute trust. CHFT's Clinical Site Commanders will be contacted by Yorkshire Ambulance Service twice daily either by phone or email firstly at 09:00 each morning and secondly in the afternoon for the new national escalation level (OPEL) status for inpatient capacity and any associated comments noted by hospitals on the Daily Bed Alert Status Report.

Operational Pressures Escalation Levels	
OPEL 1	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2	The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL 3	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms
OPEL 4	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I 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. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.

Figure 1

OPEL-Winter command and control arrangements (internal)

Operational Pressures Escalation Level (OPEL) 1 when operating within normal parameters. At OPEL 1 and 2, we would anticipate operations and escalation to be delegated to the relevant named individuals in each organisation across the A&E Delivery Board. At OPEL 3 and 4 however, it would be expected that there would be more executive level involvement across the A&E Delivery Board, as agreed locally.

A second assessment of capacity alerts will be made at 16:00 and the capacity status for each hospital again reported.

The three-hourly Patient Flow Hospital Meetings chaired by the Clinical Site Commanders involving the patient Flow Team and Divisional Managers of the day, Matrons and on call managers/Matron of the day will monitor activity on each site and determine operational actions using a standard operating procedure and escalation policy to manage capacity issues. The level (OPEL) at which the hospitals are working within will be determined at these meetings. The Deputy Chief Operating Officer will report direct into the partner organisations involved in the Joint Surge and Escalation Plan.

Each division and department is responsible for the successful implementation of their escalation plans. In the event that significant pressures are identified the Deputy Chief Operating Officer or the Divisional Directors of Operations will decide to implement the Trust Emergency Management Arrangements Strategic (Gold) and Tactical (Silver) and Operational (Bronze).

9. Workforce

Staffing levels

Agreed workforce plans and skill mix are in place for all inpatient areas and community services over the 7 day period. These will be used to assess the risk of reduced staffing due to absence and to assist in the redeployment of staff if necessary. Nurse rosters are signed off by Divisional Matrons to ensure robust cover an arrangement especially over the Xmas and New Year period and to ensure annual leave is managed appropriately over this period. Staffing gaps should be identified and mitigated by Divisional teams in hours, only last minute absences will be actioned by on-call, out of hours teams

For Xmas & New Year a further review will be completed weekly from the beginning of December with a final sign off and escalation of any risks with mitigation plans by the 2nd December 2018.

Vaccination

The target for Trust staff to have had the 'flu vaccine for this year for Calderdale and Huddersfield the ambition is to achieve 100%of frontline staff. The emphasis will be on staff in clinical and clinical support roles, but the vaccine will be available to all staff. The campaign this year has been well communicated and information on scheduled sessions, 'myth busting' and league tables of performance have been advertised on the intranet. Additional groups of staff have been trained to administer the vaccine so that it can be more accessible to staff and incentive schemes have been agreed. District nursing services in Calderdale provide flu vaccination to patients on their caseload as well as working with GPs to ensure that all vulnerable people are offered the vaccine. The Flu vaccine performance will be monitored weekly via Executive Board.

Personal Winter Plan/Engagement Plans

All members of staff have a personal responsibility to ensure that they are available for work and that they have alternative arrangements for carer responsibilities and journeys to work. All staff will be reminded of preparations they should make for winter – seasonal flu vaccination, checking public transport alternative routes, vehicle preparation as well as contingency plans. This will continue to be reinforced through the business continuity management system and staff communications strategy. In severe weather conditions staff in District nursing will report to their nearest team to their home not necessarily where they usually work. The Trust's attendance management, carer leave and adverse weather policies will be used to support staff and to maintain service levels.

10. Strengthened Operational Management

Daily support for patient flow from the Clinical Divisions is already in place, additional senior support is provided by the Director of Operations as point of escalation and will chair of the critical 12pm Patient Flow Meeting if OPEL 3 is triggered. From the beginning of January 2020 until the end of April 2020 there will be a twice weekly Winter Room introduced that will increase its frequency depending on OPEL to ensure any surge in activity above expected levels are acted upon immediately and provide additional assurance that good control and command is in place and learning is quickly acted upon.

From New Year to the end of April the on call manager will remain on site until 10pm each evening and there will be an additional support (buddy Manager) on site into the OOHs period.

If OPEL 3 is determined through the Winter Room or daily Patient Flow Meetings escalation will be sent out via a digital platform to Clinical colleagues to ensure greater awareness of the escalating position.

Urgent Care Action Cards and a revised surge and escalation plan will be relaunched in October to prevent exit block within ED, improve daily operational management in a more consistent way and prevent and any patient waiting on hospital corridors.

Lead Nurse-Patient Flow

Each hospital site will have increased presence of the lead nurses for Patient Flow through the winter period. They will ensure the patient flow meetings will be coordinated in a SMART way, are action focused and ensure the Urgent Care Actions Cards are being operationalised daily in collaboration with the divisional clinical and management teams.

Clinical Site Commander

The Clinical Site Commander will effectively manage the Trusts bed capacity, ensuring the patient's journey is safe and their experience is good. They will be the point of escalation if surge is being experienced.

Winter Transport Support Vehicles

Hold a register of registered and appropriate volunteers that have access to 4x4 vehicles and who can provide assistance with transporting staff to work and home during times when roads are impassable due to adverse weather conditions.

Divisional Operational Winter Teams

There will be a Divisional manager and Matron who will be the leads for winter to support the patient's journey, ensuring safe effective admissions, transfers and discharge. They will attend the Winter Room Meetings

“On call/site manager of the day” & Support Manager

There is an on call manager designated on site daily and an additional support (buddy) manager working on the opposite acute site.

Duty Matron

There will be a duty matron on site daily.

Reducing Admissions

Ambulatory Care in medicine and Medical Admission avoidance will be available on each hospital site to prevent avoidable medical admissions. Surgical Ambulatory will be available on the HRI site with dedicated additional surgical registrars on specific days over the x-mas and New Year period.

Reducing Delayed Discharges

SAFER Patient Flow Transformational Programme is supporting initiatives throughout 2019/20 to improve flow, prevent avoidable admissions, reduce LOS and improve timely discharges.

The weekly Long Length of Stay (LLOS) meetings will continue on both sites and feed into the winter room to determine delays and facilitate discharge. The LLOS team will continue to consist of senior members of CHFT. Liaising with partner’s organisations as required. The aim is to reduce the number of patients who are medically fit for discharge remaining in hospital, support the reduction in those patients with the longest length of stay and manage those complex discharge pathways. They will also look at reducing diagnostic and pathway delays for in patients by supporting teams with appropriate challenges to medical teams

Pharmacy

Pharmacy staff will work with medical and nursing staff to prioritise supply of medicines for discharge.

Wards should identify patients due for discharge on all ward areas as soon as possible, and e-discharge should be sent to pharmacy in a timely manner so that these can be processed quickly. Where possible, discharge prescriptions for patients who have monitored dosage systems (MDS) should be sent to pharmacy the day before discharge.

Pharmacy and nursing staff should identify patients who already have sufficient supplies of medicines at home before a request is made for a supply for discharge, which will enable pharmacy to dispense items which are genuinely required more quickly.

Enhanced weekend pharmacy service November-March to provide additional staff to manage dispensing workload and timely supply of medicines for discharge. To include a limited clinical service and availability of pharmacist prescriber on the Acute Medical Unit at CRH and MAU/short stay at HRI.

Pharmacy Prescribers will provide an enhanced service over weekends.

11. Divisional Winter Plans

CHFT's Divisional teams have prepared their winter plans through analysing their expected demand, tracking assumptions against their business plans and understanding the impact transformational work is having.

Medical Divisional Plans

The Medical Division completed the new medical staffing rotas for consultants in 2018 but these will be further enhanced with the introduction of a respiratory consultant rota 7/7. These rotas provide more specialist weekend reviews. All wards will have a daily ward round. The Medical Division has developed specific plans to provide flexible escalation capacity to meet the expected increased demand on inpatient capacity however further innovation schemes are being developed to mitigate the risk of fluctuations and risks associated with escalation capacity. With the improvements seen in reducing the longest lengths of stay within the hospital these plans will be operationalised **only** if a surge in activity described in figure 1 impact on operational performance and patient safety.

The division will stand down several meetings within the month of January 2020, to support operational resilience and response. Annual leave has been monitored and planned through an annual leave planning meeting to ensure that cover is appropriate throughout the winter months.

Many of the innovation schemes that have been planned support the division to be able to deliver good quality safe care throughout the winter months.

The division will hold an 11.30am huddle every day to look at any delays in discharge and areas of concern, present at these meetings will be GMs, Matrons and the ADN.

Acute Medical Care

Hot clinics:

Diabetes & Endocrine: 7 day service now in place reducing admissions and length of stay for diabetic patients.

Acute Medical Unit/General Medicine*:* This will be delivered from the Ambulatory Assessment Unit (AAU) on a daily basis by the Acute Medical team. AAU will be extended to provide ambulatory care until 10pm daily on each hospital site Monday to Friday. The referrals from ED will go through a designated acute consultant Monday-Friday 1-5pm. GP referrals will continue in the usual way.

An acute medical floor is now in place on the HRI site with a collocated frailty/short stay ward.

Care of the Elderly: This will be delivered by the Care of the Elderly team who work on a speciality rota covering the service 7 days a week.

There will be a significant expansion of frailty services across the Huddersfield Royal Infirmary site as part of the innovation schemes with in-reach to CRH and links to community. GP referrals for frailty will commence in December 2019, these patients will be referred via telephone with advice or asked to come to ambulatory for assessment.

Escalation Capacity - HRI

A dedicated winter escalation ward on the HRI will be open from January until the end of April 2020 with a workforce in place and a robust MDT approach including community colleagues.

Flexible Escalation Capacity
This will be based at CRH allowing the effective management of surges in demand and avoiding the use of ambulatory capacity which historically has impacted on the effectiveness of same day emergency care.

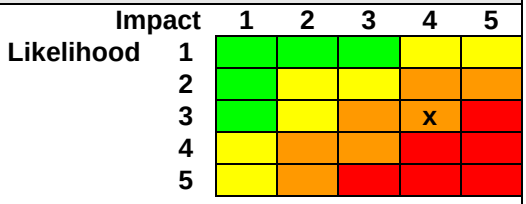
Division	Escalation Capacity	Trigger & Action	Lead
Medicine	8 escalation beds are planned flexibly, using additional beds on 6B	Triggered through the Winter Room Meetings using demand management data/daily predicted discharges after all other admission avoidance has been exhausted. **Risk assessments must be completed.** Daily tracking will be in place and Senior Divisional Team will monitor winter demand. A robust nurse staffing plan will be developed and signed off by the Associate Director for Nursing for medicine. Plan to flex these beds as required (overnight).	Winter Room -Divisional Manager/Matron/Clinical Site Commander. Director of Operations Associate Directors of Nursing

Emergency Department

The Emergency Department (ED) will have:

- Surge triggers developed for ED Consultants have been implemented to extend the working hours of the consultant until midnight
- Additional assessment capacity was created, adjacent to the ED to ensure **all** ambulance and ambulatory majors' patients even at times of surge are seen within 15 minutes.
- Front end senior nurse triage to sign post and stream to alternate appropriate services will commence in October 2019.
- Daily representation at Patient Flow Meetings with consultant attendance at critical pressure points. Actions fed back to the department and two-way communication in place
- Robust internal Escalation Plans are in place to manage surges in demand and ensure there is a zero tolerance to 12 hour trolley waits
- Daily huddle held with coordinators from ED. MAU/AMU, SAU and the clinical commanders to discuss 'what went well' the day before, with the ethos of 'working together to get results', this is a more coordinated, collective, supportive approach.
- Planned increased medical staffing over the X-mas and New Year period as mitigation against the expected increase in demand especially over the out of hours period is being developed.
- The Senior Lead Nurse B7 for each department is supernumerary
- The Frailty Team works closely with the ED team to ensure all opportunities to support avoidable admissions are taken.

Surge in Non-Elective Demand

Overview		
Impact		
• Unpredicted increase activity in EDs, SAUs and MAUs- follow triggers described in the EDs escalation plan • Increase in bed occupancy across the Trust • Increased pressure on community healthcare services to support discharges above predicted • Potential of the need to outlie patients into another speciality. • Greater potential for inpatient outbreaks of infection and outbreaks in nursing homes preventing discharges		
Proactive strategy- Actioned by the Director of Operations		
• Identify flexible beds that can be opened in the short term to support increased admissions and staffing requirements • Trigger escalation- OPEL		
Reactive strategy		
• Use of winter strategy & plan- Winter Room in place • Implement the joint surge and escalation plan- Strategic and Tactical and operational • Activate business continuity plans and escalation plans • Increase inpatient capacity by opening flexible beds as described in divisional plans		
Trigger	**Received by**	**Immediate action**
ED reporting of increased activity	Emergency department matron/manager	• Reallocate junior medical/nursing staff to support the Emergency Department • Establish additional trauma lists as required • Review the availability of trauma surgery equipment • Move from elective beds to trauma as demand dictates • Use of flexible capacity- short term • Surge & Escalation plan actions to be followed • Monitor impact via Winter Room • Review actions and impact from the twice weekly MADE
YAS reporting of increased activity	Emergency department. Patient flow team	
Low temperatures Met Office - proactive	Emergency Planning Officer	• Prepare for increased attendance by patients in the at-risk groups
Community nursing workload	General Manager – Adult Community Nursing	• Review community case load to prioritise at risk patients • Trigger business continuity plans
Assess bed capacity issues in line with regional plan	Director Of Operations	• Implement the escalation policy. • Implement joint partner surge & escalation plan • If required initiate System Tactical Call.
Requirement to expedite discharge	Clinical Site Commander Discharge Matron/Discharge Team.	• Liaise with YAS to agree priority order for patient movement. • Initiate spot purchasing agreements via LAs • Start discharges with medicines to follow. (Use of taxis of transportation of medicines post discharge.) • Use of day rooms and discharge lounges to facilitate expedite discharge. • Discharge thresholds to be challenged.

Surgical Divisional Plans

The Surgical Division has developed plans to be able to respond to increased non-elective demand, planning to reduce routine non orthopaedic elective inpatient activity in Q4, Day Case surgery will be conducted on both sites; Cancer surgery, Clinically Urgent and time critical cases will continue.

- With the elective plan now being delivered over a 9 month period certain staff groups may be able to be released through quarter 4. This will enable Anaesthetists to provide additional support to patients in the resuscitation area in ED, theatre nurses may also be able to support other ward and departments if they are not required to work in theatre areas
- In addition to current planned trauma lists, additional increases in demand will be delivered by following the Trauma Surge Pathway (Appendix 6)
- Additional trauma theatre capacity will be established before and after the Bank Holidays
- Trauma list provision will continue, as normal on the Bank Holiday days
- Current medical workforce on SAU will be increased with an additional middle grade to minimise impact on patient flow. The innovation scheme for SAU will provide dedicated nurse coordination, both of these addition will improve timely pathway management and an improved patients experience,
- Improved access to theatre will reduce pre-op bed days and overall LOS for some Minor/intermediate and complex trauma. Performance will continue be monitored regarding delays to theatre
- Increased Frailty team input with the innovation of a POP service and extended hours to provide support on the SAU to support/expedite discharge and reduce unnecessary complications for complex elderly patients.

Elective Orthopaedic activity

The Surgical Division will continue to deliver elective inpatient orthopaedic surgery as planned through the winter period reflecting the ring fenced bed capacity to manage infection risks.

From January the Surgical Division will introduce additional Laparoscopy Cholecystectomy lists when an Upper GI Surgeon is on CEPOD week. This will improve the scheduling of acute/emergency patients with cholecystitis based on clinical urgency, over and above the CEPOD list. This will improve length of stay for these patients, prevent readmission and improve patient experience.
The Division have continued to progressively moved more work to day-case this year, thereby further reducing the risk of elective cancellations.

The General Surgery rota ensures 24hr Consultant led emergency care and with investment into the surgical assessment unit will improve flow and Same Day Emergency Care.

Family & Specialist Services

Paediatrics

- During the winter period the Matron for the service continues to undertake a daily situation report and will risk assess situations regarding staffing and activity on the Paediatric ward, to support and underpin this there is an Escalation Plan in place (Appendix 2)
- Continued support to the paediatric stream in the Emergency Departments (ED) with Paediatric Nurse Practitioners during surge in both EDs and planned at Huddersfield Royal Infirmary (Appendix 3)
- The Paediatric ward operates on a workforce model that accounts for surge during the winter period which strengthens nurse staffing and leadership during the winter period with the plan to have a senior Nurse Band 6 and 7 working clinically across all shifts
- From a medical prospective the following actions will be taken between Nov and Feb to support winter pressures:
    a. The Consultant scheduled for Ward 18 HRI will cover in the morning and will if appropriate to undertake a virtual round of ward 18 patients by phone utilising EPR this will ensure they are available to help on the ward round on the Ward 3 CRH – to improve flow and timely discharge at times of peak activity.
    b. For the winter period to relocate safeguarding medicals back to CRH outpatients. To ensure that if the consultant has no scheduled medicals, they will be on site and can be deployed to support flow on the Children's Ward.
    c. To consider utilising APNPs and ANNPs to support gaps on the medical rotas, especially twilights and nights.
    d. To utilise the winter locum consultant additional PA to cover twilight shifts which is peak time for patients attending ED and the assessment unit.

Maternity

- Escalation Plan (Appendix 4)

Diagnostics

- There will be daily attendance in the Patient Flow meetings of Operational management from FSS to support flow, support prioritisation of diagnostics during increased demand. An innovation scheme supporting a new way of daily coordination is being introduced through winter to prevent delayed and improve clinician access to radiologists.

Radiology

- There will be a central contact point for in-hours escalation of specific issues – contact details will be made available to flow teams in advance of the winter period

- A second on-call system for the Emergency Department X-ray will enable extra capacity OOH during periods of exceptional demand throughout the winter period (November to March); triggers will be agreed with the ED team.

Gynaecology

During the winter period the activity theatre plan has been planned to ensure the surge in medical winter emergency activity is supported.

In addition prior to transferring to ward 4C the patient must be assessed against essential criteria as outlined below (Appendix4).

Community Division

Central Operations (COT)

Lead Nurses for the COT will provide cross-site cover into the Patient Flow Team over the Christmas and New Year period.

Discharge Team

- A daily huddle will be introduced to focus resource of the team when triggers on any specific pending delays occur this must be without reducing the robust management of the complex discharges.
- Working hours will be reviewed daily as part of the huddle and extended as required. Staff will work flexibly to support the service
- Case reviews of all patients daily with a manager of the discharge team

Home First Team

- Daily review of where the pressure points are each site and by ward area
- Stringent review and follow up of outliers to ensure plans in place and are followed
- Identification of where clinical pathways are unclear or delayed for some reason or where there is no clear discharge plan.
- To suggest where possible, Criteria Led Discharge and follow through these plans to support ward areas.

Discharge Planning

- Implement the 8 High Impact Changes to improving Patient flow and discharge
- Twice weekly MADE Room triggering into daily if required with Director level attendance from partner organisations at this point
- Senior review team led by an Associate Director or above, to carry out the long stay reviews on the wards and enable decision making and support planning discharges. Focus will be patients with a LOS of 7 days

- To escalate where needed any gaps in community or social support eg Packages of care or reablement

Patient Flow Team

- There will a Digital Operations centre developed on each acute hospital site to be the hub for all Patient Flow Meetings and as required for escalation meetings using learning from EPR go live
- The Winter Room will be in place twice weekly with cross Divisional colleagues chaired by the Deputy Chief Operating Officer/Deputy Chief Nurse/Clinical Director of Emergency Medicine, share information on divisional issues/risks affecting patients flowing through the hospital in a safe and effective way. To then agree solutions and implement supplemental actions to address these
- An additional transport service will continue to be available managed through the Clinical Site Commanders to support discharge and inter-hospital transfers
- Increased task management will be in place 'in hours' through quarter 4.

CHFT Community Healthcare Division staff accesses on-call support via the Trust on-call rota.

Priority 1 Clinical Services

The following services have been deemed as **Priority 1 Clinical Services:**

- District Nursing priority one patients(complex wound care, blocked catheters, administration of medications, OPAT and palliative care)
- Administration of medications including IV therapy and syringe drivers
- Support for discharge out of hospital
- Palliative Care
- Crisis Response Team
- Intermediate Care bed base
- IV Therapy priority one patients
- Palliative care priority one patients
- Gateway to Care
- Quest Matron support to Care Homes
- Community Respiratory Service
- Community Heart Failure Service
- Home Enternal Feeding
- Community Matrons
- Community Rehabilitation Team

Community Services Available

Gateway to Care

The service supports the co-ordination of intermediate care services and prevention of hospital admissions. The service accepts patient referrals from GPs, community clinicians, Social Workers and patients.

Referral should be made to Gateway to Care for the following services:

- Crisis Response Team
- Community Rehabilitation Team including Stroke early Supported Discharge Team, Falls Prevention Team
- Intermediate Care Beds
- Heatherstones

Hours of Operation	8.45am-5.30pm Monday to Thursday and 8.45am-5.00pm Friday
Contact Details	01422 393000

Intermediate Care

The intermediate care service is delivered by an integrated partnership of health and independent care home provider, ensuring a multi-disciplinary approach to care. Care is provided in one of our bed bases i.e:

Brackenbed View (32 beds) and Heatherstones (12 apartments)

The Service Aims to:

- Promote a faster recovery from illness
- Prevent unnecessary presentation and admission to an acute hospital bed
- Prevent premature and unnecessary admission to long term care
- Maintain independence as long as possible

Service Criteria:

- Service user/patient must be over 18 years of age
- Medically stable
- A resident of Calderdale or Registered with a Calderdale GP
- Consent to rehabilitation

Hours of Operation	24 hours a day, 7 days a week
Referrals Accepted	Via Gateway to Care (in-hours) and via Crisis Intervention Team (weekends)
Lead Manager	Donna Wood
Contact Details	07810290657 (for IMC Beds)

Heatherstones provides temporary accommodation for adults for up to 6 weeks and facilitates early discharge, or prevents the need for admission to hospital, residential or respite care. The service is most appropriate for people who want to live

independently but need short-term alternative accommodation or short-term help and support to achieve this.

The service aims to reduce individuals' dependency and reliance on direct services and prevent their level of need from increasing with people returning to their own home with the confidence and level of care required to enable them to cope long-term. Residents are expected to cook their own meals and do their own shopping and laundry. Reablement assistants provide support where needed.

Hours of Operation	Monday to Sunday 8.00am – 9.45pm 7 day service
Lead Manager	June Warman
Contact Details	01422 392229

Reablement

The Reablement service provides therapeutic care and support; with therapy care plans provided by CHFT community therapy team and then delivered by social care reablement staff. Access to reablement is via Gateway to Care following an assessment by a social worker.

Reablement is offered for up to 4 visits a day for a period of 6 weeks with the aim to increase function and reduce dependence. If care is required following a period of reablement, a care package will be commissioned and a means test assessment will be undertaken to determine what financial contribution will be required by the individual.

Hours of Operation	8.00am-9.00pm, 7 day service
Lead Manager	Tracey Proctor
Contact Details	07748 797896

Reablement Team	Allocator	Contact number
Lower Valley	Julia Green	01484 728943
Upper Valley	Karen Willows	01422 264640
Central	Jo-Anne Rice	01422 383584

Enhanced Reablement

The Enhanced Reablement service provides early supported discharge for patients requiring a period of rehabilitation supported by therapists but who could manage in their own home. Reablement is offered for up to 4 visits a day for up to a period of 6 weeks with the aim to increase function and reduce dependence. If care is required following a period of reablement, a care package will be commissioned and a means test assessment will be undertaken to determine what financial contribution will be required by the individual.

Hours of Operation	8am – 4pm
Lead Manager	Clare Folan
Contact Details	07879447218

Crisis Response Team

Crisis Response Team will provide support to someone in crisis in their own home for up to 72 hours. For example if someone is struggling in their own home after a fall, or discharge from hospital where packages of care cannot start immediately. They also assess suitability for intermediate care beds. They are a responsive service and will assess within 2 hours for urgent referrals and 24-48 hours for routine referrals.

The team consists of nurses and a physiotherapist who undertakes assessments and set care plans. Rehabilitation assistants in the team offer up to 4 visits a day for a period of 72 hours with the aim to increase function and reduce dependence. If further reablement is required after 72 hours, the locality reablement teams continue the care.

Hours of Operation Assessors	8.00am–7.00pm 7 days a week
Reablement Service Work	8.00am-9.00pm 7 days a week
Lead Nurse	Susan Johnson
Contact Details	01422 307333/07917 106263

End of Life Out-of-Hours Crisis Team

This is collaboration between Overgate Hospice, Marie Curie and CHFT. This small team provide crisis support to people out of hours who are near the end of their life. The Specialist Palliative Nurse supports the person with symptom control, physical and emotional support and works with a Marie Curie Support Worker. They provide support to the person, carers and families.

Hours of Operation	7 day service
Lead Nurse	Abbie Thompson
Contact Details (9am-5pm Mon-Fri)	01422 310874
Contact Details (Out-of-Hours)	07917 106263 Out-of-Hours Service/ 01422 379151

OPAT/ IV Therapy

This team provides antibiotic intravenous therapy to patients in their own homes. Patients remain under the care of their Physician or Consultant. This prevents some admissions and certainly reduces the LOS for many more.

- Patients have to be medically stable. Need to be under consultant referrals
- Commissioned for 12 administrations a day
- Compatible drugs need to be administered within 30 minutes

Hours of Operation	7 day/24 hour service
Lead Nurse	Jayne Woodhead
Contact Details	07795 825106

Community Nursing Services

District Nurses visit housebound patients that have complex health care needs. Patients that are able to be transported are expected to attend treatment rooms.

Hours of Operation	7 day/24 hour service
Contact Details Core Hours (8am-6pm)	07917 106263
Contact Details Evening/Night (6pm-8am)	07917 106263

Only **priority 1/urgent patients** are seen at night i.e. palliative care requiring symptom management, blocked catheters and patients requiring prescribed medication at agreed intervals.

Quest for Quality Service

CHFT has established a multi-disciplinary team consisting of community matrons, pharmacist, therapist and consultant geriatrician who caseload residents in all residential and nursing homes in Calderdale. This scheme's main role is to reduce the number of calls made to general practitioners to prevent avoidable admissions. They use Telecare and Tunstall Telehealth to promote health and wellbeing to the residents within the care homes.

The team have a responsive function to the care homes dealing with calls that would have been received by a GP and managing the residents. They also provide support to the care home staff to better manage their residents through training and education.

The pharmacist role has greatly helped with reviewing patient medication, reduction in poly-pharmacy and education and training of care home staff.

Hours of Operation	9am-6pm, 7 days a week
Lead	Liz Morley
Contact Details	07917 086450

Community Matron Service

Community Matrons provide a service to people with Long Term Conditions (LTC) who have complex health and social care needs which without effective case management are likely to result in the individual having repeated and avoidable hospital admissions and increased lengths of stay in hospital and frequent contact with primary care services.

They are based in localities with District Nursing Teams.

Hours of Operation	8.30am-4.30pm, Mon-Fri
Lead	Caroline Lane

Locality	Base	Matron	Contact Details
Upper Valley	Todmorden Health Centre	Beverley Jessop Sarah Howden	07795 252396 07901 518171
Lower Valley	Church Lane Surgery Rastrick	Rachel Clegg/ Sheila Kalanovic Mandy Kazmieski	07795 801112 07795 825037 07795 825084
South Halifax	Stainland	Jenny Dyson	07795 825139
North Halifax	Beechwood	Julie Norris Victoria Smith	07770 734748 07584 522297
Halifax Central	Lister Lane	Sheryl McGinn/Louise Watson	07769 365247 07717 347547

Specialist Nursing

There are a range of specialist nursing services that support people in community settings.

Service Area	Hours of Operation	Lead Nurse	Contact Details
Bladder and Bowel	7.00am-4.30pm Mon-Fri	Sharon Holroyd	01422 252086
Respiratory	8.30am-4.30pm 7 days/Week	Sue Scriven	01422 307328
Heart Failure **Cardiac Rehab**	9.30am-5.30pm Mon-Fri 7.30am-4.30pm Mon-Fri	Ian Ormerod Clair Jones	07500 553892 01422 224260/ 07713 739144
Parkinson's	9.00am-5.00pm Mon-Fri	Paula Roberts	01484 712515
TB	9.00am-5.00pm Mon-Fri	Mary Hardcastle Dale Richardson	07824 343770 07795 825070 01422 307307
Lymphoedema	9.00am-5.00pm Mon-Fri	Sarah Wilson	01422 350755

Respiratory Team

During the winter period the Respiratory team will increase their working hours until 8pm and double capacity at the weekend to have two members of staff instead of one. This will enable the team to provide further focus upon key services offered to reduce pressures on the hospital:

- ESD – facilitating patients going home as soon as possible with support from the respiratory team 7 days a week
- Admission avoidance from ED 7 days a week, 9am-8pm
- Crisis management for community patients via the SPA. Direct telephone access for patients 7 days a week
- Admission avoidance from the community 7 days a week

Hours of Operation	8.30am-4.30pm 7 days a week
Lead Nurse	Sue Scriven
Contact Details	01422 835195

Cardiac Rehabilitation Services

There will be increased capacity which will support extended working hours Monday – Thursday supporting the Cath Lab. This will allow the team to facilitate earlier discharges. When the Cath Lab sessions are scheduled for Saturdays this will be mirrored by the team facilitating patient flow. In focusing upon facilitating earlier discharges this would also allow the team to offer Cardiac rehab at the weekend which could reduce readmissions.

Early Supported Discharge for Stroke

This team provides support to enable patients who have had a stroke to be supported at home to reduce length of stay and increase function by facilitating people to be as active as possible. An enhanced service will be in place from November as part of the innovation scheme plans.

Hours of Operation	8.30am-5.00pm Mon-Fri
Lead Therapist	Sally Grose
Contact Details	01422 358146

Therapy Services

Therapy services provide interventions across in-patient, intermediate care and Community Services and will work flexibly across all areas to provide support where pressures manifest during the winter period.

Lead Manager	Debbie Wolfe 07825902363

Community Falls Service

The Falls Prevention Team is part of the Support and Independence Team who assess and advise people over the age of 50 who have had a fall or who are worried about their balance and frightened of falling. The team raise public awareness of falls and how to prevent them, identify older people who are at risk of falling using a simple five question screening tool, undertake detailed falls risk screening and refer patients to appropriate services to help, manage the risk of falling, provide education and advice to older people including advice on physical activity, diet, footwear and environmental hazards. The team provide strength and balance groups in local settings and /or tailored exercises in older people's homes.

Hours of Operation	8.30am-5.00pm, 5 day service
Lead Therapist	Claire Folan
Contact Details	07879 447218

Senior Managers in Community Healthcare Division

Senior Managers on-call rota, contact Calderdale Royal Switchboard on **01422 357171.**

Senior manager contact details are as follows:

Name	Role	Work mobile
Bev Walker	Director of Operations	07766905553
Andrea Dauris	Associate Director of Nursing	07920251715
Michael Folan	Head of Therapy Professions	
Nicola Ventress	Assistant Director of Finance/ Deputy Director of Operations	07765 306617
Liz Morley	Head Nurse	07747 630989
Debbie Wolfe	Head of Therapies and Service Manager for OP Physio, MSK, Podiatry, Orthotics, Speech and Language Therapy, Dietetics Children's Therapies	07825 902363
Caroline Lane	Matron for Community Nursing	07713739144
Mandy Gibbons-Phelan	Matron for Specialist Nursing	07795 825137
Caroline Smith	General Manager- Therapies	07741004547

Transportation and 4X4 Vehicles in Severe Weather

Roads that are impassable to cars due to ice or heavy snow are sometimes accessible to four-wheel-drive vehicles. The Estates Department have access to a 4X4 vehicle. The Hospital Transport Service can also arrange to hire 4X4 vehicles through their vehicle contractor, Arrow.

The following voluntary organisations in Yorkshire and the Humber have access to 4X4 vehicles:

- St John's Ambulance
- British Red Cross
- Yorkshire 4X4 club (4X4 Response)
- Age UK

It is essential that community nursing teams are able to travel to visit service users in their homes. The adult community nursing team managers maintain a list of staff with 4X4 vehicles and ensure that the nursing teams have access to 4X4 vehicles in instances of severe winter weather.

The adult community nursing teams also work closely with Calderdale Council Adult Social Care to make best use of resources.

Equipment Ordering and Provision

Patients in the community may require equipment to keep them safe, assist daily living skills and improve mobility/function in their own home.

Physiotherapists, Occupational Therapists, Nursing Teams and the Crisis Intervention Team are regular referrers to access equipment. Equipment is arranged via the Loan Stores for Calderdale Royal Hospital patients based at the Community Support Centre, Salterhebble.

Loan Stores Hours of Operation	8.00am-4.30pm Monday-Friday 8.00am-12.00pm Saturday
Lead Manager	Andrew Mould
Contact Details	01422 306725

Escalation plans and business continuity plans

There are escalation plans that have been developed to support operations across all divisions. All escalation plans are found on the intranet, the ED and Paediatric escalation plan will be included in the On Call Manager's Pack.

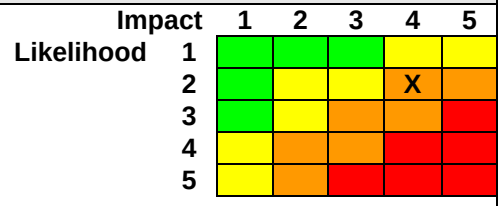
Each clinical division has identified the critical patient services they provide. Directorates have undertaken business impact analysis to identify what service functions can be reduced or suspended and have developed business continuity plans that describe the process for reducing non-critical activity and using the capacity generated to sustain critical patient services.

Cancer Pathway and Elective Pathway

The cancer agenda and targets will be maintained throughout winter. Elective surgery and cancer have rarely been cancelled due to bed pressures previously and this will continue to be the standard we adhere too. Attendance at MDT's and performance will be maintained over Christmas time and throughout winter. This will be managed by authorisation/monitoring of the number of Consultants that are off at any one time over this period.

12. Severe Winter Weather

Overview			
Business Impact			
• Absence of staff because they cannot get to work • Difficulty for staff and patients to travel around and between sites • Difficulty for community staff to access patients homes • Increase in minor injuries from slips, trips and falls • Reduced patient transport service • Difficulty discharging patients because reduced public transport, patient transport or impassable roads to their homes or other healthcare facilities • Difficulty for suppliers to get supplies to hospital			
Proactive strategy			
• Adverse winter weather plan in place and reviewed. • Weather forecasts and gritting information published on the local authority websites. • Stockpile of salt/grit for car parks and access ways to Hospital sites. • Access roads to CRH and HRI are on Local Council Highways Priority Gritting Routes. • Yorkshire Ambulance Service winter plan. • Secure contingency 4x4 vehicles through voluntary services to transport staff to and from their place of work. • Community staff advised to work to nearest location to their homes			
Reactive strategy			
• Implement flexible working arrangements where possible (adult community nursing) • Implement the joint surge and escalation plan • Contact Local Council Highways to request roads are gritted for essential appointments and discharges (this will not always be possible). • Provide accommodation for essential staff who cannot get home from work • Request that the hospital transport service collect essential staff and bring them to work (this will not always be possible)			
Trigger	**Received by**	**Immediate action**	
Met Office Cold Weather Alert	Estates/Associate Director of Urgent Care	• Cold weather alerts will be forwarded to members of the winter (surge) planning group for onward circulation to departments. • Clinical Site Commanders will assess the consequences for discharges • The Calderdale & Huddersfield Solutions have a planned process for maintaining the Hospital grounds. • Review by the outpatients and surgical management teams of impact on performance.	
YAS PTS notification that journeys are affected or have been stopped	Clinical Site Commander		
Significant number of out-patient DNA	Outpatient manager		
Staff absence reporting	Department managers	• All members of staff should make an early assessment of travel plans during inclement weather. It is the responsibility of staff to exhaust every potential transport arrangement that will enable then to attend for duty. • Staff accommodation for inclement weather will be supported by the Trust as in previous years via the Accommodation Manager • All service areas will maintain up-to-date contact lists for all their staff • Managers will use the Trust's adverse weather policy and the carer leave policy to manage staff absence. • Staff will be reallocated according to service need.	



Cold Weather Alerts

Alert trigger	Trust Actions
OPEL 1 Winter Preparedness	• Work with partner agencies to co-ordinate cold weather plans • Work with partners and staff on risk reduction awareness • Plan for a winter surge in demand for services • Identify those at risk on your caseload
OPEL 2 Alert and readiness (60% risk of severe weather)	• Communicate public media messages • Communicate alerts to staff and make sure that they are aware of winter plans • Implement business continuity plans • Identify those most at risk • Check client's room temperature when visiting
OPEL 3 Severe Weather Action	• Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that staff can help and advise clients • Signpost clients to appropriate benefits • Maintain business continuity
OPEL 4 Emergency Response Exceptionally severe weather of threshold temperatures breached >6days	• Activate emergency management arrangements • Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that the hospital sites are kept clear and accessible • Maintain business continuity

Road Clearance

In the event of severe winter weather requiring roads to be cleared of snow and ice Kirklees Council will clear the pavement outside HRI to the boundary of the hospital site as part of its planned snow clearance operations. Acre Street and Occupation Road are on priority gritting routes. The access roads to CRH (Dryclough Lane, Godfrey Road, Dudwell Lane and Huddersfield Road) are all on priority gritting routes. Information on the priority gritting routes can be found at:

http://www2.kirklees.gov.uk/winterUpdates/default.aspx
http://www.calderdale.gov.uk/transport/highways/winter-service/index.html

There may be occasions in severe winter conditions where the hospital requires urgent deliveries such as medical gases and the site road access is impassable. In these situations the Local Councils may assist with road clearance where possible.

Kirklees Council will be operating "gritter twitter" this winter which gives real time information on the council's response to the winter forecast. This information can be used to plan journeys and has been used by schools to assess whether or not to

open. The link to twitter is can be found at the Kirklees Council weblink above. Calderdale Council regularly update their website with information about planned gritting routes during periods of severe weather.

Kirklees Council will do what is possible to help ambulances with gaining access to patients that require urgent treatment / transport to outpatient appointments and hospital discharges. Examples of urgent outpatient treatments include renal dialysis and administration of drugs for life threatening conditions. Any assistance will be on the basis that the hospital confirms that the situation is urgent. Kirklees Council Highways can be contacted 24hours a day on 0800 7318765. Any Trust patient phoning the council to ask for help will be directed to contact the relevant hospital department. The hospital department will inform the patient flow team who will be responsible for liaising with Kirklees Council Highways.

Calderdale Council Highways commit to responding to requests from the emergency services only but may be able to assist in the event of an urgent request from the Hospital to grit a particular highway. The Calderdale Council Highways can be contacted via the Street Care / Customer Care number 0845 2457000.

Managing absence

The Trust's Adverse Weather Policy will be followed at all times to ensure that there is consistency across the organisation in the event that severe winter weather causes staff to be later, absent or work excess hours.

In the event that essential staff have difficulty getting to work and there are no alternate travel options, including car sharing or public transport, it may be possible for the hospital transport team to collect staff from their homes. Where staff have difficulty getting home from work and there are no other options hospital provided transportation is also an option. It may also be possible to provide additional staff overnight accommodation. Requests for additional hospital transport services or accommodation should be made by a matron or general manager to the General Manager of Operations and Facilities.

The adult community nursing team work flexibly in winter. Healthcare workers visit patients closest to their home address and are able to work from an alternative location that is closer to their home address.

Useful contact information

Organisation	Contact Name	Telephone / Email
4X4 Response	24hr call out number	Available in patient flow office
British Red Cross		
Calderdale Council Highways		01422 288002
		OOH 01422 288000
Calderdale Council Emergency Planning Team		01422 393134

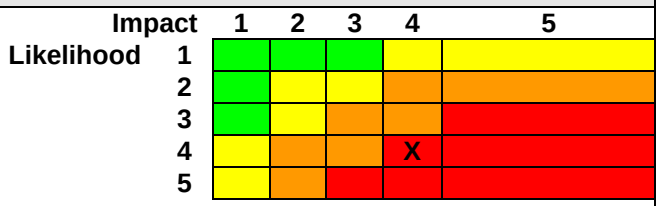
CHFT Accommodation		Via General Office
CHFT Hospital Transport Service		Via help desk
Kirklees Council Emergency Planning Team		01484 221000
Kirklees Council Highways		01484 414818
St John's Ambulance	24hr pager	Via switchboard

13. Seasonal influenza

Overview

Business Impact

- Absence of staff due to influenza illness
- Spread of the virus to staff due to ineffective use of personal protective equipment
- Lack of available supplies of personal protective equipment
- Increase costs of delivering care because of requirement of FFP3 masks and fit testing in some clinical areas
- Lack of available side rooms to isolate infectious patients
- Lack of available capacity on intensive care units to treat flu patients with serious illness
- Closure of ward areas and loss of bed days due to outbreaks of infection
- Increased monitoring and reporting requirements for flu-related activity



Proactive strategy

- Immunise staff for seasonal flu
- Community staff continue support people to stay at home
- Restate the risks and infection control requirements for managing flu patients
- Key messages reinforced by community staff
- Purchase additional supplies of face masks, gowns and goggles
- Create and manage a stockpile of FFP3 masks
- Fit test staff who may be required to use FFP3 face masks (medical, nursing and physiotherapy staff working in A&E, ICU, Respiratory and MAU)
- Near patient testing in A&E for patients with suspected seasonal flu

Reactive strategy

- Promote key flu messages for patients (if you've got flu, stay at home)
- Follow standard infection control precautions for managing flu patients
- Reassign or redeploy staff in high-risk groups as appropriate
- Implement the joint surge and escalation plan
- Implement the escalation plan for critical care if required

Trigger	Received by	Immediate action
DH reporting - proactive	DIPC	• Alert forwarded by email rule to Director of Operations, Chief Nurse, Director of Infection Prevention and Control. • Staff in the Emergency Departments and out patient departments will remind relevant patients to have their flu jabs if they have not already done so. • Implement management of flu arrangements.
Surge in flu related activity	ED matron/CD	
Surge in flu admissions	Infection control team	

Infection Control

There is an expected surge of patients with 'flu' in 2019/20. Guidance through public health and CHFT internal IPC team including the lead clinician will be managed through the Pan Flu Planning Group with all key partners within CHFT. A table top exercise will take place prior to winter to ensure the Pan Flu Plan is robust and any learning shared and acted upon prior to winter, all divisions will be represented. This will be above and beyond normal surge and escalation and the plan for this will be confirmed in due course.

There will be near patient testing provided in the Emergency Department (ED) for patients with suspected seasonal flu. Patients that require admission with suspected or confirmed influenza should be nursed in a side room with the door closed. A respiratory isolation sign should be displayed (further information on isolation of patients is available in the Isolation policy section K). All staff must wear personal protective clothing (PPE) when entering the side room. When performing aerosolising procedures staff must wear an FFP3 mask and eye protection. Transfer and movement of patients around the hospital should be kept to a minimum.

In the event that there are number of admissions with confirmed or suspected influenza it may become appropriate to cohort patients in a single bed bay or ward area.

Some members of staff will be at greater risk from flu because of a pre-existing medical condition or pregnancy. The risks to staff should already have been identified and managed through existing occupational health protocols

Personal Protective Equipment

Wards and departments should ensure that they have sufficient supplies of personal protective equipment including gloves, plastic aprons and surgical masks.

A central stockpile of surgical masks, thumb in loop gowns and eye protection is established on each site. The stockpile is managed by the materials management team and accessible to the relevant wards and departments.

FFP3 masks or the positive pressure hood are required for specific infectious diseases (MERS and by staff performing cough inducing procedures for patients with suspected or confirmed infectious condition spread via respiratory secretions. FFP3 masks must be worn when performing the following procedures:

- Intubation, exubation and related procedures (e.g. manual ventilation and open suctioning)
- CPR
- Bronchoscopy
- Surgery and post-mortem procedures involving high speed devices;
- Some dental procedures (e.g. drilling);
- Non-invasive ventilation (e.g. bi-level positive airway pressure and continuous positive airway pressure ventilation)
- High-frequency oscillating ventilation; Induction of sputum.

Staff performing these types of procedures will include staff in ED, theatre, respiratory ward, ICU, and the acute floors in addition to staff groups such as Anaesthetists, Intensivists, endocopists and physiotherapists (chest). Many wards and departments stock these masks and the following wards are 'top up' areas:

HRI = SAU, acute floor, 18, ICU, Emergency Department

CRH = acute floor, 3, 5, ICU and Emergency Department

Fit Testing For FFP3 Masks

Prior to using an FFP3 mask the make/model and size of mask MUST be fit tested to the user to ensure a seal can be attained and the member of staff will be safe. Face masks come in various shape sizes so users can determine the most effective.

There are competent 'fit testers' in most clinical areas within the Trust who can carry out the assessment (register held on the intranet). Fit test kits are available from the IPC team for competent fit testers to use. It is the responsibility of the fit testers in each area to fit test their staff and to record the make model and size of mask that they require. Staff who have been fit tested are adding onto the equipment training database by the fit tester or the staff members manager.

Where a member or staff does not successfully fit test with the FFP3 mask used by the Trust, each management team must put in place appropriate risk mitigation measures to protect the member of staff from being exposed to a respiratory infection at work. This may involve:

- Training to use the positive pressure hood
- Reassigning to an alternative task

Positive pressure hood systems have been purchased for use in the emergency departments on both sites. Training is required prior to use by a competent user.

Critical Care Escalation Plan

The Local Critical Care Network has developed a critical care network escalation plan that includes triggers and escalation levels (see appendix 2). The Trust Critical Care Escalation Plan details the arrangements for increasing level 3 capacity in the event of a surge in demand.

14. Christmas and New Year Bank Holidays

Staffing

The clinical divisions will have arrangements in place to ensure staff cover on the bank holidays over the Christmas, New Year period and the during this period when there is anticipated surge in emergency/acute demand. There will be senior divisional management cover over the Christmas and New Year period.

Reduced services

The Christmas and Bank Holiday arrangements for different services will be shared in the on call pack which will be available in each Patient Flow office. Copies of the operational arrangements for theatres and clinical support services over the Christmas and Bank Holiday period will be again available for the on call teams over the Christmas and New Year period.

Partner organisations

The Christmas and New Year cover arrangements for primary care, social care and safeguarding will be shared with the on call teams for the Christmas and New Year period and stored in the patient flow offices on both CRH and HRI sites.

Communications

The Communications Team will issue media statements during winter to reinforce key health messages.

When there is a community outbreak of diarrhoea and vomiting a press release will be issued promoting basic hand hygiene and asking the public to stay away from hospital if possible because they risk passing on an infection to vulnerable patients.

Prior to the Christmas and New Year period a press release will be issued reminding the public them when it is appropriate to use primary care services rather than accident and emergency departments and to stock of home medicines cabinets prior to the holiday.

In the event of a significant infection outbreak the Trust communications team will work with Calderdale and Greater Huddersfield CCG to implement a media and communications strategy utilising key messages which will include advice for visitors.

Training and Implementation of the Winter Plan

The Divisional Directors of Operations and identified leads for winter planning have overall responsible for ensuring that those with identified roles in the plan are familiar with the protocols set out in this document. This will be achieved by;

- Involvement of leads from each division in winter planning
- Discussion at the appropriate divisional committees
- Cascade of messages to key staff groups through email circulation and Trust news
- Publication of related documents on the Preparing for Emergencies section of the staff intranet
- Publication of the plan on the Trust intranet; and
- Winter Plan briefings for Managers, Directors, Matrons, Ward/department sisters from October 2019

- To improve capability and resilience in CHFT senior management/clinical teams there will be a number of Table top exercises to test surge and escalation, the winter plan and major incident plans

Winter Market Place

On October 3rd there will be a Winter Market Place where key teams and services including all innovation scheme leads will have a stall in the main hospital entrance at both acute sites. With further smaller market place staff being hosted in community health centres. This is a new approach to sharing the Trusts Winter Plan with not only staff but patients, carers, relatives and visitors.
Key health messages via the IPC Team and communication department will be available and gives an opportunity for wider dissemination.

Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement service policies and measures that meet the diverse needs of our service, population and workforce ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

Monitoring Compliance with this procedural document

The Deputy Chief Operating Officer and Divisional Director of Operations in collaboration with key service winter leads are responsible for the successful implementation and monitoring of the winter plan. The plan and its effectiveness will be reviewed throughout the winter period and learning shared and acted upon. The Urgent Care Board membership will also play a key role in the review process.

Associated Documents/Further Reading - Intranet

The Trust has a number of policies and plans that would be used in dealing with problems caused by winter conditions. They are both clinical and non-clinical and some are season-specific and others are for general use:
All can be found on the intranet- link
https://intranet.cht.nhs.uk/non-clinical-information/emergency-preparedness-resilience-response-local-secuirty-management-specialist/

a. Adverse weather policy
b. Pandemic influenza
c. Major Outbreak of Infection Policy
d. Emergency Management Arrangements
e. Escalation guidelines for the maternity units
f. Discharge Policy/Transfer of Care Policy

This plan has been shared with external stakeholders for comments and identification of any areas of concern. Stakeholders have been invited to host stalls of their own plans at the Winter market Place. The AEDB will undertake a system review of all plans and a Joint Surge and Escalation & Winter Plan will be agreed.

APPENDIX 1

1: Criteria and SOP for open and referral to flexible capacity

Checklist on opening additional beds.docm

Paediatric Escalation Plan, Advanced Paediatric Nurse Practitioner Escalation Plan and Maternity Escalation Policy

APPENDICES 2, 3, 4, 5 & 6

2

2016__Feb__-_Paediatric_Escalation_-_v3

3

2016__Sept__-_APNP_escalation_process

4

Escalation Policy (Maternity).pdf

5

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6

HRI trauma surge pathway.docx