The Princess Alexandra Hospital NHS Trust

# AGENDA

## Public Meeting of the Board of Directors (held remotely due to COVID-19)

**Date and time:** Thursday 4 June 2020
09.30 – 11.15

**Venue:** Microsoft Teams Meeting

| | Item | Subject | Action | Lead | |
|---|---|---|---|---|---|
| **01 Opening Administration** | | | | | |
| **09.30** | 1.1 | Apologies | - | | |
| | 1.2 | Declarations of Interest | - | Chairman | |
| | 1.3 | Minutes from previous meeting | Approve | Chairman | 4 |
| | 1.4 | Matters Arising and Action Log | Review | All | 11 |
| **02 Risk** | | | | | |
| **09.40** | 2.1 | COVID-19 including:<br>• Recovery and Restoration Plan | Inform | Chief Executive/Chief Financial Officer/ Executives | 12<br>20 |
| **10.00** | 2.2 | Board Assurance Framework 2020-21 | Review/ Approve | Head of Corporate Affairs | 27 |
| **10.10** | 2.3 | Major Incident Plan | Approve | Chief Operating Officer | 40 |
| **03 Patients** | | | | | |
| **10.20** | 3.1 | Nursing, Midwifery and Care Staff Levels including Nurse Recruitment | Discuss | Director of Nursing & Midwifery | 196 |
| **10.30** | 3.2 | Mortality | Discuss | Acting Chief Medical Officer | 200 |
| **04 Performance** | | | | | |
| **10.45** | 4.1 | Integrated Performance Report (IPR) | Discuss | Executives | 205 |
| **05 Governance** | | | | | |
| **10.55** | 5.1 | Data Protection Security Protection/Information Governance Update | Inform | Chief Financial Officer | 239 |
| **11.05** | 5.2 | Reports from Committees:<br>• New Hospital Committee 11.05.20 and Terms of Reference<br>• Quality and Safety Committee 22.05.20<br>• Performance and Finance Committee 28.05.20<br>• Audit Committee 28.05.20<br>• Workforce Committee 01.06.20 | Inform/ Approve | Chairs of Committees | 241<br>242<br>245<br>247<br>249<br>Verbal |
| **06 Questions from the Public** | | | | | |
| | 6.1 | Opportunity for Members of the Public to have a pre-submitted question answered. | | | |
| **07 Closing Administration** | | | | | |
| **11.15** | 7.1 | Summary of Actions and Decisions | - | Chairman/All | |
| | 7.2 | New Risks and Issues Identified | Discuss | All | |
| | 7.3 | Any Other Business | Review | All | |
| | 7.4 | Reflection on Meeting | Discuss | All | |

The Princess Alexandra Hospital NHS Trust

# Public Board Meeting Dates 2020/21

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| 02.04.20 | 01.10.20 |
| 04.06.20 | 03.12.20 |
| 06.08.20. | 04.02.21 |

**Purpose:**

The purpose of the Trust Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care. It determines strategy and monitors performance of the Trust, ensuring it meets its statutory obligations and provides the best possible service to patients, within the resources available.

**Quoracy:**

One third of voting members, to include at least one Executive and one Non-Executive (excluding the Chair). Each member shall have one vote and in the event of votes being equal, the Chairman shall have the casting vote.

**Ground Rules for Meetings:**

1. The purpose of the meeting should be defined on the day (set the contract).
2. Papers should be taken as read.
3. The purpose of a paper must be clearly explained and the decision/s to be made must be identified.
4. Members/attendees are encouraged to ask questions rather than make statements and are reminded that when attending meetings, it is important to be courteous and respect freedom to speak, disagree or remain silent. Behaviour in meetings should be in line with the Trust's Behaviour Charter.
5. Challenge should be constructive and a way of testing the robustness of information.
6. Members/attendees are encouraged to support the Chair of the meeting to ensure the meeting runs to time.
7. The use of mobile phones during meetings should be avoided; phones must be set to silent.
8. If the duration of a meeting is likely to exceed 2 hours a break should be taken at a convenient point.

| Board Membership and Attendance 2020/21 | | | |
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| **Non-Executive Director Members of the Board (voting)** | | **Executive Members of the Board (voting)** | |
| **Title** | **Name** | **Title** | **Name** |
| Trust Chairman | Steve Clarke | Chief Executive | Lance McCarthy |
| Chair of Audit Committee (AC) and Senior Independent Director | George Wood | Chief Finance Officer | Trevor Smith |
| Chair of Quality & Safety Committee (QSC) | Dr. Helen Glenister | Chief Operating Officer | Stephanie Lawton |
| Chair of Performance and Finance Committee (PAF) | Pam Court | Chief Medical Officer | Dr. Andy Morris |
| Chair of Workforce Committee (WFC) | Helen Howe | Director of Nursing & Midwifery | Sharon McNally |
| Chair of Charitable Funds Committee (CFC) | Dr. John Keddie | **Executive Members of the Board (non-voting)** | |
| Chair of Strategy Committee (SC) | Dr. John Hogan | Director of Strategy | Michael Meredith |
| | | Director of People | Gech Emeadi |
| | | Director of Quality Improvement | Jim McLeish |
| **Corporate Secretariat** | | | |
| Head of Corporate Affairs | Heather Schultz | Board & Committee Secretary | Lynne Marriott |

The Princess Alexandra Hospital NHS
NHS Trust

**Minutes of the Virtual Trust Board Meeting in Public**
**Thursday 2 April 2020 from 11:30 – 13:00**

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| **Present:** | |
| **Steve Clarke** | **Trust Chairman (TC)** |
| Lance McCarthy | Chief Executive Officer (CEO) |
| Ogechi Emeadi (non-voting) | Director of People (DoP) |
| Helen Glenister | Non-Executive Director (NED-HG) |
| John Hogan | Non-Executive Director (NED-JH) |
| Helen Howe (non-voting) | Associate Non-Executive Director (NED-HH) |
| John Keddie (non-voting) | Associate Non-Executive Director (ANED JK) |
| Stephanie Lawton | Chief Operating Officer (COO) |
| Jim McLeish (non-voting) | Director of Quality Improvement (DoQI) |
| Sharon McNally | Director of Nursing & Midwifery (DoN&M) |
| Michael Meredith (non-voting) | Director of Strategy (DoS) |
| Marcelle Michail | Acting Chief Medical Officer (ACMO) |
| Trevor Smith | Chief Financial Officer (CFO) |
| George Wood | Non-Executive Director (NED) |
| **In attendance:** | |
| Dr. Amik Aneja | General Practitioner |
| **Members of the Public** | |
| *There were no members of the public present due to the meeting being held virtually.* | |
| **Apologies:** | |
| Pam Court | Non-Executive Director (NED-PC) |
| **Secretariat:** | |
| Heather Schultz | Head of Corporate Affairs (HoCA) |
| Lynne Marriott | Board & Committee Secretary (B&CS) |

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| **01 OPENING ADMINISTRATION** | |
| **1.1** | The Trust Chairman (TC) welcomed all to the virtual Board meeting. In light of the current circumstances the agenda had been reduced and discussions would be concise. Members noted that Helen Howe had now been officially appointed as a Non-Executive Director (NED) (as opposed to Associate NED) and NED Helen Glenister (NED-HG) had been appointed for a second term. |
| **1.2** | At this point in the meeting members were informed of the sad news that a former Trust Associate Medical Director (AMD) Alfa Sa'adu had died with COVID-19 the previous week. The CEO confirmed that the Trust had expressed its condolences to his family at this sad time. |
| **1.1 Apologies** | |
| **1.3** | As above. |
| **1.2 Declarations of Interest** | |
| **1.4** | No declarations of interest were made. |
| **1.3 Minutes of Meeting held on 06.02.20** | |
| **1.5** | These were agreed as a true and accurate record of that meeting with no amendments. |
| **1.4 Matters Arising and Action Log** | |
| **1.6** | There were no matters arising and the action log (and one deferred item) were noted. |
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| **02 RISK** | |
| **2.1 COVID-19** *(17 minutes)* | |
| **2.1** | This item was presented by the CEO. As a first point he formally welcomed the new Acting Chief Medical Officer (ACMO) Marcelle Michail to the meeting. The Trust's former Chief Medical Officer (Andy Morris) was currently seconded to the East of England region to support the COVID-19 response. |
| **2.2** | In relation to COVID-19 he was able to update a robust governance structure was in place with a number of 'cells' meeting on a daily basis, for example, Infection Control, Operations, |

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| | People, Communications and Strategy. A huge amount of work had been undertaken to establish some COVID-19 specific wards in the hospital and to zone areas into potential and non-potential COVID-19 areas and cohort staff appropriately. That was now becoming more challenging due to the delays in test results. The hospital had also been zoned in terms of nursing provision to support nursing staff and the same would now happen for medical staff so they could provide guidance on roles and expectations. |
| **2.3** | In relation to COVID-19 he confirmed that a robust governance structure was in place with a number of 'cells' meeting on a daily basis, for example, Infection Control, Operations, People, Communications and Strategy. A huge amount of work had been undertaken to establish some COVID-19 specific wards in the hospital and to zone areas into potential and non-potential COVID-19 areas and cohort staff appropriately. That was now becoming more challenging due to the delays in receiving test results. |
| **2.4** | The CEO continued that as of that day 26 patients were currently on ventilators and were cohorted both within and outside of ITU. Subject to staffing, the hospital had the ability to treat up to 56 ventilated patients with some additional capacity in Main Theatres, Henry Moore Ward and the Day Unit. In terms of current modelling that may or may not be sufficient to treat patient numbers at their peak. That peak was currently expected to be around 14.04.20 with an expectation that patient numbers would double every three days between now and then. If there were to be a surge in patients then there was the possibility of additional capacity at Papworth Hospital and some additional field hospitals (similar to the Nightingale at Excel) were also being discussed for the region and other large towns. |
| **2.5** | The CEO continued that staffing was becoming challenging with circa 300 currently absent for varying reasons. Those staff present were feeling the pressures but were responding well, however it was anticipated those pressures would only worsen. Staff testing had begun the previous day (in small numbers) but a priority list had been drawn up for those who were 'household isolating' with no symptoms in an effort to get them back into work. In terms of PPE (personal protective equipment) the hospital had not experienced any significant availability issues – any concerns had been around the type of PPE and where to use it. Those concerns were being mirrored nationally. |
| **2.6** | The CEO informed members some robust decision-making tools had been established to manage patients at the front door and plans for resource allocation (at the point of maximum capacity) were also being discussed. The Respiratory ED was up and running and working very well and most Outpatient appointments were being undertaken remotely. In terms of the latter the on-going benefits of that would need to be maintained once business returned to normal. |
| **2.7** | On a positive note the CEO was able to update there had been one patient who had stepped down from ITU and made good progress. Less positive was that that 38 patients had deceased with the virus. |
| **2.8** | As a final point the CEO updated that a new overarching COVID-19 risk had been added to the BAF with a number of individual risks feeding into that from local COVID-19 risk registers. In his view the top four risks currently were:<br>• The number of ventilated patients the hospital would be able to care for at any one time.<br>• The use of anaesthetic machines for half of those patients currently on ventilators.<br>• How to manage patients in the next phase (in terms of capacity and stepping down).<br>• Oxygen supplies in the Trust, where those are located and flow. |
| **2.9** | The CEO handed over to the ACMO who agreed with his concerns on the above four issues. She had heard that additional ventilators may be delivered to hospitals experiencing the biggest demand and PAHT could be one of those. In addition, as mentioned earlier, she had been in some very positive discussions with Papworth in relation to surge capacity. |
| **2.10** | The Director of Nursing & Midwifery (DoN&M) added that since 13.03.20 the organisation had recorded 171 positive patients which had been a significant increase in a very short time. There were now six wards open alongside ITU and the organisation would open an End of Life ward later that day. |

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| **2.11** | The TC thanked the CEO for his update and the work the Executive team and others were undertaking. |
| **2.12** | In response to a question from NED John Hogan (NED-JH) the ACMO confirmed that various training programmes (in terms of caring for COVID-19 patients) were underway in the organisation not only for current ITU staff but also for others, including medical staff. |
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| **2.2 Board Assurance Framework (BAF) 2019/20** *(3 minutes)* | |
| **2.13** | This item was presented by the Head of Corporate Affairs (HoCA) and taken as read. A draft COVID-19 risk was presented for review and the Board was asked to consider the recommendation that BAF risk 2.1 (nurse recruitment) be reduced from 16 to 12. |
| **2.14** | NED Helen Howe (NED-HH) asked whether there should be a risk in the BAF around the lack of COVID-19 testing for staff and how that was being addressed. In response the CEO stated that his view was that should not be a stand-alone risk as it formed part of the overarching COVID-19 BAF risk but agreed it should be on the COVID-19 risk register (which fed into the BAF). He asked the Director of Quality Improvement (DoQI) to provide an update on staff testing. |
| **2.15** | In response the DoQI was able to inform members that, in line with national guidance, index swabbing of staff currently in isolation (due to family members with symptoms) had begun and a number of index cases were booked for the next two days. The decision had been taken to extend that to swabbing staff who were in isolation, either symptomatic or asymptomatic which would allow those staff to return to work if they tested negative. After that there were plans for a structured swabbing programme for staff in 'hot' zones and Critical Care areas, again in line with national guidance. The limiting factor currently was the availability of swabs. There were sufficient to start the programme which could then be scaled up as supplies increased. A standard operating procedure for testing had been approved earlier that day and he had been in receipt of confirmation from the national supply chain of the hospital's request for more swabs. |
| **2.16** | **In conclusion the Board noted and approved the new risk relating to COVID-19 and approved the reduction in score for risk 2.1.** |
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| **03 CHIEF EXECUTIVE'S REPORT/STRATEGY** | |
| **3.1 CEO's Report** *(7 minutes)* | |
| **3.1** | The CEO updated verbally on the following:<br>**CQC Winter Assurance Report**: following the Trust's response the CQC rating had been amended for Safe for Urgent & Emergency Care to 'requires improvement'. The CQC had published their report the previous day which would now be available on their website and, very soon, on the Trust's own website.<br>**Consultant Appointments:** the panel had approved three consultant appointments the previous week – two in Gynaecology and one in Urology. In line with the request, the Board approved those appointments.<br>**New Hospital:** in reference to the notes from the National Capital Development Committee members noted the hospital should receive capital funding for the new hospital greenfield site option but in return was required to meet three criteria for submission to the National Joint Investment Committee in June, those were: 1) agree an option on the land 2) establish a robust programme team and 3) agreement from both HOSCs that a formal public consultation would not be required.. Essex HOSC members were very supportive in terms of not going to public consultation and it was felt Hertfordshire would ultimately agree with that line too. Those decisions would be made at their meetings on 21st and 28th May respectively.<br>**Kao Park:** contractor work continued and remained on track for delivery the following week. A decision would then be taken as to when, in the current circumstances, staff should move over. The Trust had been unable to extend the lease on Mitre building. |
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| **3.2 PAHT 2030** *(4 minutes)* | |

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| **3.2** | This item was presented by the Director of Strategy (DoS) who reminded members that the strategy had been previously been presented to both Private Board and Strategy Committee. He drew members' attention to the slide on page 30 of the pack which set the context of where the strategy sat i.e. within the NHS long-term plan, local strategies and all the strategies within the organisation. He had tried to ensure that everything within PAHT 2030 was in the context of all other strategies within the NHS and locally. |
| **3.3** | The slide on page 33 of the pack was a diagram of how all the different parts of the strategy fitted together. The strategy was based on one vision, three goals and the 5Ps. The diagram also showed how all the strategies within the organisation fitted together to form the business and operational planning. As the courageous goals were developed, the deliverables against each of those now needed to be considered. |
| **3.4** | Alongside developing the overarching PAHT 2030 strategy, had been the delivery of the Clinical Strategy. That was currently on hold until clinical input could be resumed |
| **3.5** | As a final point the DoS updated that next steps would be 1) setting strategic milestones for delivery of the PAHT strategic priorities, 2) proposing how to deliver large scale change across the Trust and OHCP system and 3) the prioritisation process for delivery and investment. |
| **3.6** | In line with the recommendation, the Board approved the PAHT 2030 framework and content, the five strategic priorities and proposed next steps. |
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| **04 PATIENTS** | |
| **4.1 Nursing, Midwifery and Care Staff Levels including Nurse Recruitment** *(3 minutes)* | |
| **4.1** | This item was presented by the DoN&M and the paper was taken as read. Members noted the report would be presented in a different format the following month due to the current number of staff moves across the organisation. It was important to note that the 10% vacancy rate had been achieved at the end of February with the final cohort of international nurses having joined the organisation at the beginning of March. The recruitment trajectory for 2020/21 would now need to be re-set while international borders were closed. |
| **4.2** | The TC commended the achievement to date which, he emphasised, had made a huge difference to the nursing position currently in terms of the COVID-19 response. |
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| **05 PEOPLE** | |
| **5.1 Staff Survey Results 2019** *(1 minute)* | |
| **5.1** | Members noted that this item had been reviewed at WFC.23.03.20. There were no additional questions. |
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| **5.2 Fit and Proper Persons Annual Review** *(1 minute)* | |
| **5.2** | Members noted that this item had been reviewed at WFC.23.03.20. In response to a statement from the TC, the Director of People (DoP) flagged that not only had compliance with the requirements (deputy directors and above) been achieved, but the organisation had also achieved 100% compliance against its own, more stringent, target of all senior managers. |
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| **5.3 Gender Pay Gap** *(1 minute)* | |
| **5.3** | Members noted that this item had been approved at WFC.23.03.20. In line with the recommendation the Board approved (retrospectively) the report which would be posted on the Trust's website. |
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| **06 PERFORMANCE AND PLACES** | |
| **6.1 Integrated Performance Report (IPR)** *(1 minute)* | |
| **6.1** | This item was presented by the Chief Operating Officer (COO) and taken as read. It had previously been presented to PAF/QSC and members had no questions. |
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| **6.2 Interim Budget 2020/21** *(17 minutes)* | |

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| **6.2** | This item was presented by the Chief Financial Officer (CFO) and members noted that some paperwork had been circulated within the past 24 hours. The CFO updated members on the national Finance Directors' (FDs) call as follows: |
| **6.3** | There had been a recap on the information provided over the previous week via the Finance Network which had included the block contract values, CCG cash flows, frequently asked questions, specialist commissioning blocks, CCG advice on contracts and payments and the Accounts timetable and year-end guidance. There were some key and important elements still to follow including the COVID capital regime and the changes associated with that. He understood there would be some reductions in the delegated authority levels which would mean that regional and national approval would be required on expenditure over and above £250k. Also to follow would be information on top-up payments on revenue that were being promised in addition to the block payments. |
| **6.4** | There was also due to be a Procurement Policy Note sent out to provide information on prompt and accelerated payments. |
| **6.5** | The key principles of the revised financial regime with block contracts were run through. They were intended to provide financial certainty and suitable cash flows. The top-up payments would be a central payment that would sit alongside block payments and were expected to cover business as usual costs. They had been calculated based on the average run-rate of such costs over the winter months. It had been recognised that came with imperfections and would need to be revisited in some cases on a contract by contract basis particularly where transfers of contracts had taken place. That could include PAHT in relation to MSK and had been taken into account in interim budget numbers. |
| **6.6** | The underlying principle of the above was that on a reasonable costs basis all costs would be fully funded in the next financial year. There would be a secondary top-up payment which would be a retrospective 'true-up' payment which would take account of COVID costs as well as further BAU costs. It was recognised that the full identification, recording and documenting of COVID costs would be challenging but essential. |
| **6.7** | There would be top-up payments for 2019/20 and the Centre had reviewed the initial submissions made and feedback would be provided on those with the expectation there would be a final submission (as part of the final accounting process) on a date to be confirmed. It was also recognised there were issues in terms of year-end and the closing off of accounts including lost commercial revenue and equally some of the large technical accounting entries (e.g. prescribing of accruals for CCGs and annual leave). |
| **6.8** | There had been further discussions around the cash payments that were coming through and he was pleased to report the Trust had indeed received its payment on 01.04.20 making the current bank balance £21.9m. |
| **6.9** | Year-end and Annual Report had also been covered with the aim of reducing the burden of accounting and reporting at that stage but that was subject to on-going discussions with DH/Treasury. There would be a higher threshold set for the agreement of balances and proposals to reduce the scale of reporting within the Annual Report were being discussed. It was expected that final guidance would be released between 8 - 13 April 2020. |
| **6.10** | Guidance on the capital regime would follow. |
| **6.11** | In terms of the interim budget, the CFO updated that the DCFO had circulated slides which proposed an interim budget arrangement which worked on the principles put forward in the new financial regime i.e. that all costs would be covered. It worked on the basis of the previous agreement of balances figures used to calculate the block contracts from the Centre and those had been aligned and signed off by Commissioners. There had been an adjustment for MSK and the financial flows associated with that. Estimated values had been included for the anticipated top-up payments. |
| **6.12** | Individual budget holders had been advised that budgets would be rolled over at this stage in terms of establishments and budgets. The overall interim budget being put forward that day to the Board reflected that position. It was anticipated that the new financial regime would be in place until at least 31.07.20. Clearly the numbers were subject to change but in terms of good governance the recommendation to the Board was to adopt the revenue budget presented in the slides. A capital proposal had also been attached recognising that |

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| | was based on the previous submission to NHSI and reflected an over-commitment but was an initial capital proposal for the Board with further rationalisation and prioritisation to follow. He requested the Board considered the two budgets as an interim arrangement in compliance with good governance, and also consider whether oversight of changes on revenue or capital should be delegated directly to PAF and reported back to Board going forward. |
| **6.13** | In response to the above members approved that oversight of any changes to either revenue or capital should be delegated directly to PAF (and be reported back to Board). In terms of approval of the interim capital and revenue budgets, it was agreed that members would be allowed a period of 24/48 hours to consider the numbers and raise any questions, after which both would be signed off remotely by the Board. |
| **ACTION**<br>**TB1.02.04.20/01** | **Members to consider the interim capital and revenue budgets over the next 24/48 hours and raise any associated questions.**<br>**Lead: Board Members** |
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| **07 GOVERNANCE** | |
| **7.1 Reports from Committees** *(2 minutes)* | |
| **7.1** | <u>WFC.23.03.20 – Acting Committee Chair NED Andrew Holden</u><br>Members had no comments.<br><br><u>PAF.26.03.20 – Committee Chair NED Andrew Holden</u><br>Members had no comments.<br><br><u>AC.26.03.20 – Committee Chair NED George Wood</u><br>Members approved the new Terms of Reference 2020/21.<br><br><u>QSC.28.03.20 – Committee Chair NED Helen Glenister</u><br>Members noted the reporting framework for the Committee's next meeting had been reviewed in order to reduce the agenda and pressures on staff. |
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| **08 QUESTIONS FROM THE PUBLIC** | |
| **8.1** | No members of the public were present. |
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| **09 CLOSING ADMINISTRATION** | |
| **9.1 Summary of Actions and Decisions** | |
| **9.1** | These are presented in the shaded boxes above. |
| **9.2 New Issues/Risks** | |
| **9.2** | No new risks or issues were identified. |
| **9.3 Any Other Business (AOB)** | |
| **9.3** | The Director of Strategy (DoS) requested that his thanks be recorded for his Executive colleagues who, over recent weeks, had shielded him and his team from the current pressures in order to be able to focus on the work around the new hospital. The TC acknowledged that request and asked those thanks be extended to all staff currently whether frontline or not. |
| **9.4** | In response to questions raised by NED-GW and more generally, the following were noted:<br>• There was a centralised absence system for staff sickness, and welfare checks for those in self-isolation were undertaken.<br>• Members agreed there would be weekly PAF briefings going forward (in the weeks where there was no formal PAF meeting or Trust Board).<br>• NED input/support would be most welcome in terms of the Recovery Cell to be established which would focus on, amongst other things, cancelled patients/harm reviews, the financial position, access activity and transformation.<br>• There would be a fortnightly briefing for NEDs from the CEO. |

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| | • The Chair of the Charitable Funds Committee (ANED-JK) in response to some recent requests would look into ways that donations could best be made to the Trust in response to the current crisis.<br>• The ICP work was currently on hold. |
| **9.5** | As a final point NED-HH recorded her thanks to the CEO for his updates and for the circulation (to NEDs) of the COVID Daily Decisions Log. |
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| **9.4 Reflection on Meeting** | |
| **9.6** | Members agreed that meeting for the first time via Microsoft Teams had been relatively successful. |

| **Signed as a correct record of the meeting:** | |
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| **Date:** | 07.05.20 |
| **Signature:** | |
| **Name:** | Steve Clarke |
| **Title:** | Trust Chairman |

**Trust Board Meeting in Public**
**Action Log - 04.06.20**

| Action Ref | Theme | Action | Lead(s) | Due By | Commentary | Status |
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| TB1.06.02.20/24 | Hard Truths Report | Any red rated areas in the Hard Truths Report to be accompanied by a short narrative by way of explanation. | DoN&M | ~~TB1.02.04.20~~ | No RAG status available in current report due to workforce resdesign over covid period. Future reports will include narrative where RAG status is red. | Proposed for closure |
| TB1.02.04.20/01 | Interim Capital and Revenue Budgets | Members to consider the interim capital and revenue budgets over the next 24/48 hours and raise any associated questions. | Board Members | TB1.04.06.20 | Actioned. | Closed |

The Princess Alexandra Hospital NHS Trust

2.1

**Trust Board (Private) – 4 June 2020**

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| **Agenda item:** | 2.1 | | | | | | | |
| **Presented by:** | Lance McCarthy – Chief Executive Officer | | | | | | | |
| **Prepared by:** | Lance McCarthy – Chief Executive Officer | | | | | | | |
| **Date prepared:** | 28.05.20 | | | | | | | |
| **Subject / title:** | COVID-19 Update | | | | | | | |
| **Purpose:** | Approval | | Decision | | Information | x | Assurance | x |
| **Key issues:** | This paper provides an update to the Board on how PAHT has managed the COVID-19 pandemic, the changes made and the planning that has happened to date with regard to the 'recovery' phase and trying to get our activities back to a new normal for the benefit of all our patients. | | | | | | | |
| **Recommendation:** | The Trust Board is asked to note the COVID-19 update, the actions taken to date and the planned actions for the future. | | | | | | | |

| **Trust strategic objectives:** please indicate which of the five Ps is relevant to the subject of the report | Patients | People | Performance | Places | Pounds |
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| | x | x | x | x | x |

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| **Previously considered by:** | n/a |
| **Risk / links with the BAF:** | BAF Risk 1.0 – COVID-19 |
| **Legislation, regulatory, equality, diversity and dignity implications:** | Compliance with national guidance and access standards. |
| **Appendices:** | |

Your future | Our hospital

respectful | caring | responsible | committed

2.1

Trust Board – 4 June 2020

COVID-19 update

1. Introduction

This paper provides an update to the Board on how PAHT has managed with the COVID-19 pandemic, the changes made and the planning that has happened to date with regard to the 'recovery' phase and trying to get our activities back to a new normal for the benefit of all our patients.

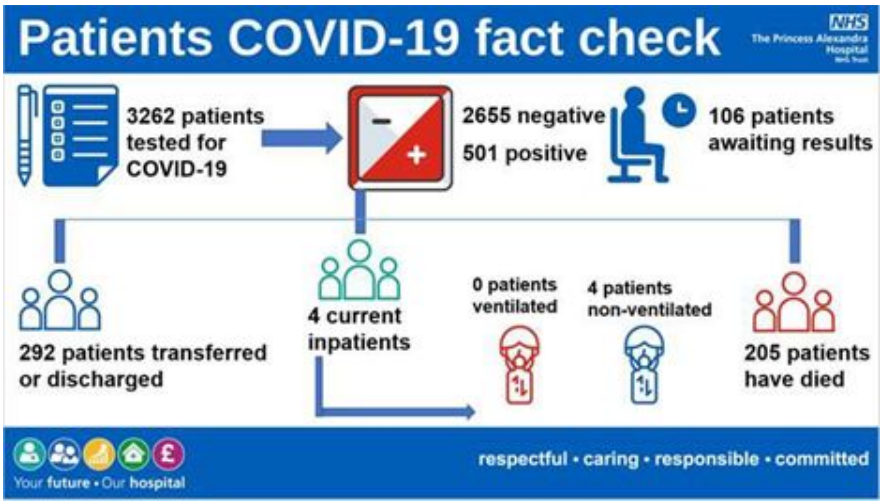
2. Headline numbers

The infographic below is as of 27 May. This is updated daily and sent to all colleagues as part of the daily COVID-19 update email.

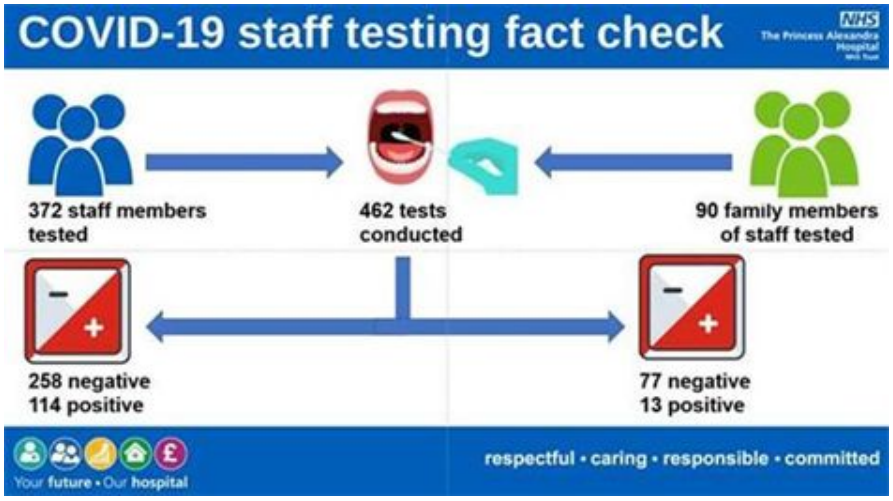
Over the last 5 weeks we have seen a steady and daily reduction in the number of patients testing positive for COVID-19. We have been testing all admissions at the point of decision to admit in to the hospital for 6 weeks, ahead of the national directive to do so to help cohort our patients appropriately and this has shown a steady decline in positive patients with many recent days having zero new positive results.

The number of known COVID-19 positive inpatients in the hospital has fallen to 4 as of 27 May, with none of these patients ventilated. This compares to a high of 33 ventilated patients on 4 April before mutual aid and support from the NHSE/I regional was enacted to transfer patients to units under less stress.

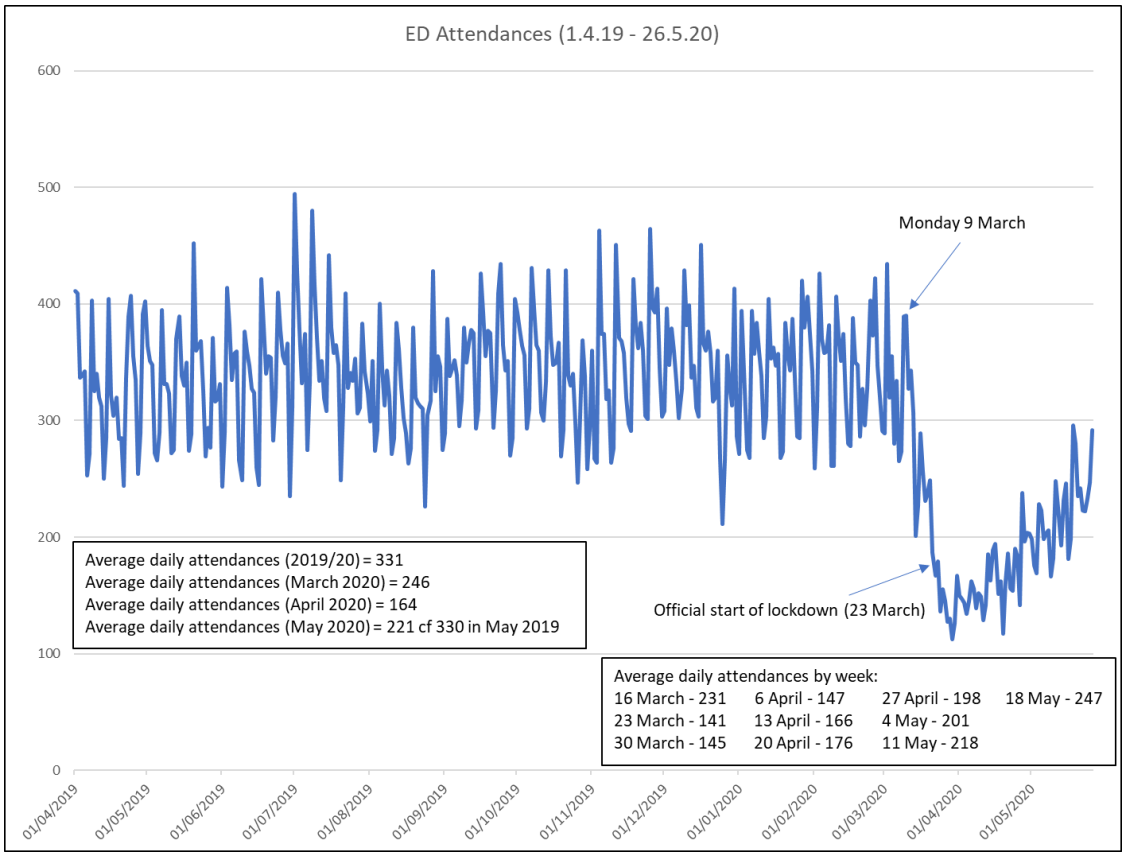
We are seeing increasing numbers of patients recover, be stepped down and discharged. The number of patient deaths with a COVID-19 positive result is now 205.



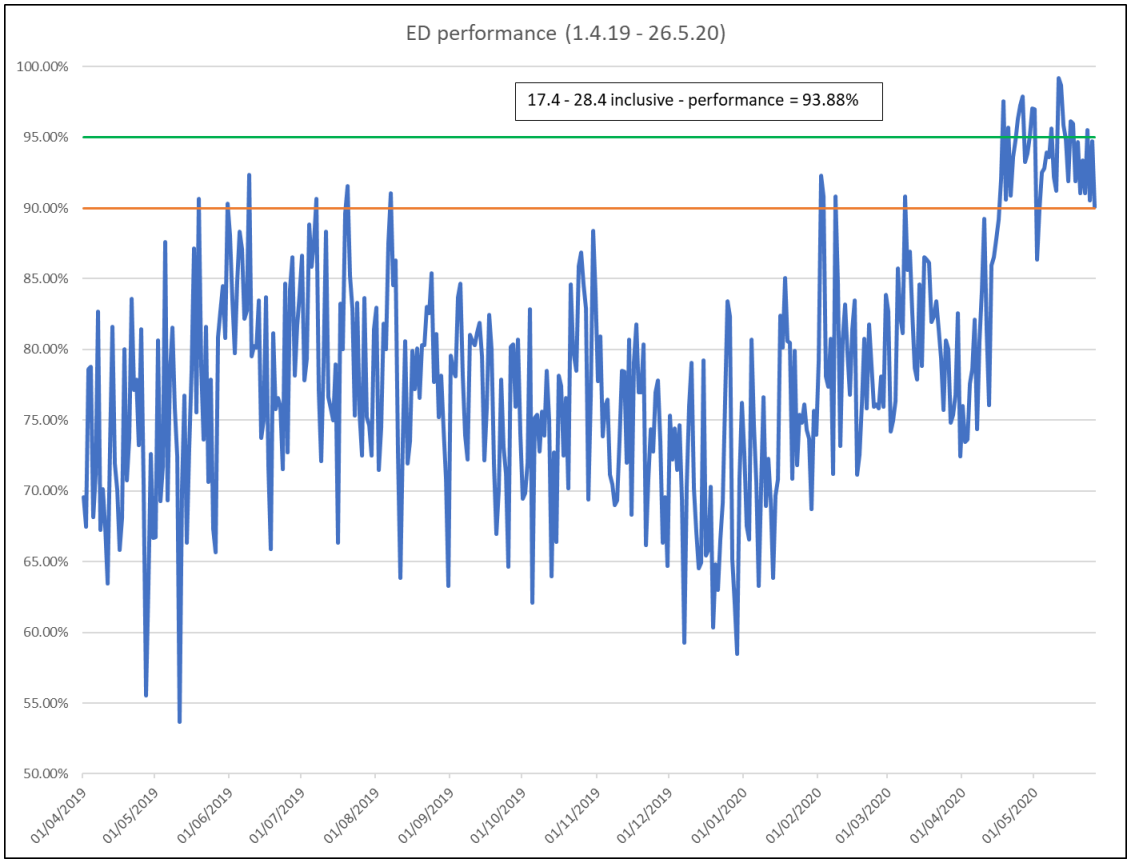

Staff testing is picking up and we have seen a large number of colleagues return to work as a result. The staff testing numbers in the infographic below are updated on a weekly basis and sent to all colleagues.




ED attendances to PAH have fallen significantly from just before the date of the official lockdown (23 March). At the lowest point, on 29 March, we saw 112 attendances. We have started to see an increase in demand for our urgent and emergency care services over recent weeks and are back up to approximately 2/3rds of pre-COVID-19 numbers. We expect this increase to continue to rise over forthcoming weeks.




With the reduction in attendances, we have worked with the ED and medical and surgical teams to continue to develop and enhance patient pathways for our urgent care patients. As a result of some of the changes to the flow of patients out of the department and the senior decision making in the ED department, our performance against the 4-hour standard has improved to expected levels over the last 6 weeks.




Across the country we have passed the peak of COVID-19 infections, with the number of new infections, hospital admissions, COVID-19 positive patients in hospital beds and the number of known COVID-19 patients ventilated, all falling on a daily basis for the last few weeks.

3. Incidents, reviews and structured judgement reviews

The East of England adult critical care network undertook a rapid response peer review of our critical care services on April 17th. This was in response to a request from the NHSE/I critical care incident cell about the impact that the overwhelming demand for critical care services as a result of the COVID-19 pandemic may have had on the care of our patients.

The review made 6 recommendations, outline below, all of which have been actioned with the exception of recommendation 5, which will take time to implement fully:

- Recommendation 1 – Maximum number in critical care currently should be 15 patients, although attempts will be made to reduce numbers below this.
- Recommendation 2 – The Critical Patient and Resource Management Centre (CPRMC) will operate the transfer services and will be requesting early proactive identification of patients for transfer.
- Recommendation 3 – PAH to identify and share their 24/7 critical care single point of contact.
- Recommendation 4 – PAH to plan cohorting of patients into one covid and one non-covid area.
- Recommendation 5 – If possible, the trust should implement a clinical information system for critical care.

- Recommendation 6 – PAH would develop a 'buddying' relationship with a nearby hospital (eg Lister Hospital)

A number of incidents have happened and been reported through our DATIX system and are being investigated in line with our normal processes and procedures. We will act quickly upon any recommendations in the same way that we do with the output of all incident reviews.

Our mortality review process has been expanded over the last 10 weeks and structured judgement reviews (SJRs) are being undertaken on all patients who have died with a positive test for COVID-19. The key theme to come out of these to date is a recurring theme from the recent non-COVID-19 SJRs that we have a high number of patients at the end of their lives admitted to hospital and dying in hospital when we should have better systems in place with our health and care colleagues for patients to die in a better setting and a setting of their choice. We are working with system colleagues to improve the appropriate discharge process for relevant patients, to improve the coordination of Treatment Escalation Plans and to improve the last 100 days of patients' lives.

We have had one staff member who has sadly died with a positive COVID-19 test. It is not possible to determine where she contracted COVID-19, as it is also not possible to determine whether any of our colleagues who have tested positive for COVID-19 have contracted it in the workplace or outside of the workplace.

## 4. Other COVID-19 related updates

### 4.1 Temporary mortuary

At the peak of our COVID-19 pressures, we installed a temporary mortuary (56 spaces) on site, operational from 12 April. By 16 April we had 16 spare spaces within the unit. Following some ongoing support from local undertakers and the Essex Local Resilience Forum and with a reduction in the number of deaths across the Trust, we were back to working within our normal mortuary capacity by the end of April.

### 4.2 Support for staff

Our colleagues have been fantastic in responding to the pandemic quickly and effectively and managing what have been at times some very challenging situations and at times a large number of very sick patients. They are generally in good humour and are coping well. We have supported colleagues in many ways including:

- Ongoing access to SHaW, chaplaincy team, mental health first aiders, Health Assured and EPUT services for their own health and wellbeing
- Support from our SHaW team for initial staff testing and welfare calls
- 'Wobble room' on Henry Moore ward for staff to have a quiet moment
- Credit card sized communication regarding support
- Absence reporting line to make contact with the hospital in times of sickness easier
- Access to staff and household testing
- PPE Safety Officers to support colleagues with PPE guidance and anxieties
- Access to free drinks and food
- Free on site car parking
- Support for home working and more agile working arrangements
- Ongoing communications with and support for colleagues who are shielding

- Project Wingman with support from British Airways and Stanstead Airport to provide a lounge style service for colleagues

In addition we have received in excess of £35,000 to our justgiving page, more than £50,000 worth of goods through an Amazon wishlist, not run by the Trust, and significant amounts of other support from local residents and local organisations and businesses in terms of food, drink and messages of support.

We will be developing a high-quality staff room for all colleagues on the PAH site once we have created a suitable space through filling Kao Park with non-clinical colleagues who do not need to be on site.

4.3 Risk register and quality briefing

We continue to update the COVID-19 specific risk register on a daily basis and have weekly oversight of this in the strategic cell meeting.

There are currently 45 risks on this specific risk register, of which 1 is significant (IE: score >=15):

- **C19-019 current score 5 x 4 = 20:** Risk that not knowing the Covid status of all patients could lead to infected patients warded resulting in transmission to staff and patients. This is a reducing risk given the number of patients testing positive and the bed availability in the hospital and is being further mitigated by in house testing of admissions on DTA.

We have in place a regular COVID-19 specific quality briefing that is reviewed by the strategic cell weekly. This provides specific information and actions related to incidents, quality markers, learning from deaths and the risk register.

4.4 PPE

Nationally there was a shortage of sterile fluid resistant gowns at the end of April. This was widely articulated in the local and national media. We did run close to being short of gowns but have not had a major concern with any elements of PPE availability at PAHT thanks to the effective and joined up working of our procurement, stores and portering teams and the links with and the hard work of the regional and national teams.

Throughout the COVID-19 pandemic there were some concerns from some colleagues about their views of the correct PPE required, differing from the PHE guidance, and there were some pockets of poor compliance with the wearing of PPE. A team of PPE Safety Officers was put in place, who have been walking the organisation daily to help to reduce anxieties and explain the latest guidance and provide updates as the guidance has changed.

4.5 Communications

There is a wealth of communication activity related to COVID-19, to colleagues internally and to stakeholders and members of the public externally. The daily updates to all colleagues are still being well received and as patients have started to recover fully, there have been a range of videos and written accounts of care received here which have been reviewed by many thousands. I and a number of Executive colleagues are also in regular contact with MPs, county council colleagues and local authority colleagues.

In addition, to support the broader understanding for our stakeholders on the pressures that PAHT has been under and the amazing response from our people, I have sent out a more detailed stakeholder briefing.

5. Recovery

Whilst continuing to manage the COVID-19 pandemic, we have turned our attention over recent weeks to recovery. We want to ensure that we can get back to a new normal as quickly as possible and ensure that our patients across all of our services are receiving the quality of care and access to services that they expect and we would expect to provide.

There was some regional and national guidance released at the end of April to support the thinking for recovery and the phases of recovery expected:

National programme for recovery:

- Phase 1 (now) - Immediate response
- Phase 2 (May - July end) - immediate response and getting critical services up and running
- Phase 3 (31.7 - 31.3) - sustaining NHS services with COVID-19
- Phase 4 (April 21 onwards)

Our recovery cell has been leading on developing comprehensive plans for providing care to all our patients who were on urgent, semi-urgent and routine waiting lists in advance of the COVID-19 pandemic, those who we expect to be referred in to our services in the near future and how we provide as much assurance as possible to the local population to access our services.

To try to maximise the public confidence in using and accessing all our services as they require, we have split the whole hospital where possible between COVID-19 areas and COVID-19-free areas. This has been an extension to the work already undertaken during the pandemic to separate ED and the IP wards. To support the return to routine elective surgery as quickly as possible, we have developed a SOP and testing procedures for patients and colleagues and working with The Rivers Hospital to access all of their facilities in full until the end of June. Routine elective surgery will be back to normal levels from the first week in June.

As part of our recovery discussions we are looking at the potential impact of COVID-19 on autumn and winter admissions to PAHT and on the broader impact on respiratory services across the local ICP and wider ICS services. As the modelling related to COVID-19 develops nationally and regionally, we will also build plans to manage a potential second peak of COVID-19 activity. Currently we are planning on keeping 20% of our inpatient bed capacity empty over forthcoming months to enable the ability to surge into this should we need to.

6. PAHT going forward

The funding for a new hospital on a new site, the national drive towards integration of services and the current COVID-19 pandemic have all combined to make this a seminal moment to fundamentally influence the future state of PAHT and the healthcare that we provide.

It is a very exciting time in the organisation’s history but also a crucial and very important time. What we do now and how we do it over the next 12 months will determine the healthcare provided for generations to come to the local populations.

Consequently as an Executive team and in conjunction with our senior medical leaders, we have been discussing how we lead PAHT now and into the future to ensure that we provide the best, and genuinely outstanding, care for all our patients and the local populations.

This includes the transformation and culture change that needs to happen and the potential use of the current estate post-COVID-19.

These changes to the ways of working, clinical service provision and redesign, culture and ways of working in the Trust and how we use are space for the next 5 years are imperative to support our clinical and non-clinical models for the new hospital as well as to deliver our ambition of providing outstanding healthcare to our local populations.

The detailed actions that come out of these discussions will support the PAHT2030 framework and will be launched in to and discussed with the organisation through the summer and autumn.

## 7. Recommendation

The Trust Board is asked to note the COVID-19 update, the actions taken to date and the planned actions and discussions for the future and how we link these in to the wider strategy of the organisation, including the development of the new hospital and the development of truly integrated services with our local health and care colleagues.

Lance McCarthy, Chief Executive, 28 May 2020

The Princess Alexandra Hospital NHS Trust

2.1

**Trust Board – 04.06.20**

| | |
|---|---|
| **Agenda item:** | 2.1 |
| **Presented by:** | Trevor Smith – Chief Financial Officer |
| **Prepared by:** | Trevor Smith – Chief Financial Officer |
| **Date prepared:** | 29.05.20 |
| **Subject / title:** | Recovery and Restoration Plan |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Purpose:** | Approval | | Decision | | Information | x | Assurance | | |

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| **Key issues:** | Our services, our patients and our staff have all been significantly impacted by Covid-19. We are now working hard to restore our services whilst embedding the many improvements we had to make very quickly during this time.<br><br>The Trust is working on its estimate of patient numbers, its capacity and its improvement plans for the reminder of the year. This is being led by our Recovery Cell with links to our partners in the Integrated Care System and Regional Team.<br><br>The full Recovery Plan document is currently being finalised and has been shared with Performance & Finance Committee members. The attached slide deck provides a summary update on the current position and our plans going forward. |
| **Recommendation:** | The Board is asked to discuss the Plan. |

| **Trust strategic objectives:** please indicate which of the five Ps is relevant to the subject of the report | Patients | People | Performance | Places | Pounds |
|---|---|---|---|---|---|
| | x | x | x | x | x |

| | |
|---|---|
| **Previously considered by:** | PAF Weekly Briefing – 14.05.20<br>Recovery Cell – 27.05.20 |
| **Risk / links with the BAF:** | BAF Risk 1.0 – COVID-19 |
| **Legislation, regulatory, equality, diversity and dignity implications:** | |
| **Appendices:** | Recovery and Restoration Plan |

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respectful | caring | responsible | committed

# Update on restoring our services and our recovery cell

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Our emergency response to the coronavirus (COVID-19) pandemic has meant that several services were required to be suspended or adapted during this period. We are now keen to reinstate our services whilst embedding the good practice, learning and use of technology applied during this recent time. Key areas we are focusing on include:

## Cancer

Although referrals into the trust are still low, these are starting to increase and we expect to be at pre-COVID-19 referral levels within the next four to five weeks. Our cancer performance is still above the national average, but a focus on our cancer capacity will be required over the coming months as patient numbers increase.

## Elective surgery/RTT

We are utilising the private sector (Ramsay Healthcare at the Rivers Hospital in Sawbridgeworth) to enable us to return to elective operating. Activity will be increasing steadily over the coming weeks.

## Diagnostics

Although we have maintained our cancer and urgent diagnostic services throughout this period, we do now have a number of routine referrals to start working through. Our services are now starting to provide more routine capacity in a safe manner in line with social distancing guidance. We are also utilising the private sector to ensure we complete the backlog of work as quickly as possible.

## What does the recovery cell do?

The recovery cell oversees the progress of the individual work streams covering each of the five P's. Each workstream is focusing on key areas of recovery as outlined below:

**People –** health and wellbeing, staff retention, organisational development, communications

**Patients –** mortality improvement, outpatients and theatres transformation, medicines optimisation

**Performance –** achieving national standards in cancer, RTT and diagnostics, national reporting

**Places –** capital investment, portering and domestics transformation, lease consolidation

**Pounds –** closure of 2019/20 accounts, COVID-19 cost recovery, procurement policy changes and service modernisation

Based on what we currently know and predictions for future activity levels and restrictions, we are looking at restoration and recovery over the next nine months. This includes our modernisation and transformation plans to ensure we maximise the big progress and positive changes we have made in how we work. This will enable us to improve to a level that is greater than our position before the pandemic.

# Our people and services update



## Staffing

Our staff have all been through a very tough and testing time, so a focus will be around ensuring we focus on all of our teams' wellbeing. This will allow us to get back to business as usual in a staged approach that will not overload our workforce.

## Outpatient waiting lists

Although we have maintained most of our outpatient activity via virtual appointments, it will be important to further build on this to enable us to fulfil the required amount of appointments in the safest way possible.

## Use of resources and financial control

We have been focused on closing down the 2019/20 accounts, Covid Cost recovery and our 2020/21 finances. Continued financial control and management of our resources are essential to make sure we make the very best use of our resources, reduce our reliance on temporary staffing and re-focus on modernisation, transformation and quality improvement plans.

## How have referrals been affected?

| | Change since COVID-19 | Current increase |
|---|---|---|
| ED attendances | Down 35% | Rising 20% per week |
| RTT referrals | Down 60% | Rising 10% per week |
| Cancer referrals | Down 35% | Rising 20% per week |
| Diagnostic referrals | Down 30% | Rising 30% per week |

## What are we currently doing to aid recovery?

- Utilisation of the Rivers Hospital (private sector) as a site for elective surgery and diagnostics
- Increasing use of technology, with virtual outpatient appointments
- Routine services starting to come back on line with sufficient PPE and social distancing measures in place
- Re-focus on our 2020/21 capital programme to continue to safeguard equipment and services
- Re-focus on 2020/21 quality improvement programme to improve services and our use of resources

# Our patients update



## What will all this mean for our patients:

As we enter this new, post-COVID-19 way of working, there will be many changes that patients will see and experience. Some key areas include:

- More outpatient clinics will be held virtually by systems such as ‘Attend Anywhere’, giving patients and clinicians a direct video link to each other from the comfort of the patient’s home
- Appointment letters and clinical correspondence will be more accessible via text messages rather than via letters in the post
- Historic ‘walk-in’ services may need to be replaced by more ‘appointment based’ services
- Staff and patients, where appropriate, across all patient contact services will likely be wearing PPE
- Waiting room access will be controlled with protective screens at many reception points
- Extended waiting list times for diagnostics

- We have shared our plans with our clinical commissioning group (CCG) and primary care colleagues, working together to reassure the public through regular communication
- There will be a clear standardised information sheet with a clear explanation of how we will maintain patient safety whilst receiving care in hospitals during COVID-19
- Visitor guidelines have also been updated and will be shared with patients and their families
- Post-discharge care/follow up and a pre-discharge process will be in place to support our patients safely home following treatments
- Post discharge advice and support will be provided using our videoconferencing facilities
- Guidelines are also in place to support our patients for when to visit the hospital, when to go to A&E, when they can consult remotely, and when they should access online/local pharmacy support (e.g. for minor injuries)

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2.2

Trust Board - 4 June 2020

| | |
|---|---|
| **Agenda Item:** | 2.2 |
| **Presented by:** | Head of Corporate Affairs - Heather Schultz |
| **Prepared by:** | Head of Corporate Affairs - Heather Schultz |
| **Date prepared:** | 28 May 2020 |
| **Subject / Title:** | Board Assurance Framework 2020/21 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose:** | Approval | x | Decision | | Information | | Assurance | |

| | |
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| **Executive Summary:** [please don't expand this cell; additional information should be included in the main body of the report] | The Board Assurance Framework 2020/21 is presented for review. Risks, risk ratings and outcomes of Committee reviews in month are summarised (Appendix A) and detailed BAF risks as at the end of May 2020 are attached (Appendix B).<br><br>Following discussion at QSC it is recommended that the score for BAF Risk 1.0 Covid-19 is reduced from 20 to 16. PAF reviewed BAF Risk 4.2 ED standard and recommended the risk score is reduced from 20 to 16. |
| **Recommendation:** | The Board is asked to approve the Board Assurance Framework and reductions in risk scores for BAF risks 1.0 and 4.2. |

| **Trust strategic objectives:** [please indicate which of the 5Ps is relevant to the subject of the report] | Patients | People | Performance | Places | Pounds |
|---|---|---|---|---|---|
| | x | x | x | x | x |

| | |
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| **Previously considered by:** | WFC, PAF, QSC, New Hospital Committee in May 2020. |
| **Risk / links with the BAF:** | As reflected in the attached BAF. |
| **Legislation, regulatory, equality, diversity and dignity implications:** | Compliance with national legislation and regulations and the Code of Governance. |
| **Appendices:** | Appendix A summary, and Appendix B - Board Assurance Framework 2020/21 |

respectful | caring | responsible | committed

| 5P | Executive Lead | Committee | BAF Risks June 2020 | Current risk score | Trend |
|---|---|---|---|---|---|
|  | Chief Executive | QSC | 1.0 Covid-19: Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered. | 16 |  |
|  | Chief Nurse/Chief Medical Officer | QSC | 1.1 Outcomes:Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality. | 16 |  |
|  | Chief Finance Officer/DoI&IT | PAF | 1.2 EPR<br>Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes | 16 |  |
|  | DoP | WFC | 2.3 Workforce: Inability to recruit, retain and engage our people | 12 |  |
|  | DoS | PAF | 3.1 Estates & Infrastructure<br>Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery. | 20 |  |
|  | DoS | Trust Board/ Strategy Committee | 3.2 Financial and Clinical Sustainability across health and social care system<br>Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system. | 16 |  |
|  | DoS | Trust Board/ Strategy Committee | 3.3 Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust. | 12 |  |
|  | DoS | Trust Board/ Strategy Committee | 3.4 Sustainability of local services<br>Failure to ensure sustainable local services continue whilst the new hospital plans are in development and funding is being secured. | 16 |  |
|  | COO | PAF | 4.2 4 hour Emergency Department Constitutional Standard<br>Failure to achieve ED standard | 16 |  |
|  | CFO | PAF | 5.1 Finance<br>Concerns around failure to meet financial plan including cash shortfall. | 20 |  |

The Princess Alexandra Hospital NHS
NHS Trust

# The Princess Alexandra Hospital Board Assurance Framework

## 2020-21

| Risk Key | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Extreme Risk | | 15-25 | | | | | | | | | | | | |
| High Risk | | 8-12 | **The Princess Alexandra Hospital Board Assurance Framework 2020-21** | | | | | | | | | | | |
| Medium Risk | | 4-6 | | | | | | | | | | | | |
| Low Risk | | 1-3 | | | | | | | | | | | | |
| **Risk No** | | **PRINCIPAL RISKS** | | | | **KEY CONTROLS** | **ASSURANCES ON CONTROLS** | **BOARD REPORTS** | | | | | | |
| | | **Principal Risks** | | **RAG Rating (CXL)** | **Executive Lead and Committee** | **Key Controls** | **Sources of Assurance** | **Positive Assurances on the effectiveness of controls** | **Residual RAG Rating (CXL)** | **Gaps in Control** | **Gaps in Assurance** | **Review Date** | **Changes to the risk rating since the last review** | **Target RAG Rating (CXL)** |
| | | What could prevent the objective from being achieved | What are the potential causes and effects of the risks | | Which area within our organisation this risk primarily relate to | What controls or systems are in place to assist in securing the delivery of the objectives | Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective | We have evidence that shows we are reasonably managing our risks and objectives are being delivered | | Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective. | Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective | | | |
| | | | | | | Evidence should link to a report from a Committee or Board. | | | | | | | | |
| | **Strategic Objectives 1-5** | | | | | | | | | | | | | |
| **BAF 1.0** | | **COVID-19:**<br>~~**The emerging COVID-19 pandemic will overwhelm the Trust and wider health economy impacting on the health and safety of our patients and people, operational delivery, staffing, finances and procurement as well as the Trust's reputation. -**~~<br>**Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered.** | Causes:<br>i) Highly infectious disease<br>ii) Failure of public to adhere to Public Health messages and increasing Covid demand<br>iii) National issues regarding supply chains<br>iv) Configuration of PAHT estate<br>v) Current vacancy rates<br>vi) Public perceptions around accessing services as normal | **5 X 5= 25** | Chief Executive supported by Executive team QSC | i) Level 4 national incident declared by NHS England<br>ii) PAHT incident co-ordination centre and incident management team established<br>iii) COVID-19 incident management governance structure in place<br>iv) Compliance with national directives<br>v) Ongoing engagement with STP and Local Resilience Forum, Local Delivery Board re-instated<br>vi) COVID-19 patient pathways instigated<br>vii) Staff being redeployed to provide additional support<br>viii) Non COVID Priority Business Cell established for business as usual matters<br>ix) Daily executive oversight of incident management<br>x) Recovery and restoration planning (PAHT/ICP and ICS)<br>xi) Separation of hospital into Covid and Covid free areas<br>xii) Use of independant sector for elective surgery | i) Incident Management Team Meeting<br>ii) Strategic Incident Management Cell<br>iii) IPC Cell<br>iv) Site Management Cell<br>v) Communications Cell<br>vi) People Cell<br>vii) Recovery Cell<br>viii) Clinical Cell | i) Incident management action and decision logs (daily)<br>ii) QSC updates (March, April and May )<br>iii) Trust Board updates (March, April and May )<br>iv) Trust Incident Coordination Centre open 08:00 - 20:00 7 days a week | ~~**5 X 4= 20 4x4=16**~~ | ~~i) Lack of staff capacity to deliver oxygen to required areas~~<br>ii) Loss of staff with key skills and training due to virus; shielding/isolating or sickness<br>iii) Reliance on supplies nationally<br>iv) Modelling information for next peak (local, regional and national) dependant on lock down and public behaviour<br>v) Plans for use of the Rivers up until end of June. | Under review | 18.05.20 | **New risk:Risk score reduced from 20 to 16 since first review at Board in April.** | **5x2=10 (April 2021)** |
| | | | **Effects**:<br>i) Increased numbers of patients and acuity levels<br>ii) Shortages of staff, staff shielding and increased sickness<br>iii) Shortages of equipment, medicines and other supplies<br>iv) Lack of system capacity<br>v) Staff concerns regarding safety and well-being<br>vi) Changing national messaging<br>vii) Potential for patient harm due to cancellation of elective surgery | | | | | | | | | | | |

| Risk Key | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Extreme Risk | | 15-25 | | | | | | | | | | | | |
| High Risk | | 8-12 | **The Princess Alexandra Hospital Board Assurance Framework 2020-21** | | | | | | | | | | | |
| Medium Risk | | 4-6 | | | | | | | | | | | | |
| Low Risk | | | | | | | | | | | | | | |
| **Risk No** | | **PRINCIPAL RISKS** | | | | **KEY CONTROLS** | **ASSURANCES ON CONTROLS** | **BOARD REPORTS** | | | | | | |
| | | **Principal Risks** | | **RAG Rating (CXL)** | **Executive Lead and Committee** | **Key Controls** | **Sources of Assurance** | **Positive Assurances on the effectiveness of controls** | **Residual RAG Rating (CXL)** | **Gaps in Control** | **Gaps in Assurance** | **Review Date** | **Changes to the risk rating since the last review** | **Target RAG Rating (CXL)** |
| | | What could prevent the objective from being achieved | What are the potential causes and effects of the risks | | Which area within our organisation this risk primarily relate to | What controls or systems are in place to assist in securing the delivery of the objectives | Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective | We have evidence that shows we are reasonably managing our risks and objectives are being delivered | | Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective. | Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective | | | |
| | | | | | | Evidence should link to a report from a Committee or Board. | | | | | | | | |
| | | **Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, integrating care with our partners and improving our CQC rating** | | | | | | | | | | | | |
| **BAF 1.1** | | Variation in outcomes in clinical quality, safety, patient experience and higher than expected mortality. | Causes:<br>i) Unwarranted variation in care<br>ii) System wide flow<br>iii) Workforce gaps | **4 X 5= 20** | Director of Nursing/ Chief Medical Officer **Quality and Safety Committee** | i) Robust quality and safety governance structures in place including infection control<br>ii) Robust Appraisal/ medical and nursing<br>iii) End of Life and deteriorating patient simulation programme for all staff, across ICP and ICS<br>iv) Education & training in communication skills such as breaking bad news training.<br>v) Sharing the Learning Programme<br>vi) Commissioner reviews and engagement in quality and Safety processes<br>vii) Risk Management Training Programme<br>viii) Escalation prescribing processes<br>ix) Electronic handovers, Hospital at Night and E-Obs and observation compliance reports<br>x) Schwartz Rounds<br>xi) NHSI/NHSE Oversight<br>xii) Red2 Green Board rounds supported by EDST<br>xiii) Patient Experience Strategy<br>xiv) NED lead appointed for Mortality<br>xv) Mortality Strategy including dashboard, tracker, updates on workstreams and learning from deaths.<br>xvi) '15 steps' walkabouts<br>xvii) Nursing Establishment review (bi-annually) and successful nursing recruitment campaign<br>xviii) Safer Staffing policy<br>xix) Real time patient feeback implemented across all wards<br>xx) Robust management of variations in neonatal outcomes<br>xxi) Engagement in external reviews MBRRACE-HSIB and LeDeR and Healthcare Safety Investigation Branch (maternity)<br>xxii) Medical examiners (MEs) and Lead ME appointed and Mortality Surveillance Group established<br>xxiii) Complaints workshops held<br>xxiv) Joint GIRFT and Model Hospital quality improvement programme<br>xxv) Patient flow module live<br>xxvi) Electronic fluid prescribing pilot live<br>xxvii) Appointment of medical PS&Q leads<br>xxviii) Complaints process being revised and grading system introduced<br>xxix) Fish Change accreditation<br>xxx) Quality peer review process in place<br>xxxi) Covid-19 governance structure/meetings in place | i) National Survey ii) Cancer Survey<br>iii) CEO Assurance Panels<br>iv) SIG meetings<br>v) QSC, PAF, Risk Management Group and Board meetings<br>vi) Patient Safety and Quality meetings, PRMs and Patient Experience meetings<br>vii) Infection Control Committee<br>viii) Integrated Safeguarding meetings<br>ix) Patient Panel meetings/ Vulnerable Patient Group<br>x) PLACE Inspections<br>xi) Medicines Management Committee<br>xii) End of Life and Mortality Surveillance Group<br>xiii) AKI & Sepsis Group<br>xiv) Urgent Care Improvement Board<br>xv) Deteriorating Patient Group<br>xvi) Cardiac arrest review panels<br>xvii) Weekly Long Length of Stay meetings<br>xviii) Quality Compliance Improvement Group | i) CEO Assurance Panels (as required)<br>ii) Reports to QSC on Patient Experience March 2020, monthly Serious Incidents, monthly Safer Staffing, Patient Panel (bi-monthly) , Safeguarding, monthly Infection Control and Covid-19 updates<br>iii) Monthly Mortality improvement report to QSC including updates on ME reviews and monthly IPR report<br>iv) Dr Foster reports, CQC inspection reports (March 18 and draft June 19) and GIRFT reports<br>v) Real time Dr Foster reports and engagement<br>vi) GMC Survey results (July 2019) and WFC report June 2020<br>vii) Clinical Audit internal audit report 18/19 - tiaa (limited assurance)<br>viii) CMO/CFO Coding Meetings and quarterly Coding reports to PAF<br>ix) Positive staff survey outcomes (2019) measuring safety culture and engagement<br>x) Freedom to Speak Up Guardians quarterly reports to WFC (March 20) and Guardian of Safe Working reports to Trust Board (Dec18).<br>xi) Patient stories and learning from deaths presentations to Public Board meetings (bi-monthly)<br>xii) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance)<br>xiii) International Nurse Recruitment business case to SMT/PAF and Board (June/July 19)<br>~~xiv) Presentation to Board on role of Medical Examiner (Jan 2020)~~<br>xv) Presentation to QSC on documentation and strategic direction to having one electronic system (QSC February 20)<br>xvi) Critical care network review peer review April 2020 | **4x4=16** | Lack of modernisation in some reporting processes including:<br>i) Clinical audit plan developed and to be implemented - improved tracking of local audits and drive to improve collation and input of data for national audits<br>ii) Disparity in local patient experience surveys versus inpatient survey<br>iii) Staffing, site footprint and bed constraints<br>iv) Access to Qlikview<br>v) NICE oversight and management of compliance with guidance<br>vi) Frequency and consistency of approach to mortality reviews<br>vii)<br>**ACTIONS:**<br>i) Inpatient Survey action plan in place and Staff Survey action plan in place<br>ii) Ongoing work with Dr Foster in relation to mortality<br>iv) Review of quality/safety and risk leadership structure<br>v) NHS Patient Safety Strategy 2019 published. Trust to review and align to best practice<br>vi) Structured Judgement Review champions being appointed | i) Clinical evidence of improvements made following compliance with national audits, NICE,NCEPOD.<br>ii) Demonstrating an embedded learning programme from Board to ward. | 18/05/2020 | Risk rating not changed | **4x3=12 September 2020** |
| | | | Effects:<br>i) Increase in complaints/ claims or litigation<br>ii) Persistent poor results in National Surveys<br>iii) Poor reputation<br>iv) Recurrent themes in complaints involving communication failure<br>v) Loss of confidence by external stakeholders<br>vi) Higher than expected Mortality rates | | | | | | | | | | | |

| Risk Key | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Extreme Risk | | 15-25 | | | | | | | | | | | | |
| High Risk | | 8-12 | **The Princess Alexandra Hospital Board Assurance Framework 2020-21** | | | | | | | | | | | |
| Medium Risk | | 4-6 | | | | | | | | | | | | |
| Low Risk | | 1-3 | | | | | | | | | | | | |
| **Risk No** | | **PRINCIPAL RISKS** | | | | **KEY CONTROLS** | **ASSURANCES ON CONTROLS** | **BOARD REPORTS** | | | | | | |
| | | **Principal Risks** | | **RAG Rating (CXL)** | **Executive Lead and Committee** | **Key Controls** | **Sources of Assurance** | **Positive Assurances on the effectiveness of controls** | **Residual RAG Rating (CXL)** | **Gaps in Control** | **Gaps in Assurance** | **Review Date** | **Changes to the risk rating since the last review** | **Target RAG Rating (CXL)** |
| | | What could prevent the objective from being achieved | What are the potential causes and effects of the risks | | Which area within our organisation this risk primarily relate to | What controls or systems are in place to assist in securing the delivery of the objectives | Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective | We have evidence that shows we are reasonably managing our risks and objectives are being delivered | | Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective. | Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective | | | |
| | | | | | | | | Evidence should link to a report from a Committee or Board. | | | | | | |
| | **Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, integrating care with our partners and improving our CQC rating**<br>**Strategic Objective 5: Our Pounds - we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2019/20 and our local system control total** | | | | | | | | | | | | | |
| **BAF 1.2** | | **EPR**<br>Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes. | Causes:<br>i) Poor engagement with the system, usability, time/skills<br>ii) Timely system fixes/enhancements | **5 X 4= 20** | Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee** | i) Weekly DQ meetings held at ADO level<br>ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board.<br>iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions.<br>iv) Performance Mgt Framework in place.<br>v) Training programme.<br>vi) Super users in place to deliver focused support.<br>vii) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability<br>viii) Access Policy<br>ix) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management)<br>x) Development of capacity planning tools/information<br>xi) PWC review and actions identified<br>xii) ICT Newsletter issued<br>xiii) Daily ICT/COSMIC meetings ongoing<br>xiv) Real time data now available<br>xv) CDS 011 now live<br>xvi) Maternity MDS configuration completed.<br>xvii) Monthly Contract Performance monitoring meeting with supplier established. | i) Access Board<br>ii) ICT Programme Board (chaired by CFO)<br>iii) Board and PAF meetings<br>iv) Weekly meetings with Cambio<br>vi Weekly DQ meetings<br>vi) Monthly performance reviews vii) Monthly EPR Board to Board meetings<br>viii) Exec to Exec meeting on 25.11.19 | i) Weekly Data Quality reports to Access Board and EDB<br>ii) External Audit reports to Audit Committee on Quality Account Indicators (July 19 - adverse conclusion)<br>iii) Monthly DQ reports to PAF and quarterly ICT updates<br>iv) EPR outline business case developed and presented to SMT and PAF September 19. | **4 X 4= 16** | i) Continue to develop 'usability' of EPR application to aid users<br>ii) Resource availability<br>iii) Capacity within operational teams<br>iv) Elements of system remain onerous (completion of discharge summaries)<br>v) External system support<br>vi) Compliance with refresher training<br>vii) Cambio delivery schedule slippage | Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed.<br>Responsiveness and quality of delivery of PFM - testing processes and actions identified by tiaa internal audit (limited assurance). | 16.03.20 | Risk rating unchanged | **4x3=12 end of March 2020 (subject to monthly review of progress)** |
| | | | **Effects**:<br>i)Patient safety if data lost, incorrect, missing from the system.<br>ii) National reporting targets may not be met/ missed.<br>iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance<br>iv) Inability to plan and deliver patient care appropriately | | | | | | | **ACTIONS:**<br>i) Ongoing training and support<br>ii) Re-establishing relationship/engagement with Cambio<br>iii) Refresher training underway<br>iv) Revised roadmap to incorporate new statutory/legal requirements e.g GDPR | | | | |

| Risk Key | | |
|---|---|---|
| Extreme Risk | | 15-25 |
| High Risk | | 8-12 |
| Medium Risk | | 4-6 |
| Low Risk | | 1-3 |

**The Princess Alexandra Hospital Board**
**Assurance Framework 2020-21**

| Risk No | | PRINCIPAL RISKS | | | | KEY CONTROLS | ASSURANCES ON CONTROLS | BOARD REPORTS | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Principal Risks | | RAG Rating (CXL) | Executive Lead and Committee | Key Controls | Sources of Assurance | Assurances on the effectiveness of controls | Residual RAG Rating (CXL) | Gaps in Control and Actions | Gaps in Assurance | Review Date | Changes to the risk rating since the last review | Target RAG Rating (CXL) |
| | | What could prevent the objective from being achieved | What are the potential causes and effects of the risks | | Which area within our organisation this risk primarily relate to | What controls or systems are in place to assist in securing the delivery of the objectives | Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective | We have evidence that shows we are reasonably managing our risks and objectives are being delivered. | | Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective. | Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective | | | |
| | | | | | | | | Evidence should link to a report from a Committee or Board. | | | | | | |
| | **Strategic Objective 2: Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results.**<br>**Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators** | | | | | | | | | | | | | |
| **2.3** | | **Workforce:**<br>Inability to recruit, retain and engage our people | **Effects:**<br>i) Reputation impact and loss of goodwill.<br>ii) Financial penalties.<br>iii) Unsatisfactory patient experience.<br>iv) Potential for poor patient outcomes<br>v) Jeopardises future strategy.<br>vi) Increased performance management<br>vii) Increase in staff turnover and sickness absence levels<br><br>Effects:<br>Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation | **4 X 4 =16** | Director of People, OD & Communications<br>**Workforce Committee** | i) People strategy 'joy to work at PAHT'<br>ii) Behaviour charter and vision and values<br>iii) People management policies, systems, processes & training<br>iv) Management of organisational change policies & procedures<br>v) Freedom To Speak Up Guardian roles<br>vi) Equality and inclusion champions<br>vii) Event in a Tent held annually<br>viii) Staff recognition awards held locally and trust wide annually<br>ix) Enhanced controls around temporary staffing<br>x) Line Manager development programme underway<br>xi) Behaviour workshops held<br>xii) New consultant development programme launched<br>xiii) Staff engagement groups and Staff Council<br>xiv) International recruitment programme for nurses and ED doctors<br>xv) Medical staffing review underway<br>xvi) Additional recruitment ('Bring back staff') during Covid | i) WFC, QSC, SC, PAF, SMT, EMT.<br>ii) People board<br>iii) JSCC, JLNC<br>iv) PRMs and health care group boards<br>v) People Cell established (Covid-19) | i) Workforce KPIs reported to WFC bi-monthly and IPR (monthly)<br>ii) People strategy deliverables<br>iii) Staff survey results 2019 (WFC March 2020)<br>iv) Staff friends and family results (WFC March 2020)<br>v) Medical engagement surveys, action plans and GMC surveys (WFC November 2019 and June 2020) | **4 x3 = 12** | Pulse surveys targeted for all staff<br>Communications strategy<br>Medical engagement<br>Effective intranet/extranet for staff to access anywhere 24/7<br>Roll out of e-rostering to all areas<br>Management of staff health and well-being during and post Covid<br><br>Actions<br>i) Implementation of communication strategy - Q2 2020/21<br>ii) Recruitment plans for medical staff<br>iii) Extranet for staff - Q1 20/21<br>iv) Staff survey action plan:health and well being, manager development and learning culture (Q2 20/21)<br>v) Ongoing psychological support for staff to be put in place - Covid-19 | None identified. | 11/05/2020 | **Risk score not changed.** | **4 x2 = 8 (at end of 5 year People Strategy but to be reviewed in September 2020)** |

| Risk Key | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Extreme Risk | | 15-25 | | | | | | | | | | | | |
| High Risk | | 8-12 | **The Princess Alexandra Hospital Board Assurance Framework 2020-21** | | | | | | | | | | | |
| Medium Risk | | 4-6 | | | | | | | | | | | | |
| Low Risk | | 1-3 | | | | | | | | | | | | |
| **Risk No** | | **PRINCIPAL RISKS** | | | | **KEY CONTROLS** | **ASSURANCES ON CONTROLS** | **BOARD REPORTS** | | | | | | |
| | | **Principal Risks** | | **RAG Rating (CXL)** | **Executive Lead and Committee** | **Key Controls** | **Sources of Assurance** | **Positive Assurances on the effectiveness of controls** | **Residual RAG Rating (CXL)** | **Gaps in Control** | **Gaps in Assurance** | **Review Date** | **Changes to the risk rating since the last review** | **Target RAG Rating (CXL)** |
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| | **Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.** | | | | | | | | | | | | | |
| **BAF 3.1** | | **Estates & Infrastructure**<br>Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery. | **Causes:**<br>i) Limited NHS financial resources (Revenue and Capital)<br>ii) Lack of capital investment,<br>iii) Current financial situation,<br>iv) Inherited aged estate in poor state of disrepair<br>v) No formal assessment of update requirements,<br>vi) Failure to comply with estates refurbishment/ repair programme historically,<br>vii) Under-investment in training of estate management & site development<br>viii) Inability to undertake planned preventative maintenance<br>ix) Lack of decant facility to allow for adequate repair/maintenance particularly in ward areas.<br>x) Key workforce gaps in compliance, energy and engineering. | **5 X 4= 20** | Director of Strategy **Performance and Finance Committee** | i) Schedule of repairs<br>ii) Six-facet survey/ report received (£105m)<br>iii) Potential new build/location of new hospital<br>iv) Capital programme - aligned to red rated risks.<br>v) STP Estate Strategy developed and approved.<br>vi) Modernisation Programme for Estates and Facilities underway<br>vii) Robust water safety testing processes<br>viii) Annual asbestos survey –completed and red risks resolved.<br>ix) Trust's Estate strategy being developed<br>x) Annual fire risk assessment completed and final report received, compliance action plan being developed.<br>xi) New estates and facilities leadership team in place<br>x) Sustainability Manager in post<br>xi) Emergency Capital funding £4.3m<br>xii) Compliance Manager appointed | i) PAF and Board meetings<br>ii) SMT Meetings<br>iii) Health and Safety Meetings<br>iv) Capital Working Group<br>v) External reviews by NHSI and Environmental Agency<br>vi) Water Safety Group<br>vii) Weekly Estates and Facilities meetings<br>viii) Project Genesis Steering Group | i) Reports to SMT (as required)<br>ii) Signed Fire Certificate<br>iii) Annual H&S reports to Trust Board and quarterly to PAF.<br>v) Ventilation audit report<br>vi) Water Safety Report (PAH site)<br>vii) Annual and quarterly report to PAF: Estates and Facilities May 20 - annual report)<br>viii) IPR monthly<br>ix) Annual Sustainability report to PAF (June 20)<br>x) Internal Audit report (tiaa) - review of PPM (limited assurance report) - Audit Committee Dec 2019, action plan in place<br>xi) Capital projects report (PAF Feb 20) | **5x4=20** | i) Planned Preventative Maintenance Programme (time delay) and amber backlog maintenance risks now emerging red risks<br>ii) Ventilation systems<br>iii) Sewage leaks and drainage<br>iv) Electrical Safety/Rewiring (gaps)<br>v) Maintaining oversight of the volume of action plans associated with compliance.<br>~~vii) Sustainability Management Group to be established~~<br>**ACTIONS:**<br>~~i) Backlog maintenance review underway and alignment of capital to identified risks with business cases to support investments.~~<br>ii) EBME review underway<br>iii) Review of estates function underway<br>iv) Compliance action plan (including PPM) in place | i) Estates Strategy /Place Strategy developing within STP<br>ii) Compliance with data collection and reporting<br>iii) PPM data not as robust as required<br>iv) PAM assurance not robustly updated. | 11/05/2020 | **Residual risk rating unchanged.** | **4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)** |
| | | | **Effects:**<br>i) Backlog maintenance increasing due to aged infrastructure<br>ii) Poor patient perception and experience of care due to aging facilities.<br>iii) Reputation impact<br>iv) Impact on staff morale<br>v) Poor infrastructure,<br>vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade,<br>vii) Poor patient experience,<br>viii) Single sex accommodation issues in specific areas,<br>ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements,<br>x) Ergonomics not suitable for new models of care.<br>xi) Failure to deliver transformation project and service changes required for performance enhancement<br>xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings<br>xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health. | | | | | | | | | | | |

| Risk Key | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Extreme Risk | | 15-25 | | | | | | | | | | | | |
| High Risk | | 8-12 | **The Princess Alexandra Hospital Board Assurance Framework 2020-21** | | | | | | | | | | | |
| Medium Risk | | 4-6 | | | | | | | | | | | | |
| Low Risk | | 1-3 | | | | | | | | | | | | |
| **Risk No** | | **PRINCIPAL RISKS** | | | | **KEY CONTROLS** | **ASSURANCES ON CONTROLS** | **BOARD REPORTS** | | | | | | |
| | | **Principal Risks** | | **RAG Rating (CXL)** | **Executive Lead and Committee** | **Key Controls** | **Sources of Assurance** | **Positive Assurances on the effectiveness of controls** | **Residual RAG Rating (CXL)** | **Gaps in Control** | **Gaps in Assurance** | **Review Date** | **Changes to the risk rating since the last review** | **Target RAG Rating (CXL)** |
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| | | | | | | | | Evidence should link to a report from a Committee or Board. | | | | | | |
| | **Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.** | | | | | | | | | | | | | |
| **BAF 3.2** | | **Financial and Clinical Sustainability across health and social care system**<br>Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system | **Causes:**<br>i) The financial bridge is based on high level assumptions<br>ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them<br>iii) The resources required for delivery at a programme and workstream level have not been defined or secured<br>iv) The current governance structure is under development given the shift in focus from planning to delivery.<br>v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements. | **4 X 4= 16** | DoS<br>Strategy Committee | i) STP workstreams with designated leads<br>ii) System leaders Group<br>iii) New STP governance structure<br>iv) STP priorities developed and aligned across the system.<br>v) CEO's forum<br>vi) Integrated Clinical Strategy in development<br>vii) STP Estates Strategy being developed.<br>viii) STP Clinical Strategy in place<br>ix) STP wide Strategy Group implemented<br>x) Independant STP Chair and independant STP Director of Strategy appointed.<br><br>STP meetings focussing on management of Covid-19 | STP CEO's meeting (fortnightly)<br>Transformation Group meetings<br>Joint CEO/Chairs STP meetings (quarterly)<br>Clinical leaders group (meets monthly)<br>STP Estates, Finance meetings | i) Minutes and reports from system/partnership meetings/Boards<br>ii) CEO reports to Board and STP updates<br>iii) STP report to Strategy Committee (Oct 2019)<br>iv) STP lead's presentation to Trust Board (Aug '19). | **4 X 4= 16** | Lack of STP demand and capacity modelling.<br><br>**ACTIONS:**<br>System agreement on governance and programme management<br>System leadership capacity to lead STP-wide transformation<br>Trust to nominate representatives on proposed STP/ACP workstreams | | 11/05/2020 | **No changes to risk rating.** | **4x3=12 September 2020** |
| | | | **Effects:**<br>i) Lack of system confidence<br>ii) Lack of pace in terms of driving financial savings<br>iii) Undermining ability for effective system communication with public<br>iv) More regulatory intervention | | | | | | | | | | | |

| Risk Key | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Extreme Risk | | 15-25 | | | | | | | | | | | | |
| High Risk | | 8-12 | **The Princess Alexandra Hospital Board Assurance Framework 2020-21** | | | | | | | | | | | |
| Medium Risk | | 4-6 | | | | | | | | | | | | |
| Low Risk | | 1-3 | | | | | | | | | | | | |
| **Risk No** | | **PRINCIPAL RISKS** | | | | **KEY CONTROLS** | **ASSURANCES ON CONTROLS** | **BOARD REPORTS** | | | | | | |
| | | **Principal Risks** | | **RAG Rating (CXL)** | **Executive Lead and Committee** | **Key Controls** | **Sources of Assurance** | **Positive Assurances on the effectiveness of controls** | **Residual RAG Rating (CXL)** | **Gaps in Control** | **Gaps in Assurance** | **Review Date** | **Changes to the risk rating since the last review** | **Target RAG Rating (CXL)** |
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| | | | | | | | | Evidence should link to a report from a Committee or Board. | | | | | | |
| | **Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.** | | | | | | | | | | | | | |
| **BAF 3.3** | | **Strategic Change and Organisational Structure**<br>Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust. | **Causes:**<br>i) Staff and stakeholders lack of awareness and/or understanding of drivers and issues cross the system<br>ii) Scale, pace and complexity of change required.<br>iii) Infrastructure (IT, buildings) not supportive of change<br>iv) Financial resources lacking to support change<br>v) Focus on immediate operational and financial priorities versus the longer term strategic planning<br>vi) Lack of clarity regarding contracting and organisational models in support of ICP<br>vii) Management resource and team with relevant capability and skills to drive change and strategy development to be developed.<br>viii) Uncertainty around future CCG structure and relationships | **4 X 4= 16** | DoS Strategy Committee | i) Good relationships with key partner organisations<br>ii) CEO chairing ICP Board<br>iii) CEO and Chair attending STP meetings<br>iv) Clinical Strategy being developed.<br>v) Strategy Committee established and Strategy team in place<br>vi) Development of MSK service and engagement of senior clinicians.<br>vii) One Health and Care Partnership established<br>viii) Financial principles for integrated working developed, allocative contract and due diligence underway<br>ix) NHSE/I assurance process underway<br>x) Legal advice sought on governance and staff transfers<br>xi) Transformation plan in development | i) ICP Board and STP meetings<br>ii) Expert Oversight Groups and workstreams (finance,people, IT)<br>iii) ICP senior leaders meetings<br>iv) Executive to executive meetings and Board to Board meetings (as required) | i) ICP Reports to Strategy Committee<br>ii) CEO report to Board (bi-monthly)<br>iii) ICP update Board development session Jan 2020 | **4x3=12** | i) Data quality impacting on business intelligence (SLR)<br>**ACTIONS:**<br><br>PAH long term strategy being developed | ~~Reporting from EOGs/workstreams to be established.~~<br>Development of governance structures for integration and legislation CCG Accountable Officer process delayed and underway | 11/05/2020 | **Risk rating not changed.** | 4 x 2= 8<br>**September 2020** |
| | | | **Effects:**<br>i) Poor reputation<br>ii) Increased stakeholder and regulator scrutiny<br>iii) Low staff morale<br>iv) Threatened stability and sustainability<br>v) Restructuring fails to achieve goals and outcomes<br>vi) Impact on service delivery and quality of care<br>vii) Poor staff survey<br>viii) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure<br>ix) Undermines regulatory confidence to invest in hospital/system solutions | | | | | | | | | | | |

| Risk Key | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| xtreme Risk | | 15-25 | | | | | | | | | | | | |
| High Risk | | 8-12 | **The Princess Alexandra Hospital Board Assurance Framework 2020-21** | | | | | | | | | | | |
| edium Risk | | 4-6 | | | | | | | | | | | | |
| Low Risk | | 1-3 | | | | | | | | | | | | |
| **Risk No** | | **PRINCIPAL RISKS** | | | | **KEY CONTROLS** | **ASSURANCES ON CONTROLS** | **BOARD REPORTS** | | | | | | |
| | | **Principal Risks** | | **RAG Rating (CXL)** | **Executive Lead and Committee** | **Key Controls** | **Sources of Assurance** | **Positive Assurances on the effectiveness of controls** | **Residual RAG Rating (CXL)** | **Gaps in Control** | **Gaps in Assurance** | **Review Date** | **Changes to the risk rating since the last review** | **Target RAG Rating (CXL)** |
| | | What could prevent the objective from being achieved | What are the potential causes and effects of the risks | | Which area within our organisation this risk primarily relate to | What controls or systems are in place to assist in securing the delivery of the objectives | Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective | We have evidence that shows we are reasonably managing our risks and objectives are being delivered | | Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective. | Where are we failing to gain evidence that our controls/systems, on which we place reliance. | | | |
| | | | | | | | | Evidence should link to a report from a Committee or Board. | | | | | | |
| | **Strategic Objective 3 : Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.** | | | | | | | | | | | | | |
| **BAF 3.4** | | **Sustainability of local services**<br>Failure to ensure sustainable local services continue whilst the new hospital plans are in development. ~~and funding is being secured.~~ | **Causes:**<br>i) Limited NHS financial resources (Revenue and Capital)<br>ii) Long periods of underinvestment in backlog maintenance<br>iii) Lack of capital investment,<br>iv) Current financial situation,<br>v) Inherited aged estate in poor state of disrepair<br>vi) Complexity of STP<br>vii) Insufficient quantity and expertise in workforce capability | **4 X 4= 16** | Director of Strategy<br>New Hospital Committee | i) Potential new build/location of new hospital<br>ii) STP Footprint and Estate Strategy developed.<br>iii) Herts & West Essex STP Estates workstream<br>iv) Pathology workstream led by CEO<br>v) Estates and Facilities Infrastructure subgroup for West Essex<br>vi) SOC affordability model<br>vii) SOC approved and submitted to NHSI<br>viii) Detailed analysis of current site option commissioned<br>ix) Master planning work being aligned to Six Facet Survey and Health Planning, phasing of development on PAH site or off site.<br>x) Alignment of strategic capital and tactical capital plans<br>xi) MSK service developments underway<br>xii) Funding confirmed<br>xiii) PAH part of HIP 1 funding programme for capital investment<br>xiv) PCBC completed, submitted and reviewed by NHSI<br>xv) New members of strategy team appointed<br>xvi) OBC in development (completion date is March 2021) | i) PAF, Strategy Committee and Board meetings<br>ii) SMT Meetings<br>iii) Capital Planning Group<br>iv) Weekly Estates and Facilities meetings<br>v) Stakeholder group<br>vi) New Hospital Committee established | i) STP reports to Strategy Committee (bi-monthly)<br>ii) Reports to SMT<br>iii) STP work plans<br>iv) Our New Hospital reports to Strategy Committee (Oct 2019 and updates to Board (May 2020).<br>v) PAHT 2030 report to Trust Board (April 2020)<br>vi) PCBC approved at Trust Board (September 2019)<br>~~vii) MAU business case approved at Trust Board September 2019~~<br>vii) New hospital update to Trust Board (May 2020) | **4 x 4 = 16** | i) Balancing short term investment in the PAH site vs the required long term investment<br>~~Gaps in Strategy team~~<br>Availability of clinical and non-clinical staff to provide input on plans during Covid.<br><br>**ACTIONS:**<br><br>Clinical strategy being developed and underpinned by 5P plans<br>~~Phase II work underway~~ | i) Clinical strategy in development | 05/05/2020 | **No change to residual risk rating.** | **4 x 3 =12**<br><br>**March 2021 (on completion of OBC)** |
| | | | **Effects:**<br>i) Failure to deliver strategy and transformation project and service changes required for service and performance enhancement<br>ii) Poor patient perception and experience of care due to aging facilities.<br>iii) Reputation impact<br>iv) Impact on staff morale<br>v) Poor infrastructure,<br>vi) Deteriorating building fabric and engineering plant<br>vii) Poor patient experience,<br>viii)Backlog maintenance<br>ix) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.<br>x) Lack of integrated approach<br>xi) Increased risk of service failure<br>xii) Impact on throughput of patients | | | | | | | | | | | | |

| Risk Key | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Extreme Risk | | 15-25 | | | | | | | | | | | | |
| High Risk | | 8-12 | **The Princess Alexandra Hospital Board Assurance Framework 2020-21** | | | | | | | | | | | |
| Medium Risk | | 4-6 | | | | | | | | | | | | |
| Low Risk | | 1-3 | | | | | | | | | | | | |
| **Risk No** | | **PRINCIPAL RISKS** | | | | **KEY CONTROLS** | **ASSURANCES ON CONTROLS** | **BOARD REPORTS** | | | | | | |
| | | **Principal Risks** | | **RAG Rating (CXL)** | **Executive Lead** | **Key Controls** | **Sources of Assurance** | **Positive Assurances on the effectiveness of controls** | **Residual RAG Rating (CXL)** | **Gaps in Control** | **Gaps in Assurance** | **Review Date** | **Changes to the risk rating since the last review** | **Target RAG Rating (CXL)** |
| | | What could prevent the objective from being achieved | What are the potential causes and effects of the risks | | Which area within our organisation this risk primarily relate to | What controls or systems are in place to assist in securing the delivery of the objectives | Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective | We have evidence that shows we are reasonably managing our risks and objectives are being delivered<br>Evidence should link to a report from a Committee or Board. | | Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective. | Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective | | | |
| | **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators** | | | | | | | | | | | | | |
| **BAF 4.2** | | **4 hour Emergency Department Constitutional Standard**<br>Failure to achieve ED standard | **Causes:**<br>i) Access to community and OOH services.<br>ii) Change in Health Demography with increase in long term conditions.<br>iii) Gaps in medical and nursing workforce<br>iv) Lack of public awareness of emergency and urgent care provision in the community.<br>v) Attendances continue to rise annually (5.1% over the last 2 years).<br>vi) Changes to working practice and modernisation of systems and processes<br>vii) Delays in decision making, patient discharges and delays in social care and community impacting on flow<br>viii) Increases in minor attendances | **4 X 5 = 20** | Chief Operating Officer Performance and Finance Committee | i) Performance recovery plans in place<br>ii) Regular monitoring and weekly external reports<br>iii) Daily oversight and escalation<br>iv) Robust programme and system management<br>v) Escalation calls with NHSI<br>vi) Work in progress to develop new models of care<br>vii) Local Delivery Board in place<br>viii) System reviewing provision of urgent care<br>ix) Exec attendance at safety huddles<br>x) ED action plan reported to PAF/Board<br>xi) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries<br>xii) Protection of assessment capacity work underway<br>xiii) Weekly Urgent Care operational meetings and Urgent Care Board in place<br>xiv) On site support from ECIST and NHSI medical lead<br>xv) Focus on length of stay in ED for all patients<br>xvi) Focus on improving assessment capacity<br>xvii) GP attending weekly length of stay review meetings<br>xviii) Covid controls in place including separation of ED, new pathways in place, reduced ED attendances<br>xix) Improved ambulance handover process and improved staffing levels | i) Access Board meetings<br>ii) Board, PAF and SMT meetings<br>iii) Monthly Operational Assurance Meetings<br>iv) Monthly Local Delivery Board meetings<br>v) Weekly System review meetings<br>vi) Escalation meetings with NHSI/~~NHSE~~<br>vii) Weekly HCG reviews<br>viii) System Operational Group<br>ix) Weekly Length of Stay meetings | i) Daily ED reports to NHSI<br>ii) Monthly escalation reports to NHSE<br>iii) Monthly PRM reports from HCGS<br>iv) Monthly IPR reported to PAF/QSC and Board reflecting ED performance - delivery of standard has improved in the 4 weeks prior to review of risk.<br>~~v) Presentation on ED performance and 'next steps' to PAF and Board (May/June 19).~~ | **4x5=20**<br>**4x4=16** | i) Staffing (Trust wide) and site capacity<br>ii) System Capacity<br>iii) Leadership issues<br><br>**Actions:**<br>i) Local Delivery Board monitoring ED performance<br>iii) Monthly Performance review meetings and weekly Urgent Care Board review | None noted. | 14/05/2020 | **Risk score reduced to 16 from 20 to reflect current improvement in delivery of standard** | **4x3 =12 September 2020 (on consistent delivery of standard - 95%)** |
| | | | **Effects:**<br>i) Reputation impact and loss of goodwill.<br>ii) Financial penalties.<br>iii) Unsatisfactory patient experience.<br>iv) Potential for poor patient outcomes<br>v) Jeopardises future strategy.<br>vi) Increased performance management<br>vii) Increase in staff turnover and sickness absence levels | | | | | | | | | | | |

| Risk Key | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Extreme Risk | | 15-25 | | | | | | | | | | | | |
| High Risk | | 8-12 | **The Princess Alexandra Hospital Board Assurance Framework 2020-21** | | | | | | | | | | | |
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| | | | | | | | | Evidence should link to a report from a Committee or Board. | | | | | | |
| | **Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2019/20 and our local system** | | | | | | | | | | | | | |
| **BAF 5.1** | | **Finance**<br>Concerns around failure to meet financial plan including cash shortfall. | Causes:<br>i) Operational performance impacting on financial performance including recovery of PSF/FRP ii) CCG affordability, QIPPs, contractual disputes and challenges, iii) ability to deliver recurrent CIPs, iv) workforce shortages and associated temporary staffing usage/costs v) high levels of unplanned expenditure including maintenance of aging estate, vi) Capture and billing of activity. vii) Potential impact of pension changes | **5 X 4= 20** | **Exec leads :** CFO<br>**Committee** : Performance and Finance Committee | i) Access to Interim Revenue Support loans<br>ii) Cost Improvement Programme<br>iii) Formal reconciliation process with CCG<br>iv) Internal and external Agency controls and reporting<br>v) SMT, PAF and Audit Committee<br>vi) Health Care Group PRM meetings<br>vii) Enhanced Performance Reviews<br>viii) Regular Balance sheet reviews<br>ix) Approved Governance Manual<br>x) Budget sign off process<br>xi) Enhanced financial reporting and controls<br>xii) Regulatory returns required e.g. agency spend<br>xiii) Increased frequency of reporting for selected HCGs<br>xiv) Medical agency protocol<br>xv) Financial Recovery Plan - due Sept 2019<br>xvi) Demand and Capacity planning and HCGs year end forecasts<br>xviii) Use of resources assessment 26.03.19<br>xxvix) The Trust and CCG are jointly developing revised system financial principles e.g. allocative/block payment or minimum guarantee payment<br>xxx) CCG/STP/Central allocations and support at ICP and STP level | i) Internal Audit & External Audit opinion.<br>ii) External reviews<br>iii) NHSI/E reporting<br>iv) Internal Trust reporting<br>v) Cash Management group<br>vi) Joint meetings with CCG<br>vii) Delivery Group - weekly<br>viii) Staffing Task Group and CQUIN Group | i) Monthly reports including bank balances and cash flow forecasts to PAF and Board<br>ii) CIP reports<br>iii) Internal Audit reports: Financial Reporting and Budget Monitoring (substantial assurance)<br>Key Financial Systems (substantial assurance)<br>Non-SLA Income (limited assurance)<br>iv) Financial Recovery Plan<br>v) FAM reports monthly<br>vi) PRM packs monthly<br>vii) Recovery plans and trajectories reported to Delivery Group (weekly) | **5 x 4 = 20** | i) Organisational and Governance compliance e.g. waivers<br>ii) Activity and capacity planning<br>iii) CIP delivery<br>iv) CQUIN - risk of recovering full income<br>v) Management of temporary staffing costs | Demand and Capacity Workforce planning | 22.05.20 20 | | 4 x 3 =12 (end Sept 2020) |
| | | | Effects:<br>i) Ability to meet financial control target and loss of £21 PSF/FRF<br>ii) Delay to payment to creditor/ suppliers<br>ii) Increased performance management<br>iv) Going Concern status<br>v) Risk to securing central funds<br>vi) Impact on capital availability<br>vi) Unfavourable audit opinion (VfM,Section 30 Letter)<br>vii) Restrictions on service development<br>viii) Recruitment & retention<br>ix) Increased likelihood of dispute/arbitration processes<br>x)Reputational risks | | | | | | | **ACTIONS:**<br>Future Modernisation<br>Demand and Capacity Planning and Modelling to be regularised<br>Clinical and operational forums in place to review QIPP schemes.<br>~~Review of Capital reporting and planning for 19/20 underway.~~<br>Intensive support for job planning, rota and roster management.<br>Focus on Medicine and Surgery HCGs.<br>Review of CIP processes<br>Collective Executive targetting of temporary staffing | | | | |

The Princess Alexandra Hospital NHS Trust

2.3

**Trust Board (Public) 04.06.20**

| | |
|---|---|
| **Agenda item:** | 2.3 |
| **Presented by:** | Stephanie Lawton – Chief Operating Officer |
| **Prepared by:** | Chris Allen – Emergency Planning & Resilience Manager |
| **Date prepared:** | May 2020 |
| **Subject / title:** | Major Incident Plan |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose:** | Approval | x | Decision | | Information | | Assurance | |
| **Key issues:** | As part of the Civil Contingencies Act 2004 the Trust is required to plan to deal with emergencies affecting the organisation and the community. This plan outlines the arrangements the Trust will take in dealing with emergency situations allowing us to fulfil our Statutory duties. | | | | | | | |
| **Recommendation:** | The board is recommended to approve the attached plan. | | | | | | | |

| **Trust strategic objectives:** please indicate which of the five Ps is relevant to the subject of the report | Patients | People | Performance | Places | Pounds |
|---|---|---|---|---|---|
| | x | x | x | x | x |

| | |
|---|---|
| **Previously considered by:** | Trust Policy Group |
| **Risk / links with the BAF:** | There is a risk of potential legal and regulatory action should the attached plan not be approved. |
| **Legislation, regulatory, equality, diversity and dignity implications:** | Civil Contingencies Act 2004<br>NHS Standard Contract<br>NHS England EPRR Core Standards<br>NHS England EPRR Framework |
| **Appendices:** | Major and Critical Incident Plan |

Your future | Our hospital

respectful | caring | responsible | committed

2.3

Controlled Copy Number – **Uncontrolled Copy**
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NHS
The Princess Alexandra Hospital
NHS Trust

# Major and Critical Incident Plan

IN THE EVENT OF AN INCIDENT BEING DECLARED
**DO NOT READ THIS PLAN**
REFER DIRECTLY TO YOUR ACTION CARD

V4.0

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# Action Card List

| Action Card Number | Incident Role | Undertaken By | Page |
|---|---|---|---|
| 1 | Gold Commander | Executive On-Call | 62 |
| 2 | Silver Commander (Nurse) | Clinical Site Manager | 66 |
| 3 | Silver Commander (Manager) | Senior Manager On-Call | 71 |
| 4 | Tactical Advisor | Tactical Advisor On-Call | 76 |
| 5 | Switchboard | Switchboard Operator | 78 |
| 6 | Loggist | Any Trained Loggist | 80 |
| 7 | Bronze ED Nurse | ED Nurse in Charge | 84 |
| 8 | Bronze ED Consultant | On-Call ED Consultant | 86 |
| 9 | Bronze Triage Nurse | Experienced ED Nurse | 88 |
| 10 | P1 Area Doctor | Anaesthetic Consultant | 92 |
| 11 | P2 Area Doctor | Surgical Consultant | 94 |
| 12 | P3 Area Doctor | Orthopaedic Consultant | 96 |
| 13 | ED Doctor | ED Doctor / Any doctor assigned to ED | 98 |
| 14 | ED Nurse | ED Nurse / Any nurse assigned to ED | 100 |
| 15 | Triage Receptionist | ED Receptionist | 102 |
| 16 | P1, P2, P3 Receptionist | ED Receptionist | 104 |
| 17 | Paediatric Nurse | Paediatric Nurse | 106 |
| 18 | Paediatric Consultant | Paediatric Consultant | 108 |
| 19 | ED Porter | ED Porter | 110 |
| 20 | Bronze Porter | Portering Supervisor | 114 |
| 21 | Bronze EAU Nurse | Nurse in Charge – EAU | 116 |
| 22 | Bronze ITU Nurse | Nurse in Charge – ITU | 118 |
| 23 | Medical Advisor | Chief Medical Officer or Deputy | 120 |
| 24 | Bronze Theatre Nurse | Nurse In Charge – Theatres | 122 |
| 25 | Bronze Relatives | Patient Experience Team | 124 |
| 26 | Bronze Staff Coordinator | Allocated by Silver Manager | 126 |
| 27 | Bronze Medical Doctor | Physician of the Day | 128 |
| 28 | Bronze Pharmacist | Lead Pharmacist | 132 |
| 29 | Bronze Estates | On-Call Estates Manager | 134 |
| 30 | Bronze Facilities | On- Call Facilities Manager | 136 |
| 31 | CSSD Lead | Person in Charge CSSD | 138 |
| 32 | Mortuary Lead | On-Call Mortuary Technician | 140 |
| 33 | Bronze Radiographer | Person in Charge – Radiography | 142 |
| 34 | Security | Security | 144 |
| 35 | Hospital Chaplain | Chaplain | 146 |
| 36 | Communications Lead | Head of Communications | 148 |
| 37 | Bronze Press | Communications Manager | 150 |
| 38 | On-Call Haematology | On-Call Haematologist | 152 |
| 39 | Runner | Allocated by Silver Nurse | 154 |
| 40 | Ward / Dept Manager / Person In Charge | Ward / Dept Manager / Person In Charge | 156 |

| | | | |
|---|---|---|---|
| | Red | Essential Role | Used in all incidents |
| | Yellow | Emergency Dept. Role | Used when incidents are related to the emergency department |
| | Green | Supporting Role | Used as required dependant on the incident |

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# CONTENTS

# Document Control

## Disclaimer

Due to the nature of the plan, some elements may require dynamic management during delivery.
**This plan should only be used in an Incident if it is the current version on the Trust Intranet or is a Controlled Copy.**

## Author

Christopher Allen Emergency Planning and Resilience Manager

## Version Control

| Date | Revision/Amendment Details & Reason | Author |
|---|---|---|
| 01/08/2015 | Full plan update – Vers 3.0 | Chris Allen |
| 12/11/2015 | Minor changes following Trust Policy Groups – Vers 3.1 | Chris Allen |
| 10/04/2020 | Full plan update – Vers 4.0 | Chris Allen |

## Review

This plan will be subject to regular review

| | |
|---|---|
| Annual | Review Trust wide to ensure content remains current |
| 3 Yearly | Full review and new edition produced |
| Post incident | As part of any post incident review, the plan will be reviewed and updated |

V4.0

## Sign Off

| Steven Clarke<br>**Trust Chairman** | | Lance McCarthy<br>**Chief Executive Officer** | |
|---|---|---|---|
| **Signature** | | **Signature** | |
| **Date** | | **Date** | |

## Circulation

| **Printed Controlled Copies** | **Electronic Controlled Copies** |
|---|---|
| Incident Coordination Centre x 4 | Intranet |
| Strategic Coordination Centre x 2 | ResilienceDirect |
| Emergency Department x 2 | Trust Website (Redacted version) |
| Paediatric Emergency Department x 1 | |
| Emergency Planning Office x 1 | |
| Fall Back Incident Coordination Centre x 4 | |

# 1. Chief Executive Foreword

This document is the Major Incident Plan for The Princess Alexandra Hospital NHS Trust. It outlines the arrangements to be undertaken by the Trust at the time of a Major Incident or emergency. It has been prepared in the light of advice from the Department of Health (DH) NHS Emergency Planning Guidance, Civil Contingencies Act 2004 and through consultation and close liaison with other relevant agencies. This process ensures an integrated approach to emergency management in line with the Essex Local Resilience Forum (LRF).

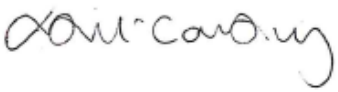
A Major Incident is any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations.

It is important that we consider the wide range of events that we may be called upon to deal with. A 'Big Bang' Major Incident, such as the London bombings on the 7th July 2005 place real pressure on NHS services. A national Incident such as a disruption to road fuel supply or a severe weather Incident can disrupt the continuity of NHS services across the country. Similarly 'rising tide' Major Incidents, such as infection disease outbreaks can have a catastrophic impact of the health of the population which may need a prolonged coordinated response.

A Major Incident can occur at any time of the day or night. It is vital that we are prepared and can respond at short notice to provide a coordinated range of emergency, medium and long term services to patients, relatives and friends, and our own staff.

As the Chief Executive, I acknowledge that final responsibility for emergency planning and resilience rests with my appointment. However, all relevant staff must familiarise themselves with the contents of this plan, not only to monitor their individual areas of responsibility as preparation for their response to an Incident, but to feedback useful information and suggested improvements to the Emergency Planning and Resilience Team.

I am satisfied that this plan ensures that The Princess Alexandra Hospital NHS Trust has effective arrangements in place to respond to a Major Incident.



**Lance McCarthy**
Chief Executive Officer

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# 2. Introduction

As a Trust we need to be able to plan for, and respond to, a wide range of Incidents that could impact on health or patient care. These could be anything from prolonged period of severe pressure, extreme weather conditions, an outbreak of an infectious disease, or a major transport accident. A critical Incident or emergency is any event that cannot be managed within routine service arrangements. It requires the implementation of special procedures and may involve one or more of the emergency services, the NHS or a local authority.

The Civil Contingencies Act (CCA) (2004) requires category one responders (such as The Princess Alexandra Hospital NHS Trust), to show that they can deal with such Incidents while maintaining services to patients. NHS funded organisations, including commissioners and providers of NHS funded care, whilst not all Category one responders, must also show they can deal with such Incidents, this programme of work is referred to in the health community as emergency, preparedness resilience and response (EPRR).

This plan builds upon the philosophies of NHS resilience, as an organisation we must use the Integrated Emergency Management (IEM) cycle to anticipate, assess, prevent, prepare, respond and recover from disruptive challenges. The IEM cycle ensures a constant review of activity and therefore robust preparedness arrangements.

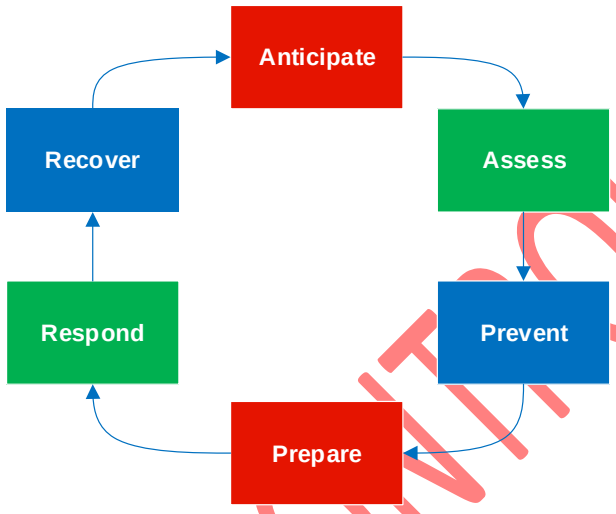



*Fig 1 – Integrated Emergency Management Cycle*

## 2.1 Aim

To provide a framework by which the Trust will respond to and recover from Critical and Major Incidents.

## 2.2 Objectives

- To save lives
- To protect property
- To limit impact on services
- To maintain patient safety and quality
- To return as soon as possible to a new normality

## 2.3 Associated documents, policies and plans

| | |
|---|---|
| Civil Contingencies Act 2004 | Act of Parliament |
| Heath and Social Care Act 2012 | Act of Parliament |

| | |
|---|---|
| NHS Standard Contract | NHS England |
| Everyone Counts: Planning for Patients | NHS England |
| EPRR Documents and Supporting Materials | NHS England |
| National Occupational Standards for Civil Contingencies | Skills for Justice |
| ISO 22301:2012 | ISO |
| National Ambulance Service Command and Control Guidance | National Ambulance Resilience Unit |
| Joint Doctrine: The Interoperability Framework | Joint Emergency Services Interoperability Program |
| West Essex Escalation Protocol | West Essex Clinical Commissioning Group |
| Bed Management Concept of Operations | The Princess Alexandra Hospital |
| CBRNe Plan | The Princess Alexandra Hospital |
| Mass Casualty Plan | The Princess Alexandra Hospital |
| Pandemic Flu Plan | The Princess Alexandra Hospital |
| Fuel Plan | The Princess Alexandra Hospital |
| Cold Weather Plan | The Princess Alexandra Hospital |
| Heatwave Plan | The Princess Alexandra Hospital |
| Fire Procedures | The Princess Alexandra Hospital |
| Child Abduction Procedures | The Princess Alexandra Hospital |
| Mass Prophylaxis Plan[1] | The Princess Alexandra Hospital |
| Stansted Airport Emergency Orders[2] | Stansted Airport |
| Ambulance Divert Protocol | NHS England |
| Handover Delays Protocol | NHS England |
| A&E Bed Wait Protocol | NHS England |

Copies of all of these plans and documents are available via the Resilience Team, Trust Intranet or ResilienceDirect.

## 2.4 Scope

All staff should be aware of the existence of the plan and of their general responsibilities when responding to a Major Incident. Staff who have a named designated role in the plan should be aware of the detail of the plan and the relevant action card. Staff and departments that have other designated roles and responsibilities in the plan should be aware of the existence of the plan and their action cards. An introduction to the plan will form part of Trust induction.



[1] This plan is Classified as Official-Sensitive and is therefore not a public document
[2] This plan is Classified as Official-Sensitive and is therefore not a public document

# 3. Context

## 3.1 Definition of a Critical and Major Incident

A Major or Critical Incident can be described as any event that cannot be managed within routine service arrangements. Each require the implementation of special procedures and may involve one or more of the emergency services, the wider NHS or a local authority, a critical incident or emergency may include;

- Times of severe pressure, such as winter periods, a sustained increase in demand for services such as surge or an infectious disease outbreak that would necessitate the declaration of a Critical Incident, however not a Major Incident;
- Any occurrence where the Trust is required to implement special arrangements to ensure the effectiveness of its internal response. This is to ensure that Incidents above routine work but not meeting the definition of a Major Incident are managed effectively.
- An event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK. The term ‘‘Major Incident’’ is commonly used to describe such emergencies. These may include multiple casualty Incidents, terrorism or national emergencies such as pandemic influenza.
- An emergency is sometimes referred to by organisations as a Major Incident. Within NHS funded organisations an emergency is defined as the above for which robust management arrangements must be in place.

The term critical incident or emergency is deliberately broad to ensure that potential Incidents are not missed. It recognises the fundamental importance of community confidence and trust in the Trust’s response to any Incidents.

In the first instance the Trust must consider declaring a Critical Incident before escalating to a Major Incident. A Critical Incident is when our facilities and/or resources, or those of its neighbours, are overwhelmed.

A critical Incident or emergency to the NHS may not be any of these for other agencies, and equally the reverse is also true. An Incident may present as a variety of different scenarios, they may start as a response to a routine emergency call or 999 response situation and as this evolves it may then become a Critical Incident or be declared as a Major Incident, examples of these scenarios are:

- **A big bang Incident** – such as a serious transport accident, explosion or series of smaller Incidents.
- **Rising tide** – a developing infectious disease epidemic or a capacity/staffing crisis.
- **Cloud on the horizon** – a serious threat, such as a Major chemical or nuclear release developing elsewhere but needing preparatory action.
- **Headline news** – public or media alarm about a personal threat.
- **Internal Incidents** – such as fire, loss of a utility, equipment failure, industrial action, and referred to as Critical Incidents
- **Deliberate or accidental release of chemicals, biological, radiological or nuclear materials**.
- **Mass casualties** – where it is not possible for one organisation to cope with the number of people affected.
- **Pre-planned Major events** – such as those agreed by the Local Authority for Harlow and the local area.

## 3.2 Underpinning Requirements and Principles of EPRR

Under the NHS Constitution 2012, the NHS is there to help the public when they need it most; this is especially true during a critical or major incident.

Each NHS funded organisation must therefore ensure it has robust and well tested arrangements in place to respond and recover from these situations.

Extensive evidence shows that good planning and preparation for any Incident or emergency saves lives and expedites recovery.

The Civil Contingencies Act 2004 (CCA) delivers a single, framework for the provision of civil protection in the UK. The principal objectives of the Act are to ensure consistency of planning across all government departments and its agencies, whilst setting clear responsibilities for frontline responders at a local level.

The Act divides responder organisations into two categories, depending on the extent of their involvement in civil protection work, and places a proportionate set of duties on each.

### 3.2.1 Category One Responders

Category one responders are those organisations at the core of emergency response (e.g. emergency services, local authorities). The category includes all Acute Trusts and Ambulance NHS Trusts, Public Health England (PHE) and the NHS England.

Category one responders have legal responsibilities in six specific areas, which are:

Co-operating with other responders;

- Co-operate with other responder organisations to enhance coordination and efficiency when planning for an emergency;
- Co-operate with other responder organisations to enhance coordination and efficiency when responding to and recovering from an emergency.

Risk assessment;

- Assess the risk of emergencies occurring within their area and use this to inform contingency planning;
- Collaborate with other organisations to compile community, local or national risk registers; and
- Ensure internal corporate risk management processes to include risk to continuation of services.

Emergency planning;

- Ensure emergency plans are in place in order to respond to emergencies linked with relevant risk registers;
- Ensure validation and exercising of emergency plans;
- Ensure appropriate senior level command and decision making 24/7;
- Ensure appropriate Incident Coordination Centre (ICC) facilities to control and coordinate the response to an emergency;
- Ensure relevant response staff are trained to an appropriate level for their role in response; and
- Ensure robust communication mechanisms.

Communicating with the public;

- Maintain arrangements to make available information on emergency preparedness matters to the public;
- Maintain arrangements to warn, inform and advise the public in the event of an emergency.

Sharing information;

- Share information with other local responder organisations to enhance co-ordination both ahead of and during an emergency.

Business continuity;

- To maintain plans to ensure that they can continue to deliver their functions in the event of an emergency so far as is reasonably practicable
- Assess both internal and external risks whilst developing and reviewing Business Continuity Plans (BCPs)

Primary care, community providers, mental health and other NHS organisations (NHS Blood and Transplant, NHS Logistics and NHS Protect) are not listed in the Civil Contingencies Act 2004. However, Department of Health (DH) and NHS England guidance expects them to plan for and respond to Incidents in the same way as category one responders in a manner which is proportionate to the scale and services provided.

As part of the Cabinet Office Capabilities Programme, there are several health work streams which are led by the DH including: mass casualties; infectious diseases; and essential services (health). The DH may require NHS funded organisations to contribute to any applicable work streams led by DH of by other Government departments. Detailed information can be found on the UK Resilience and Home Office websites.

### 3.2.2 Category Two Responders

Category two responders, such as Clinical Commissioning Groups (CCGs) and NHS Property Services are seen as *'co-operating bodies'*. They are less likely to be involved in the heart of the planning, but they will be heavily involved in Incidents that affect their sector through cooperation in response and the sharing of information;

Although category two responders have a lesser set of duties, it is vital that they share relevant information with other responders (both category one and two) if EPRR arrangements are to succeed;

Category one and two responders come together to form local resilience forums (LRF) based on police areas. These forums help to co-ordinate activities and facilitate co-operation between local responders. For the NHS, the strategic forum for joint planning for health emergencies is via the Local Health Resilience Partnerships (LHRPs) that will support the health sector's contribution to multi-agency planning through Local Resilience I.

## 3.3 NHS Wide EPRR Objective

The NHS service-wide objective for emergency preparedness, resilience and response is:

*To ensure that the NHS is capable of responding to incidents or emergencies of any scale in a way that delivers optimum care and assistance to the victims, that minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of functioning; it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries.*

## 3.4 Principles

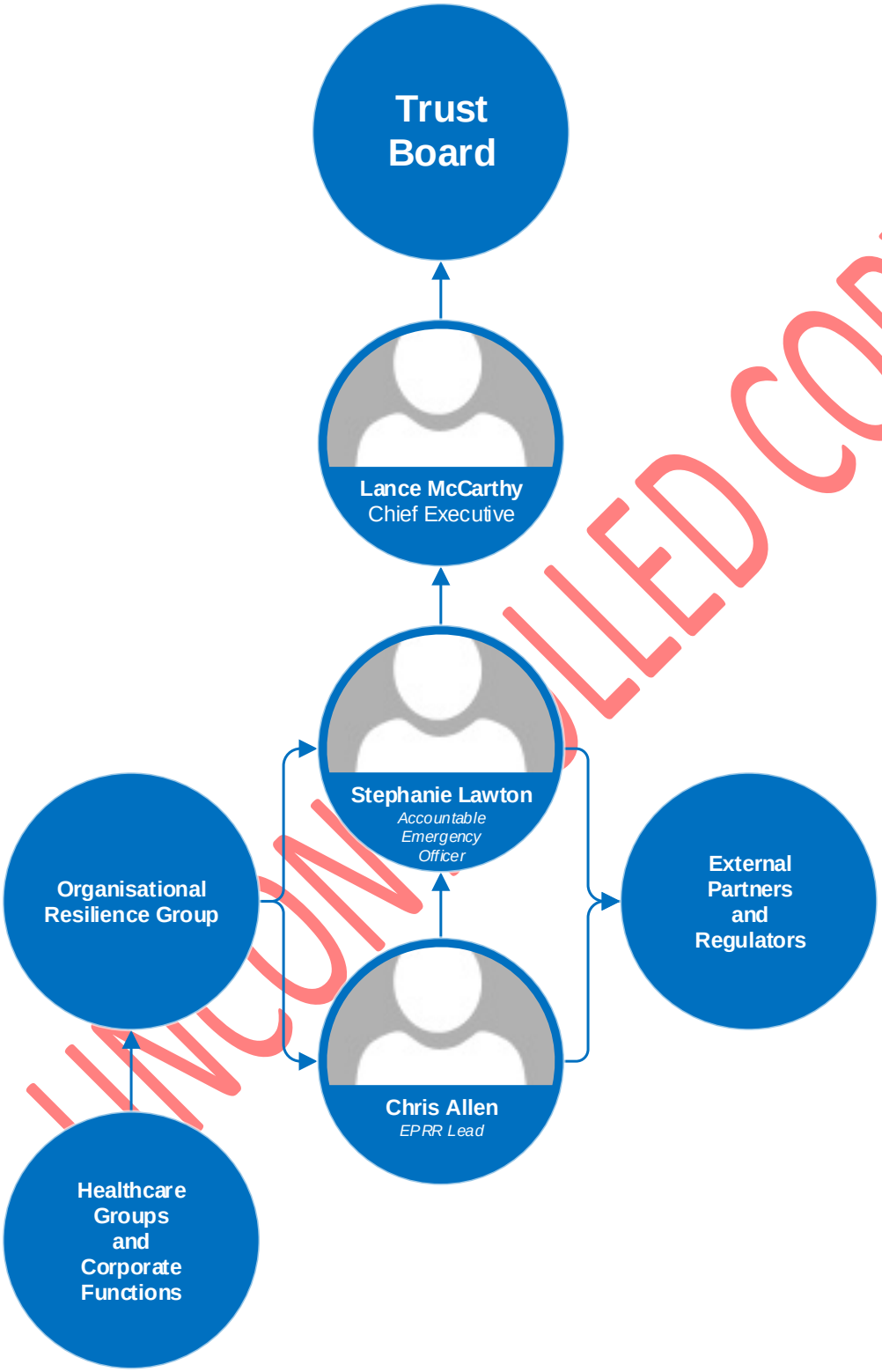
The underpinning principles for NHS emergency preparedness, resilience and response are:

- The management of an Incident should be at the level closest to the people affected by the Incident as is practical.
- Speed and flexibility at local operational level, delivered by acute health care providers, ambulance services, primary care providers, Public Health England (PHE), NHS Blood and Transplant (NHS BT), 111 services, NHS Professionals, independent and third sector healthcare and staffing providers;
- Active mutual aid across organisational boundaries, across national boundaries within the UK and across international boundaries where appropriate; and;
- A strong central capacity in the NHS England (at area team, regional and national levels) to oversee the health service working with the Department of Health (DH).

It is the nature of incidents and emergencies that they are unpredictable and each will present a unique set of challenges. The task is not to anticipate them in detail. It is to have a set of expertise available and to have developed a set of core processes to handle the uncertainty and unpredictability of whatever happens.

V4.0

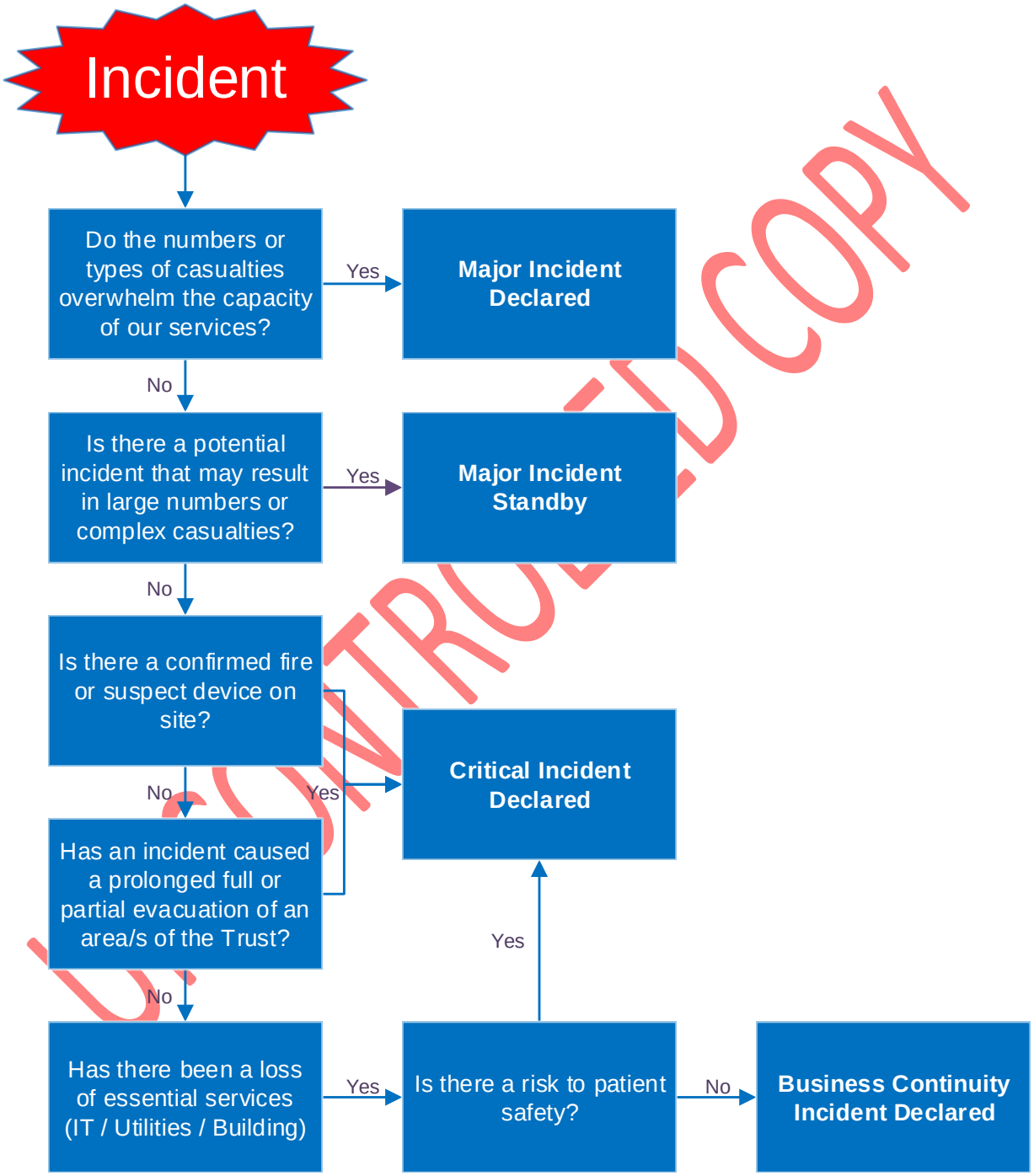
## 3.5 Trust EPRR Planning Structure



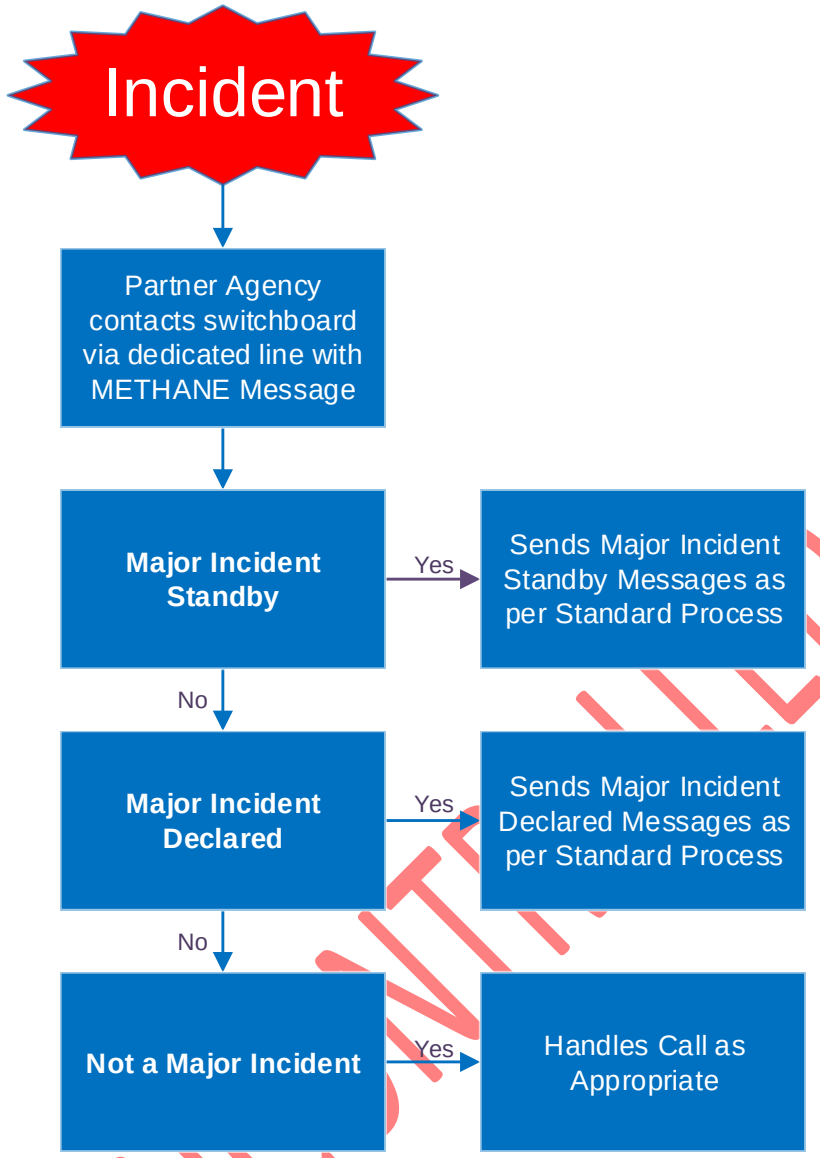
# 4. Incident Declaration and Notification

## 4.1 Internally Declared Incidents

TEXT



## 4.2 Externally Declared Incidents



# 5. Alert Levels

## 5.1 Trust Messages

### 5.1.1 Major Incident Stand By

When the situation is unclear, at an early stage or has the potential to escalate. The purpose of the Major Incident Standby is to get the organisation ready to implement special arrangements if these become necessary.

### 5.1.2 Major Incident Declared

When the situation requires special arrangements to be implemented in part or in full. The Major Incident Declared message starts the implementation of special arrangements to deal with the Major Incident.

### 5.1.3 Major Incident Cancelled

The situation is not as serious as thought and special arrangements will not be required.

### 5.1.4 Major Incident Stood Down

The organisation has completed its response and normal working arrangements are now re-instated. The Hospital Incident Coordination Centre is responsible for issuing the 'STAND DOWN' instruction after a Major Incident. No other person has the authority to do this.

### 5.1.5 Critical Incident Declared

When the situation requires special arrangements to be implemented in part or in full. The Critical Incident Declared message starts the implementation of special arrangements to deal with the Critical Incident.

### 5.1.6 Critical Incident Stood Down

The organisation has completed its response and normal working arrangements are now re-instated. The Hospital Incident Coordination Centre is responsible for issuing the 'STAND DOWN' instruction after a critical Incident. No other person has the authority to do this.

## 5.2 NHS England Categorisation

NHS England has determined Incident alert and response levels, to standardise the categorisation of Incidents as described in the table below. The alert levels will be agreed in liaison with NHS England and will be used in communication.

| Level | Response Level |
|---|---|
| 0 – Green | An Incident requiring health support that can be responded to and managed by local health provider organisations within their respective business as usual capabilities. |
| 1 – Yellow | An Incident requiring health support from a number of health provider organisations across an NHS England Area Team boundary and will require an Area Team to coordinate the NHS local support. |
| 2 – Amber | An Incident requiring health support from a number of health provider organisations across NHS England Area Teams across an NHS England Region and requires regional coordination to meet the demands of the Incident. |
| 3 – Red | An Incident requiring health support that requires NHS England National coordination to the NHS and NHS England Response |

# 6. Incident Response

## 6.1 Alerting

Staff will receive via Pager[3], Text Message, internal bleep system and Desk[4]Alerts information and alerts which may require the activation of the Trust response to a Major Incident these include:

- Receipt of a Major Incident Standby Message
- Receipt of a Major Incident Declared Message
- Receipt of a Critical Incident Declared Message
- Receipt of information from the Trust on-call manager, senior manager, NHS England, or our commissioners pertaining to an internal Incident, surge in demand for services or disruption to business as usual operations

An Alert, Cancellation or Stand Down may have been declared by another organisation (e.g. NHS England (Essex)) but this does not necessarily mean that the same instruction will be issued to the Trust. For example – NHS England (Essex) might declare a Major Incident following a serious train crash in south Essex, but the Trust might only be slightly affected so would not need to declare a Major Incident itself.

Internal and external Incidents, which will or may have significant impact on the hospital, can be declared by the following:

- Emergency Medicine (ED) Consultant
- ED Shift Manager
- Executive Director
- Senior Manager On-Call
- Clinical Site Manager
- Tactical Advisor
- Fire Team Leader (for fires only)
- An external Category 1 responder[5]

Consideration should be given to the Incident that may require a Critical / Major Incident being declared, and the reasons for declaring it. If in doubt request a stand by and seek advice from the On-Call Senior Manager, Executive or Tactical Advisor.



[3] Dependant on message type the distribution will vary, the Senior Manager On-Call, Executive On-Call and Tactical Advisor On-Call will receive all messages.
[4] DeskAlerts are pop up messages that will display on all Trust Owned Computers
[5] As defined previously

# 7. Command Arrangements

## 7.1 Executive Director On-Call

The Trust Chief Executive has ultimate responsibility and remains accountable for Trust's business delivery throughout all situations; however in a response to extreme pressure, Major Incidents or emergencies this is usually discharged through on-call executive directors, who operate on a 24hour a day on-call system.

The Executive Director on-call is the second line senior manager, who will strategically manage the site during business as usual, and in times of extremis.

## 7.2 Senior Manager On-Call

The Senior Manager on-call is the first line senior manager, who will tactically manage the site during business as usual, and in times of extremis.

## 7.3 Tactical Advisor

Tactical Advisors are the Trust's EPRR specialists. One of their roles is to advise the Tactical (Silver) Commander and act as a multiagency liaison at large or Major Incidents. At smaller Incidents where a Silver Commander is not needed the Tactical Advisor may act independently as the Silver Commander. [6]

## 7.4 Allocation of Roles

Roles in the Gold and/or Silver Command Teams will initially be filled by the on-call staff available. However, if there is a more appropriate member of staff who has local knowledge or skills that better match a specific Major Incident role, then the Hospital Incident Coordination Centre is able to re-allocate the role accordingly.

The attached actions cards are designed to provide guidance to personnel within these roles and are not designed to be a step by step guide. Dependent on the type of Incident, some or all of the roles may be filled.

## 7.5 Expectations on On-Call Commanders

- Must be able to respond in person to a call-out
- Must be able to attend the Hospital Incident Coordination Centre (HICC) within 60 minutes of a call-out
- Must be contactable for the duration of their on-call
- Must carry their Identity Card with them at all times
- Must carry their On-Call Pack
- Must carry their On-Call log book
- Must be familiar with the Trust Major Incident Plan
- Must be familiar with the Action Card for their role



[6] Further information on the Tactical Advisor Role is available from the Emergency Planning and Resilience Team.

# 8. Hospital Incident Coordination Centre

When a Major Incident is declared, the Trust will set up a dedicated and equipped Hospital Incident Coordination Centre (HICC) from which it will manage the Incident.

The Hospital Incident Coordination Centre is located:

**Hospital Operations Centre**
**A3**
**Lower Ground Floor**
**Princess Alexandra Hospital**

| | | |
|---|---|---|
| **Telephone:** | Internal | 2999 |
| | External | 0844 351 1041 |
| **Email:** | paht.majorincident@nhs.net | |

In the event this location cannot be used the Fall Back Incident Coordination Centre is located:

**HR Department**
**3rd Floor**
**Mitre Building**

| | | |
|---|---|---|
| **Telephone:** | Internal | 1258 |
| | External | 0844 351 1041 |
| **Email:** | paht.majorincident@nhs.net | |

The dedicated ICCs should be set up and used wherever possible, however it is acknowledged that there will be circumstances when this is not possible because either on-call staff cannot physically get to the hospital Incident coordination centre or they are physically unusable. In this case, all on-call staff should have a Trust mobile phone, web access to generic email addresses and On-Call pack that will aid them in their response until a suitable Incident Coordination Centres can be set up and staffed.

## 8.1 Strategic Co-ordination Room

The Strategic Coordination Room is located:

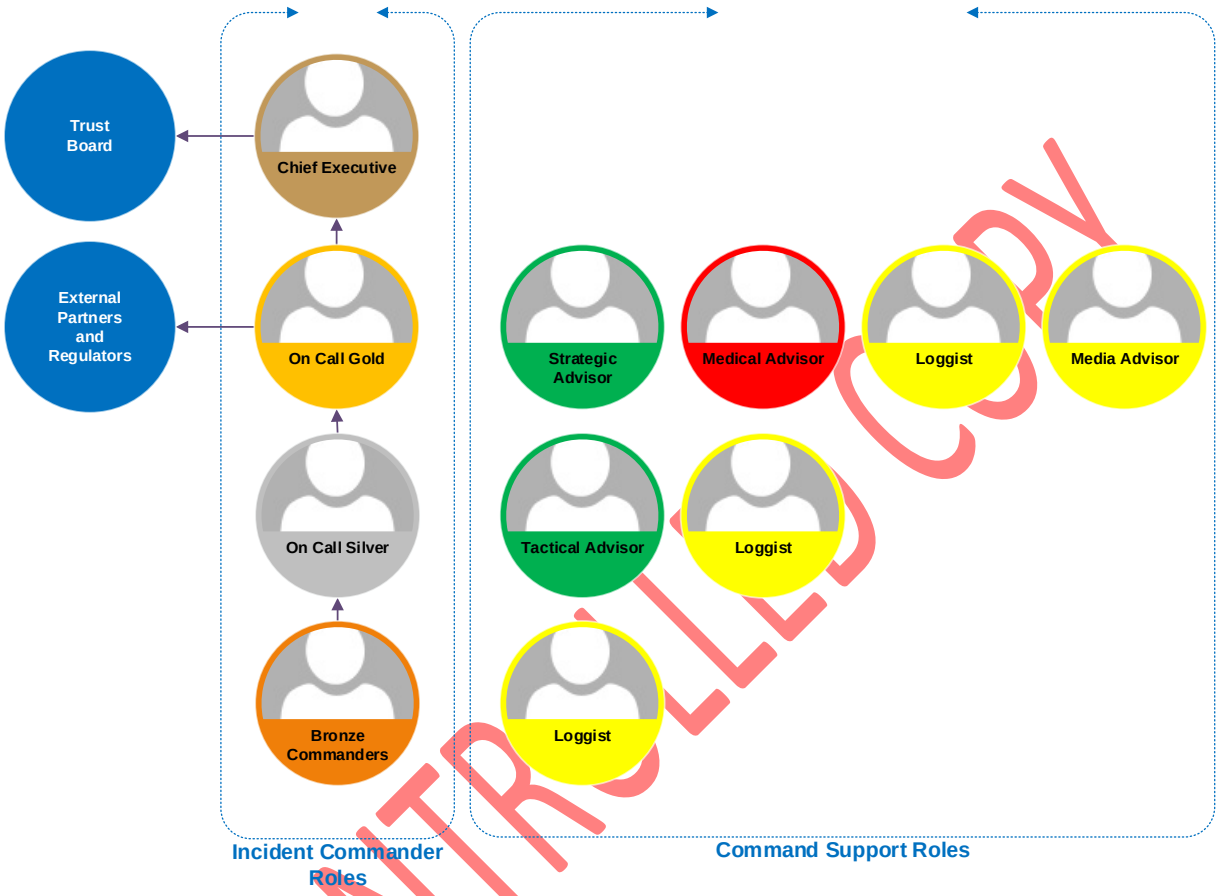
**Meeting Room 1**
**Trust Board Headquarters**
**Kalmar House – Building 9**
**Princess Alexandra Hospital**

| | | |
|---|---|---|
| **Telephone:** | Internal | 7574 |
| | External | 01279 827574 |
| **Email:** | paht.majorincident@nhs.net | |

However, if this is not possible or practical any room with a phone and computer can be used. Rooms within Trust premises are preferable as there is a HSCN connection.

**The Gold Command Room must always be in a physically separate room from the Hospital Incident Coordination Centre.**

# 9. Command and Control Arrangements






The efficiency of the Command and Control arrangements relies on the good discipline of each Commander within the GSB[7] roles; good discipline promotes cohesion within the system.

It is important that those who have a role within the command structure understand what they have to do, how to do it and when.

## 9.1 Gold (Strategic) Commander

The Gold Commander works at the strategic level and has overall responsibility for the command, response and recovery of an Incident. The Gold Commander will set the Trust's strategic aims (the Gold Strategy) for the Incident, providing a framework for the Silver Commanders to work within.

Whilst it is not the responsibility of the Gold Commander to make tactical decisions, the Gold Commander still have responsibility for ensuring that the tactics which are being employed are effective.

The Gold Commanders responsibilities in line with their National Occupational Standards performance criteria can be found in Section 18.

The key channels of communication for the Gold Commander are:

[7] GSB – Gold, Silver, Bronze

- Gold level representatives of partner organisations, including, Ambulance Service, Other Trusts, CCG, NHS England
- Silver (Tactical) Commanders
- Communications Team
- Gold Commander Loggist
- Medical Advisor
- Strategic Advisors, or other specialist roles

## 9.2 Silver (Tactical) Commander

The Silver Commander works at the Tactical level, their role is to take responsibility for developing the tactical plan for the use of resources. The tactical plan will be developed within the framework of the gold strategy and any available intelligence and associated risks.

Due to the dynamics of a Major Incident the Silver Commander may put a tactical plan into place before the gold strategy has been set. Where this is the case, the tactical plan should be reviewed against the strategy once it becomes available.

The Silver Commander should provide a framework and parameters for the Bronze Commanders to operate within. The Silver Commander must support the Bronze Commander to achieve their objectives and manage the Incident effectively; however they must not get involved in the direct operational management of the Incident.

It is critical that the Silver Commander can effectively manage the Incident and coordinate the trust response. With this in mind they should locate themselves alongside the Silver Commanders of the emergency services and responding agencies in order to ensure a multi-agency approach to the resolution of an Incident[8].

The Silver Commanders responsibilities in line with their National Occupational Standards performance criteria can be found in Section 18.

The key channels of communication for the Silver Commanders are:

- Silver level representatives of partner organisations, including, Ambulance Service, Other Trusts, CCG, NHS England
- Gold (Strategic) Commanders
- Tactical Advisor
- Bronze (Operational) Commanders
- Command Loggist
- Communications Team

## 9.3 Bronze (Operational) Commander

The Bronze Commander workers at an operational level and have responsibility for the activities undertake at the scene[9]. As such they will be located at the Incident scene.

The Bronze Commander ensures that the Silver Commander's tactical plan is carried out and that they understand the gold strategy. Importantly they must understand and be able to discharge their responsibilities within these.

As the Operational Commander they will provide leadership and management to the Functional Roles[10] and any other direct reports.

[8] This will be dependent on the situation and size of the incident. Where a lead CCG approach is taken, the Trust may be represented by the lead CCG at the Coordination Group as opposed to representing itself.
[9] For most Major Incidents within the Trust, the scene is considered to be the Emergency Department, but may be any operational area (i.e. ITU) or could be the scene of an internal incident (i.e. flood) with an estates manager as bronze.
[10] For example Triage Nurse, Estates staff etc.

The Bronze Commanders responsibilities in line with their National Occupational Standards performance criteria can be found in Section 18.

The key channels of communication for the Silver Commanders are:

- Bronze Commanders of partner organisations, including, Ambulance Service, Other Trusts, CCG, NHS England
- Silver (Tactical) Commanders
- Hospital Ambulance Liaison Officer (for ED Bronze)
- Decontamination Officer (for ED Bronze)
- Triage Officer (for ED Bronze)
- Command Loggist
- Functional Roles as assigned for the area

## 9.4 Span of control

The span of control refers to the number of communication lines or direct reports an individual is expected to manage. Five reporting lines are commonly recognised to be the optimum number for one person. It is possible however that given consideration to the environment, type of Incident and level of resource, a Commander could manage up to seven lines, although due to the same factors, this may be as low as two or three due to the complexity and instability of the Incident.

Bronze Commanders will be delegated the task of assigning tasks within their areas. It is imperative that each part of the Incident is afforded the same attention. To assist with this, Commanders may assign key roles to other appropriately trained individuals. These are referred to as the functional roles.

## 9.5 Functional Roles

Upon the assigning of functional roles by Bronze Commanders, they must ensure that the appointed persons are able to discharge their responsibilities of that role adequately. Where this is not the case, there is a danger that the level of support required for that individual will result in the Bronze Commander micro managing them or undertaking the role themselves.

## 9.6 Record Keeping and Logging

There had been much emphasis on recording decisions following criticism directed at emergency services during high profile cases.

Commanders are responsible for recording all decisions that they make in relation to an Incident in an appropriate command decision log. Logging is essential to facilitate operation debriefing, provide evidence for enquiries, and identify lessons for the future.

Comprehensive logging should be made of all events, decisions (including those deferred and not taken) and the reasoning behind the decisions and actions taken.

# 10. Incident Management

## 10.1 Strategy

Any Critical or Major Incident must have a strategy set by the Gold Commander. This strategy will provide the guidance, parameters and justifications for the Trust's command structure, to respond to the Incident.

The strategy should be specific to each Incident, and no generic, although some 'common' themes will run through every strategy, such as saving life, reducing harm and the need to ensure the health, safety and welfare of staff.

The Gold Commander may begin the development of the strategy on notification of the Incident, and they will then build on it once further information, and intelligence becomes available. The strategy should not be considered 'final' until the Incident has closed, and must be regularly reviewed throughout the Incident.

In the development phase the Commander should continually refer to the Dynamic Decision Making Cycle (see section 10.3) which will guide them through the points for consideration during the development of the strategy. The strategy must take account of the identified and anticipated risks identified during the threat and risk assessment process. Other drivers include the limitations and constraints of organisational and national policy as well as the individual capability of Commanders and resources, ensuring everyone remain within their scope of practice.

Whilst the strategy will provide objectives for the Incident command and parameters for the Silver Commanders to work within, it should not be too constraining and prevent them from performing their role. The Silver Commander should in fact be consulted on the development of the strategy, as they will add to the intelligence picture and can offer advice on the type of tactics which may be used.

The Gold Commander owns the strategy and is ultimately accountable and responsible for its content and delivery. It is imperative that all aspects of the strategy and associated decisions are logged in the Commander's decision log, including the rationale for these and any amendments.

The strategy should be in plain English to ensure it can be understood by all the relevant people (internally and externally). The use of overly technical terms and acronyms should be avoided wherever possible. The use of such terminology by the emergency services in their planning and management has been the subject of much criticism in public inquiries and inquests.

When issuing the strategy, a full and informative (though concise) briefing should be provided to the Silver Commanders to ensure the parameters that are being set for them to work within, are clear and understood.

## 10.2 Tactical Options

The tactical plan will ideally be developed following receipt of the strategy from the Gold Commander. However, due to the nature of Critical / Major Incidents it is unlikely that the Gold Commander will be in place before the Silver Commander. Where this is the case, the Silver Commander should discuss initial thoughts and direction with the Gold Commander.

Through the use of the Dynamic Decision Making Cycle (see section 10.3) the Silver Commander will be able to identify the appropriate tactics to use in the management of the Incident. This is a critical element of the cycle and the selection of tactics will be reinforced by the fact due diligence should have been paid to the preceding factors of information, intelligence, threats, risks, policies and procedures.

The selected tactics will be dependent on the type and scale of the Incident presented. Other considerations will be: pre-existing plans (such as heat wave plan) the environment in which the Incident occurs, the number and types of casualties and the capacity and capability of the resources available. Examples of the tactical options include:

- Ambulance Divert
- Deployment of CBRNe[11] assets for decontamination
- Lockdown
- Treat and Transfer

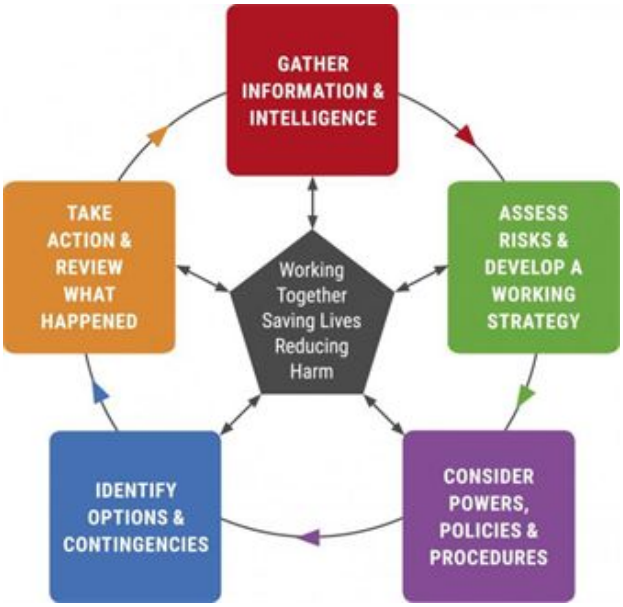
Communication of the tactical plan to the Bronze Commanders will be through an oral briefing. This provides opportunity for ensuring the intention of the plan is understood and assimilated, but also for any necessary challenge to be made by the Bronze Commander. Briefings should follow a systematic method such as IIMARCH[12] (see section 10.10). An entry should be made in both the Bronze and Silver Commanders' logs that this briefing has taken place.

The tactical plan objectives should be recorded in a written command decision log. It is the Silver Commanders responsibility to ensure that this takes place.



[11] Chemical, Biological, Radiological, Nuclear
[12] Information, Intent, Method, Administration, Communication, Human Rights

## 10.3 Dynamic Decision Making Cycle




Where information is recorded in the log, actions do not always include the rationale behind them. It is important to ensure that the rationale for a decision is recorded, to ensure that in the event of a review, inquest etc. it is clear as to why a decision was made at that time, it should be remembered that such reviews may take place many years after the event

The use of the Dynamic Decisions Making Cycle helps to ensure effective Command and Control by ensuring that Commanders are making reasoned, lawful and justifiable decisions.

## 10.4 Consequences of decisions

An assessment of the potential consequences arising from a particular decision should be assessed against the mnemonic STEEPLE, which lists seven factors all decision makers should take into account when determining operational / Incident-related decisions. The decision and rationale should be recorded within a written policy or decision log as part of the audit trail of the Incident. These are:

- Social;
- Technological;
- Economic;
- Ethical;
- Political;
- Legal;
- Environmental.

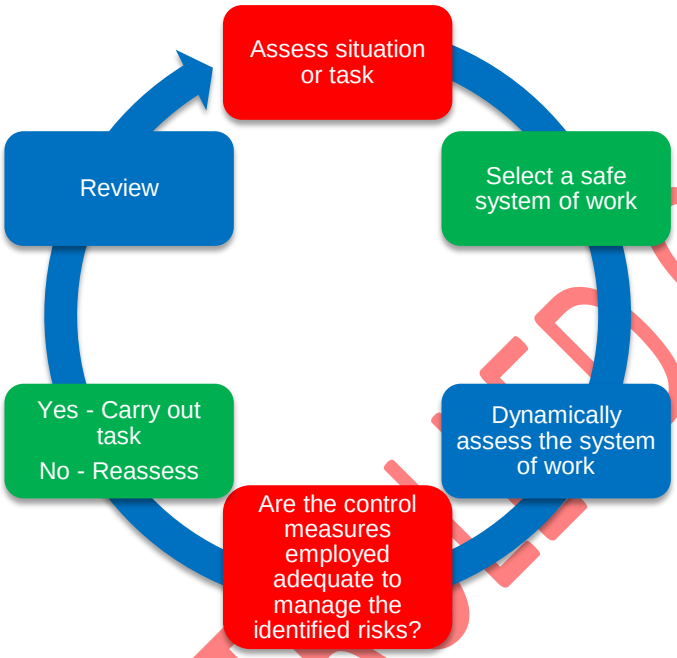
## 10.5 Risk Identification and Management

Commanders need to identify and manage all the risks and hazards that pose a direct or indirect threat to the people under their command and those who may be affected by their action or inaction (co-responders, patients and public). This is achieved through the application of recognised and documented risk assessment and the implementations of appropriate control measures. Not until this process has been completed can a decision be made on the tactics to be used.

The Dynamic Risk Assessment (see section 10.6) allows for a structured approach to risk management. During the section of the safe system of work, the mnemonic ERICPD[13] (see section 10.7) can be applied to assist in choosing the appropriate course of action.

## 10.6 Dynamic Risk Assessment

It is important to remember that a Dynamic Risk Assessment is only effective if it is regularly reviewed. Control measures may need to be increased or decreased, what were safe areas, may become unsafe. The review also allows Commanders to reassess the systems of work and their appropriateness for the tasks in hand.






Step one of the risk assessment is to analyse the situation or task. Commanders will commence the process from the moment they are informed of the Incident. This will take the form of analysing the information or intelligence, any identified hazards reported and knowledge of existing plans and procedures.

The intelligence picture will be further enhanced on their arrival at the Hospital Incident Coordination Centre. Commanders will need to enhance their situational awareness. This will be achieved by considering the following:

- Available intelligence and information
- The type and nature of the Incident and available resources (staff, equipment, facilities etc.)
- Specific plans, procedures etc.
- Any significant hazards arising from the Incident
- The risks presented to:
  - Trust Staff
  - Other Staff (partner agencies, contractors, etc.)
  - Patients
  - The Public

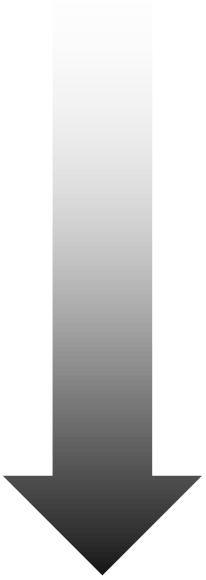
## 10.7 ERICPD

In order that Commanders can select a safe system of work they must review the available options in line with existing plans and procedures. Selection of the appropriate course of action will be dependent on the availability

[13] Eliminate, Reduce, Isolate, Control, PPE, Discipline

of trained and competed personnel and appropriate resources. For example to facilitate a decontamination response a commander must have available adequately trained CBRN responders, PPE and individuals capable of erecting and operating decontamination showers.

During the select of a safe system of work, Commanders should use the mnemonic ERPICPD. This provides a structured approach to applying control measures to identified risks in a hierarchical manner.



| | |
|---|---|
| **Eliminate** | Complete removal of the hazard |
| **Reduce (by substitution)** | Level of risk by reducing the nature of the hazard |
| **Isolate** | Remove hazard from people or the people from the hazard |
| **Control** | Control exposure to the hazard by controlling who has access or use procedures limiting exposure time |
| **PPE** | Issue Personal Protective Equipment |
| **Discipline** | Ensure employees follow safe systems of work |

## 10.8 Operations and Resource Management

Initial identification of the Incident and communication of this and the resource requirements will assist in mitigating the impact of the Incident on the Trust.

A universally accepted way of achieving this initial communication is through the use of a critical message. Within the UK health services and emergency services the mnemonic METHANE is used[14]. The message should contain the following:

| | | | |
|---|---|---|---|
| M | MAJOR INCIDENT | Has a major incident or standby been declared? (Yes / No - if no, then complete ETHANE message) | *Include the date and time of any declaration.* |
| E | EXACT LOCATION | What is the exact location or geographical area of the incident? | *Be as precise as possible, using a system that will be understood by all responders.* |
| T | TYPE OF INCIDENT | What kind of incident is it? | *For example, flooding, fire, utility failure or disease outbreak.* |
| H | HAZARDS | What hazards or potential hazards can be identified? | *Consider the likelihood of a hazard and the potential severity of any impact.* |
| A | ACCESS | What are the best routes for access and egress? | *Include information on inaccessible routes and rendezvous points (RVPs). Remember that services need to be able to leave the scene as well as access it.* |
| N | NUMBER OF CASUALTIES | How many casualties are there, and what condition are they in? | *Use an agreed classification system such as 'P1', 'P2', 'P3' and 'dead'.* |
| E | EMERGENCY SERVICES | Which, and how many, emergency responder assets and personnel are required or are already on-scene? | *Consider whether the assets of wider emergency responders, such as local authorities or the voluntary sector, may be required.* |

All Incidents will offer their own challenges in terms of available resources; for examples a mass casualty Incident will require large numbers of staff within the Emergency Department, however, the Trust will still be expected to maintain its core business and meet performance targets.

Early identification of the Incident type, any hazards, numbers of people involved and resource requirements will assist the Silver Commanders in planning for the resourcing of the Incident. They will also ensure that a system is in place for the management of the resources.

[14] Joint Emergency Services Interoperability Programme

The Silver Commander will make requests to the Gold Commander for additional or specialist resources. Requests for mutual aid should be made via the Gold Commander, who will initiate discussions with NHS England.

## 10.9 Command Briefing

Briefing of the command team and staff is one of the single most important aspects of command. It is the first opportunity that the Commander will have to deliver their plan with subsequent rationale and decisions to those who are expected to carry out the orders.

The briefing should be a two way process where the Commanders welcome questions and feedback; this will allow the Commander to ensure that the plan has not only been received, but also understood and assimilated by those that have received it.

Where necessary, Commanders should ensure specialists or individuals who can add value to the briefing is included within it.

If a face to face briefing is not possible then additional methods can be employed. For example, written briefs, telephone or video conferencing. Commanders should be cognisant of relevant protective markings or sensitivity of information when choosing a briefing route and that all notes and logs made before, during and after briefings may be disclosable.

Regardless of the method used, a full and accurate record of the brief should be made and retained as part of the command decision log, including who delivered the brief, who received it, the date, time and location. This should be repeated for all subsequent briefings and updates.

Briefings will always work better if they are structured (see section 10.10).

## 10.10 IIMARCH

| | | |
|---|---|---|
| **I** | **I**nformation | What, Where, When, How, How May, So What, What Might?<br>Timeline and History of incidents, and Key Facts from METHANE |
| **I** | **I**ntent | Why are we here, what are we trying to achieve?<br>Strategic aim and objectives, joint strategy |
| **M** | **M**ethod | How are we going to do it?<br>Command, Control, Co-ordination arrangements, tactical and operational policy and plans, contingency plans |
| **A** | **A**dministration | What is required for effective, efficient and safe implementation?<br>Identification of commanders, tasking, timing, logging, welfare etc. |
| **R** | **R**isk Assessment | What are the relevant risk, and what measures are required to mitigate them?<br>Use ERICPD hierarchy for risk controls as required. |
| **C** | **C**ommunications | How are we going to initiate and maintain communications with all interested parties? Internal, partners, regulators and public? |

| H | Humanitarian | What humanitarian and human rights issues are arising or may arise from this event and the response to it? |
|---|---|---|

## 10.11 Information Sharing

Information sharing is a crucial element of civil protection works that underpins all forms of cooperation. Information should be shared formally and as part of a culture. The Trust should consider it good practice as well as their duty to share information with other responders, in the planning, response and recovery phases of Incidents.

The initial presumption is that all information should be shared, with the exception of sensitive information which includes:

- Information prejudicial to national security
- Information prejudicial to public safety
- Commercially sensitive information

Decision making in the context of an emergency, including decisions involving the sharing of information, does not remove the statutory obligations of agencies or individuals, but it is recognised that such decisions are made against an overriding priority to save life and reduce harm.

The sharing of person and sensitive data (including police intelligence) requires further considerations before sharing across agencies, and the Dynamic Decision Making Model can be used as a tool to guide decision making on what to release and to whom. In particular, in considering the legal and policy implications, the following are relevant:

- A legal framework to share information is required – in an 'emergency' situation this will generally come from Common Law (save life/property), the Crime and Disorder Act 1998 or the Civil Contingencies Act 2004
- Formal Information Sharing Agreements (ISAs) may exist between some or all responding agencies but such existence does not prohibit sharing of information outside of these ISAs
- There should be a specific purpose for sharing information
- Information shared needs to be proportionate to the purpose and no more than necessary
- The need to inform the recipient if any of the information is potentially unreliable or inaccurate
- The need to ensure that the information is shared safely and securely – it must comply with the Government Classifications Policy if appropriate
- What information is shared, when, with whom and why, should be recorded in the Incident log.

## 10.12 Strategic and Tactical Coordination Groups

In the event of a large scale Incident (especially those involving multiple emergency services) the decisions may be made to form a Strategic Coordination Group (SCG) and a Tactical Coordination Group (TCG).

These groups are formed by the relevant commanders from each agency involved in the Incident. Gold Commanders form the SCG, which will normally be located at Essex Police Headquarters (for those Incidents occurring in Essex). The Silver Commanders then form the TCG at a location closer to the scene (often a Police station, but may be any suitable location with communication links).

Acute Trusts will generally be represented at the SCG and TCG by NHS England and/or the Ambulance service. However, where the Trust is directly involved in the Incident (such as an Incident which as occurred on site), there may be a need for the Trust to attend either / or both the SCG and TCG.

## 10.13 Vulnerable Groups

Within the Civil Contingencies Act 2004, the particular needs of vulnerable persons are recognised. The general definition of vulnerable persons is:

*People present or resident within an area known to local responders who, because of dependency or disability, need particular attention during emergencies.*

In terms of the Act, vulnerable persons are defined as those:

- Under the age of 16. Particular attention should be paid therefore to schools, nurseries, childcare centres and medical facilities for children;
- Inhibited in physical movement, whether by reason of age, illness (including mental illness), disability, pregnancy or other reason. Again, attention should be paid to hospitals, residential homes and day centres likely to be housing any of these people and also to means of accessing records for those resident in the community whose address is recorded on lists held by health services, local authorities and other organisations;
- Deaf, blind and visually impaired or hearing impaired. The means of accessing these people during an emergency or when one is likely, should be recorded in plans.

### 10.13.1 Children

May be involved in an incident or emergency, either as casualties or as members of families or groups caught up in the event. It is essential for Incidents involving large numbers of children, that the Safeguarding Children team are alerted as soon as possible to provide support through their links with Education and Social Care.

### 10.13.2 Non-English Speakers

At the scene of an Incident simple language guides will generally be available to assist with Incident management. Existing arrangements within the Trust will be sufficient for dealing with the usual number of people from the non-English speaking groups, telephone and face to face interpretation services are available from the PALS team or Switchboard (out of hours). However, the scale of an Incident, or the particular nature of the Incident, or the particular group involved in an Incident, may require assistance being sought from other sources. Assistance should be sought from the Patient Experience Team as soon as possible, should they be, or there be a potential for a lack of interpreter services.

### 10.13.3 People with Learning Difficulties or Mental Illness

The Trust's existing facilities and procedures should be sufficient to assist people with learning difficulties and those with mental illness during the course of an Incident. However, there may be small numbers for whom additional and/or specialist assistance may be required. Assistance should be requested via the Hospital Incident Coordination Centre who will request that the Gold Commander contacts the Executive On-Call for North Essex Mental Health Partnership Trust.

# 11. Specific Incidents

## 11.1 Mass Casualty

Some of the factors that distinguish a mass casualty Incident from a more typical Major Incident are its likely scale, duration, intensity and the probability that there will be other compounding factors such as loss of services/infrastructure, shortage of essential supplies or the possibility of civil dislocation. They are likely to involve greater numbers, both in terms of casualties and fatalities and could involve either Incidents occurring simultaneously, or at multiple sites.

Based on their assessment at the scene the responding Ambulance Service will declare a mass casualty Incident and will notify NHS England. NHS England will then activate the Mass Casualties Framework and implement various options based on their assessment of the situation. Once a mass casualty Incident has been declared all relevant organisations, which dependant on locality and severity of Incident will activate their own Major Incident Plans.

If a mass casualty Incident is declared in a region neighbouring the Trust we may be required to provide mutual aid (if available).

### 11.1.1 Responsibility of the Trust

During an Incident with mass casualties, NHS England may request that the Trust provide support to acute hospitals to increase their ability to deal with incoming patients by assisting with the accelerated discharge process and the provision of alternative care for minor injuries (e.g. Urgent Care Centres or healthcare clinic facilities) in conjunction with local healthcare providers.

In the event of a Major Incident, Local Authorities are responsible for establishing reception centres for evacuated / displaced persons. The Trust[15] might be asked to provide staff and/or resources to support primary care or provide community health within reception centres, although voluntary services may attend.

The types of rest centre that may be set up are:

- Rest Centres
- Friends and Family Reception Centres
- Survivor Reception Centres
- Humanitarian Assistance Centres
- Community Assistance Centres

The Trust response to a mass casualty Incident will involve the command and control arrangements as contained within this plan. The Incident Director should refer to the Trusts Surge Management Plan and will;

- Liaise with NHS England regarding the provision of additional support for community health services for minor illnesses and injuries to individuals involved in the Incident
- Defer non-urgent planned activity
- Expedite discharges from beds and create additional capacity, in total 20% total additional capacity is required (10% in the first 6 hours and a further 10% within 12 hours, along with an doubling level 3 ITU capacity and maintaining this for a minimum of 96 hours).
- Maintain access to critical and essential health services (business continuity measures)
- Assist when necessary with the distribution of countermeasures or other medication for individuals involved in the Incident. This may include vaccines, antivirals, antitoxins and antibiotics etc., and the treatment of prophylaxis (oral or vaccination) to the identified population.
- Ensure staff have access to the appropriate Personal Protective Equipment to carry out their work

[15] This would be an exceptional event as generally this support would be provided by Community Trusts.

- Ensure staff are trained in the use of any Patient Group Directions, clinical methods and health and safety requirements before administering mass countermeasures or other medication out with their normal duties
- Assist with the identification of vulnerable or specific groups of individuals who should be prioritised to receive healthcare interventions (e.g. pregnant women may require different medication or additional advice before receiving medication)
- Ensure any regional or local public health advice in relation to the Incident is made available for Trust service users (in collaboration with the local health and social care economy).

## 11.2 CBRNe[16], HAZMAT[17], MAHP[18] OR COMAH[19] INCIDENTS

### 11.2.1 Internal CBRN or HAZMAT Incidents

Chemical, Biological, Radiological, Nuclear or explosive (CBRNe) Incidents or other Hazardous materials (Hazmat) response is coordinated by the Public Health England (PHE) Centre for Emergency Preparedness and Response. Copies of the PHE (formally Health Protection Agency (HPA)) guidance for identifying and responding to CBRN Incidents are available in every Hospital Incident Coordination Centre. The Trust CBRNe plan[20] also include;

- Procedures for identifying potential CBRNe Incidents;
- Steps for managing the initial response to a CBRNe Incident;
- Lockdown procedures for any contamination Incident occurring within the Trust;
- Contact details the East of England Ambulance Service's Hazardous Area Response Team (HART) who will come immediately and assess the situation, and treat any affected staff and patients immediately at scene.

The importance of early recognition of contamination, and immediate command and control measures to contain any contaminated casualties and premises is of the highest importance. This includes the 'Lock Down' of any main patient interface location.

### 11.2.2 External CBRNe or HAZMAT Incidents

All NHS Acute Trusts have a duty of care and responsibility to decontaminate the walking wounded from a scene of any local Hazmat/CRBNe Incident.

A Chemical, Biological or Radiological event is significantly different to a HAZMAT (hazardous materials) Incident, as it is deemed to be a terror attack.

At the scene of any Hazmat Incident, casualties and the affected public will be decontaminated by their respective Ambulance Service, and in large scale Hazard Incidents, by the Fire Brigade.

Radiation (Emergency Preparedness and Public Information) Regulations, (REPPIR) 2001 are in place to advise how organisations will respond to an actual or potential radiation emergency. NHS England will provide instruction on any actions required in response to an Incident.



[16] Chemical, Biological, Radiological, Nuclear, Explosive – Relates to deliberate releases
[17] Hazardous Materials – Relates to accidental releases
[18] Major Accident Hazard Pipelines
[19] Control of Major Accident Hazards
[20] This plan is Classified as Official-Sensitive and is therefore not a public document

### 11.2.3 Distribution of Counter Measures or Prophylactic Treatments[21]

In an Incident that affects a wide geographical area, or involves a large number of people being exposed without immediate detection; it is conceivable that the national stocks of countermeasures would be called upon as part of the response to the Incident. In response to this all Acute Trusts have Mass Prophylaxis Centre Plans in place and the Trust may be required to provide assistance or support dependant on severity of the Incident.

### 11.2.4 Control of Major Accident Hazards (COMAH)

The Control of Major Accident Hazards Regulations (COMAH) 2005, apply mainly to the chemical industry specifically sites that have large stores of chemicals such as chlorine, liquid petroleum gas, explosives etc. They ensure that businesses take all reasonable measures to prevent Major accidents involving dangerous substances; and limit the consequences to people and the environment of any Major accidents, which do occur. Top tier sites are deemed more hazardous and require an off-site plan, which details the response of the emergency services, health service and local authority. These plans are confidential and copies are held within the Hospital Incident Coordination Centre.

Within the Trust footprint there are a number of sites, which would be classified under the COMAH banner; a full list of all sites are held within the Hospital Incident Coordination Centre.

In response to a COMAH Incident, it should be noted that the Trust is a secondary responder and via NHS England actions may include the following:

- Follow any advice or actions required requested by NHS England/Public Health England (PHE)
- Liaise with NHS England, Acute Hospital Trusts and Commissioners where necessary.
- Establish and maintain communications with other responding agencies.
- Provide advice to staff and service users
- Provide public advice regarding health issues and disseminate advice
- Liaise with PHE/NHS England and provide health monitoring as required.
- Provide health support to Local Authority Emergency Reception Centres as appropriate.

### 11.2.5 Major Accident Hazards Pipelines (MAHP) [22]

The Pipelines Safety Regulations 1996 (PSR) require a local authority to prepare emergency plans for pipelines which have the potential to cause a Major accident. The Regulations also require a pipeline operator to establish emergency procedures for such pipelines.

For the purposes of PSR, the aim of an emergency plan can be described as: ‘To detail action to be taken to minimise the consequences to the health and safety of people in the event of an emergency involving a Major accident hazard pipeline’.

A copy of the Major Accident Hazards Pipelines Plans, along with a list of the pipelines are covered under these plans are held in the Hospital Incident Coordination Centre.



[21] This plan is Classified as Official-Sensitive and is therefore not a public document
[22] This plan is Classified as Official-Sensitive and is therefore not a public document

## 11.3 Evacuation, Shelter and Lockdown

### 11.3.1 Evacuation and Shelter

The decision to evacuate a site or call invacuation to shelter people will most likely be made at a local level or tactical level by the relevant Silver Commander. The Gold Commander should monitor the evacuation and put out any mutual aid requests directly to the relevant partners and update NHS England as necessary.

### 11.3.2 Lockdown

Lockdown procedures are invoked to control the movement and access of people (NHS staff, patients and visitors) around the site or specific building/area in response to an identified risk, threat or hazard that might impact the security of patients, staff and assets or the facilities capacity to operate. Lockdown is achieved through a combination of physical security measures and the deployment of security personnel

Requests for Lockdown may come from the police (or other partner agency) or be invoked directly by the Silver Commander if the Incident is deemed by them to warrant it. More information can be found by referring to the Trusts Lockdown policy and procedures (held within the Hospital Incident Coordination Centre). Additional support and guidance for any lockdown procedures can be provided to the Gold and Silver Commander by the Trust Tactical Advisor, Security Manager or Local Security Management Specialist (LSMS).

## 11.4 Suspicious Packages / Bomb Threats

Suspicious packages and bomb threat procedures are detailed within the Trust bomb threat Policy. Suspicious Packages should be dealt with using the procedures and all bomb threats. The bomb threat Policy should be printed off and made available in every clinical and non-clinical Trust area and are stored on the intranet. When responding to a suspicious package or bomb threat the Gold Commander and Silver Commander should take the advice of the relevant response agencies and invoke Evacuation, Shelter and Lockdown plans and the associated Business Continuity/Major Incident Plans as required.

# 12. Maintaining Business Continuity

During a Critical or Major Incident, Trust resources (e.g. staff, vehicles, equipment) may be diverted to deal with the Incident. Some services will therefore have to be scaled down or cancelled. For example, non-urgent clinics or client home visits may be cancelled, some staff may be sent home and others may be sent to work in different locations. However, it is essential that the Trust maintains its key services and that patient care is maintained during the disruption caused by the Incident as far as is reasonably practicable in the circumstances. The Trusts business continuity plans should be referred to and all decisions that impact on the delivery of our services must be logged and the decisions why. This must also be communicated to NHS England and/or commissioners at the earliest opportunity, together with the reasons why this action has been taken.

As part of each services business continuity plan, each service has identified key partners and suppliers. The procurement team hold a list of all suppliers and require suppliers to have business continuity plans in place. In the event of an Incident Procurement Team may be asked to provide a core information service for obtaining any relevant goods and services required in the response and recovery. The team will provide a stores and supplies focal point for staff during the Incident.

# 13. Maintaining Contract Compliance

Below is information related to the management of an Incident in line with the clauses related to Emergency Planning, Resilience and Response contained within the NHS Standard Contract

The Incident Co-Ordination Centre must be used during any Incident or Emergency (for example Critical or Major Incident Declared). Advice can be taken from a Tactical Advisor if there is doubt, however the final decision will lie with the Gold Commander. *(SC30.5.3 / 30.9.1)*

Any Critical or Major Incident must immediately be declared to the NHS England Director On-Call and the CCG Director On-Call. During working hours the CCG Delivery Team should also be informed. *(SC30.10)*

The Trust is required to provide at the request of the Coordinating Commissioner any support or assistance required by the Commissioners and/or Healthwatch England in response to any national, regional, or local public health emergency or Incident. *(SC30.12)*

Service users who are receiving treatment prior to, during or following a incident or emergency, must not be discharged or transferred unless it is clinically appropriate to do so. *(SC30.15 / 30.15.1 / 30.15.2)*

If the impact of the incident or emergency is such that the demand for non-elective care increases, and the Trust establishes to the satisfaction of the CCG that the ability to provide elective care is reduced, then elective care can be suspended or scaled back as required. The Trust must provide the CCG with written confirmation every 2 calendar days on its ability to provide elective care. (*SC30.16)*

In these situations:

- The commissioners must also use reasonable effort to reduce if requested by the Trust. *(SC30.17.2)*
- The Trust must continue to provide non-elective care (and associated elective care) subject to our discretion to transfer or divert a service user if it is considered to be in the best interest of all service users to whom we are providing non-elective care whether or not they are using services as a result of the incident or emergency. *(SC30.17.3)*

If despite the Trusts best efforts there are transfers, postponements and/or cancellations we must provide the CCG with:

- The identity of each service user transferred and the alternative provider *(SC30.18.1)*
- The identity of each service user who has not been, but is likely to be transferred, the probably transfer date and the identity of the intended alternative provider *(SC30.18.2)*
- Cancellations and postponements of admission dates *(SC30.18.3)*
- Cancellations and postponements of out-patient appointments *(SC30.18.4)*
- Other changes to elective or outpatient lists *(SC30.18.5)*

The Trust must report the end of any incident or emergency as soon as is reasonably practical, and must fully restore the availability of elective care. It is important to remember not to ‘stand down’ too early in the recovery phase, to ensure a full return to a new normality. (*SC30.19)*

# 14. Communications

## 14.1 Communications Lead

In the event of a Critical or Major Incident, the Head of Communications, or somebody acting on their behalf, will attend the Hospital Incident Coordination Centre as soon as possible. That person will be designated Communications Lead for the duration of the Incident or until relieved.

The Communications Lead will have overall responsibility for all internal and external communications, as well as liaising with the NHS England communications office(s), Commissioners and external partners communications office(s), the DH communications office and the media specialists for Strategic Gold Command (if not NHS England).

## 14.2 Communications Resources

The following systems are in place for communications during a Major Incident:

- Paging/text message system for notifying all senior staff of a 'DECLARED' Major Incident via email, Desk Alert, pager message, bleep message and text message;
- Direct dial lines in the Hospital Incident Coordination Centre;
- Dedicated fax machines;
- Generic Email addresses (i.e. paht.majorincident@nhs.net (for full list see on-call packs)

Located in the Hospital Incident Coordination Centre, via on-call packs and electronically are:

- Registers of key internal and external contact numbers;
- List of key contacts in non-statutory/voluntary organisations;
- Site addresses for all services.

All services and teams are responsible for maintaining a register of the current contact details for their staff for use during Critical / Major Incidents.

## 14.3 Internal Communications

It is vital that staff are kept up to date with accurate information about the Incident, not only for their own information but also to share with service users, patients and visitors. All communications with staff will be mindful of the personal, as well as the professional, impact of the Incident.

### 14.3.1 Message Classification

As part of the messaging processes, communications will be prefixed as below:

| | |
|---|---|
| **INFORMATION** | No action required, but there is information to share |
| **ALERT** | No immediate action required, however information is important and the situation may develop |
| **FOR ACTION** | Action is required, an incident has occurred or a request has been made that requires a response |

### 14.3.2 Staff who are on call to respond to a Major / Critical Incident

Staff who are on-call will automatically be informed of a Critical/Major Incident via the pager system.

### 14.3.3 Staff who are on duty and on site at the time of the Incident

The Communications Lead will draft core messages / Frequent Questions and Answer (FAQs) pages will be shared with staff via:

14.3.3.1 Email

The 'Communications' email address will be used to send out information to all staff, using the distribution lists used for the weekly update. Information will be sent at regular intervals (e.g. every hour). Information should not be sent out from any other source, to avoid confusion. All email communication will invite questions to the communications@pah.nhs.uk address, so that FAQs can be answered in subsequent emails.

14.3.3.2 Intranet

The Trust Intranet will be updated regularly (will be dependent on Incident severity and longevity) with the latest messages sent out by email and answers to FAQs.

14.3.3.3 Social media

The Trusts social media sites will be updated regularly with the latest information and messages.

14.3.3.4 Telephone

Where electronic means of communication are not available, the telephone will be used to contact key contact points (i.e. Healthcare Group Leads) for verbal cascade within their Healthcare Groups. Healthcare Groups Leads may therefore need to identify 'runners' at each site to help distribute information and instructions to staff.

14.3.3.5 DeskAlerts

DeskAlerts[23] are pop up messages that will appear on all Trust computer screens, and can be used to pass key information and instructions. The DeskAlert system does not require any external internet connection, and can be used in the event of any disruption to the NHSMail system.

### 14.3.4 Staff who are off duty and off site

In the event of a Critical / Major Incident, staff may be away from their office base, working at a remote site, working in the community or off duty. **All** staff therefore have the responsibility for contacting their office base as soon as they are made aware of a Major Incident. This is so that they can:

- Assure their manager of their personal safety;
- Inform their manager of their location;
- Receive instructions from their manager about any changes to their duties arising from the Incident.

A register of current contact details of all Trust staff is maintained within each Healthcare Group.

There may be circumstances in which the Trust issues a public appeal for staff to attend, seeks assistance from neighbouring Trusts or where staff living locally, make their way to the site to help. In these cases the appropriate teams will establish a staff holding area where such staff can be registered and deployed as appropriate.

The staff holding area is designated as:

**Physiotherapy Department**
**B27**
**Ground Floor**
**Princess Alexandra Hospital**

## 14.4 External Communications

### 14.4.1 Communications with External Agencies

[23] Messages can be sent via DeskAlerts by the Emergency Planning Team or the IT Team.

During a Critical / Major Incident the Gold Commander will ensure that NHS England, and all other relevant external agencies have a direct dial point of contact and email address for the Gold Commander. This direct dial line can be a mobile phone number, one of the dedicated emergency landlines, or fax line. External agencies should **not** be phoning switchboard, as this will lead in delays in relaying information, but where this is unavoidable agencies should be given the emergency bypass switchboard number[24] which is available in the Hospital Incident Coordination Centre or from the Tactical Advisor.

### 14.4.2 Communications between Gold Commanders and Silver Commanders

When operating out of the Hospital Incident Coordination Centre within the Trust, telecommunications between Gold Commander and Silver Commanders should wherever practicable be via the usual Trust extension numbers to keep other lines clear for external communications.

### 14.4.3 Communication with Service Users, Patients and the Public

It is important that information for service users, patients and the public is kept simple, clear, concise, accurate and consistent. They should also be timely. To ensure the messages are consistent and accurate the Gold Commander and Communications Lead will liaise with emergency services and NHS England (as appropriate).

### 14.4.4 Trust Wide Communication with Hospital Incident Coordination Centre

The Hospital Incident Coordination Centre dedicated internal number is: Ext 2999

The Hospital Incident Coordination Centre dedicated email address is: paht.majorincident@nhs.net

### 14.4.5 Emergency Department Communication with the Hospital Incident Coordination Centre

The Emergency Department has a dedicated hotline to the Hospital Incident Coordination Centre which is located at the Major Incident Triage Point.

### 14.4.6 Telephone Helpline

Depending on the nature of the Incident, it may be necessary to establish a telephone helpline). The need for advice or support to be provided in different languages must also be considered. This will divert traffic away from the main switchboard to dedicated call handlers. It will also provide a destination for calls being made inappropriately to other known direct dial numbers.

The On-Call Telecomms manager can arrange for the setting up of a Telephone Helpline as required.

### 14.4.7 Trust Website

The Trust website will be regularly updated (as appropriate to the Incident) with information about the Incident, and details of the telephone helpline if appropriate.

### 14.4.8 Trust Social Media Networks

The Trust social media accounts will be regularly monitored and will be updated with information regarding the Incident.



[24] The use of this number is highly discouraged, and should only be used as a last resort.

## 14.5 Media Enquiries

All media enquiries will be referred to the Communications Office or Gold Commander who will inform the Communications Lead. The Communications Lead will then agree a response with the Gold Commander. Before issuing any statements the Communications Lead will ensure the information is consistent and accurate and where appropriate will check it against statements from the:

- Strategic Coordination Group (if running);
- NHS England;
- Commissioners (e.g. CCGs etc.)
- Department of Health media office;
- Media Leads for the emergency services and partner organisations

No member of staff should discuss any aspect of the Incident with the media unless expressly requested to do so by the Gold Commander or Communications Lead (this includes by use of social media). All media enquiries and responses will be logged.

# 15. Workforce

## 15.1 Management of Personnel

To ensure that the Trust's essential services continue to function during a Critical or Major Incident, the Trust will require staff to work flexibly both in terms of their role and their working arrangements. There are a range of measures (detailed below) that the Hospital Incident Coordination Centre can put in place to ensure the Trust's essential services continue to function.

All changes made to staff working arrangements have to be clearly documented within the Major Incident Log Book and relayed to HR as soon as reasonably practicable (it is best practice to have HR staff present in the Hospital Incident Coordination Centre if such changes are being considered). Staff are not obliged and cannot be forced to make changes to their contract.

### 15.1.1 Changing Working Hours

The Hospital Incident Coordination Centre can temporarily create extra staff capacity by inviting staff to change their working hours. This could include:

- Asking part time staff to temporarily increase their contractual hours;
- Asking staff who work flexible hours to temporarily alter them;
- Allowing staff to work hours in excess of 48 hours;
- Allowing staff who have recently retired to assist the response (HR has a list of applicable staff);
- Suspending and cancelling pre-booked leave.

### 15.1.2 Redeployment

Staff may be directed to work at locations other than their usual workplace; this is supported in all existing staff contracts. Examples include:

- Working at or near the site of the Major Incident;
- Working at a local authority evacuation rest centre;
- Working in a different department;
- Working at another site managed by the Trust (e.g. if the site where they normally work is inaccessible due to the Incident);
- Working at an acute hospital or at a site managed by another Trust.

All staff working away from their normal location must inform their office base:

- When they come on duty;
- If they are directed to work somewhere else;
- When they go off duty.

Each Healthcare Group will carry out a risk assessment of their areas locally capturing acuity and dependency in relation to service user's needs. The outcome of the local risk assessment will determine any necessary redeployment.

### 15.1.3 Cancelling or Suspending Training and Meetings

Should a Critical or Major Incident occur within normal office hours, the Hospital Incident Coordination Centre can ask for the suspension of all current and scheduled internal training. The Hospital Incident Coordination Centre can also cancel or suspend any current or future meeting in the Trust. Where Trust staff are at external training courses or meetings the Hospital Incident Coordination centre can request (directly or indirectly) that staff return to the Trust as soon as is practicable and advise staff not to attend training and meetings until the further notice.

## 15.2 Staff Welfare

An emergency is a stressful time where staff are likely to be called in unexpectedly from home and expected to work in unfamiliar environments for extended periods. The Gold, Silver and Bronze Commanders have the responsibility to ensure the wellbeing, health and safety of all staff that are assisting in the Incident response.

### 15.2.1 Rest Breaks

Whenever possible, staff must take regular breaks to avoid them becoming overtired and 'burnt out'. The Gold and Silver Commanders have the responsibility for ensuring staff welfare and will develop realistic rotas early on in the response for all areas within the Trust.

### 15.2.2 Shift Arrangements

In the event of a Critical or Major Incident having a substantial impact it may be necessary to continue operation of the Hospital Incident Coordination Centre for a number of days or weeks. In particular in the early phase of an emergency the Hospital Incident Coordination Centre may require to operate continuously for an extended period of time.

A robust and flexible shift system will need to be in place to effectively manage an Incident. The Silver and Gold Commanders will schedule suitable staffing and shift arrangements for all staff to deliver the Hospital Incident Coordination Centre. Outline shift arrangements are presented below:

- Requirements for each shift should be monitored at each handover
- Handover briefings must be appropriately detailed
- During the first two shift changes 1-2 hours of hand over time may be required.
- Shift changes should be considerate of both staff welfare and operational requirements
- Where possible initial shift changes in teams should be staggered
- Where possible there should be continuity of staffing
- Staff welfare and health and safety policies must be followed.

### 15.2.3 Health and Safety

During a Critical or Major Incident, the Trust will continue to ensure that it complies with legal obligations to ensure employee's health, safety and welfare at work as far as is reasonably practicable.

In doing so, as previously discussed the Gold and Silver will need to take account of the following when making decisions:

- Any known/stated restriction on work that could safely be undertaken by an individual on health grounds. This may include, for example, in the case of communicable infection, whether the individual had received an appropriate vaccination;
- Any training or professional qualification that would be a prerequisite to carrying out response duties safely or other circumstance that may make working unreasonably unsafe, for example severe staff shortages;
- Any official communication from bodies with emergency powers by law, for example, advising against travel/other activity in all/some circumstances; and the
- The need for personal protective equipment for example in CRBN Incidents.

# 16. Financial Management

## 16.1 Trust Management

It is acknowledges that during the response to or recovery from an Incident additional costs may be incurred either through the procurement of additional supplies and services or through the alteration of existing contracts. It is the responsibility of the Gold Commander to ensure that all additional costs are appropriately authorised and recorded.

## 16.2 Delegated Authority to Vary Existing Contracts

NHS England Gold Command may act on behalf of one or more Trusts, sourcing, procuring and entering into a contract for the provision of goods, services or personnel to those trusts as Agent for the trust(s). After such circumstances discussion will occur between NHS England, Clinical Commissioning Groups and providers regarding the liability for associated expenditure.

During an emergency the rule of thumb is that all costs will lie where they fall. NHS England Gold Command may as part of their duties require the variation of existing contracts for the supply of goods services or staff. They are explicitly empowered (during a Major Incident) to direct that goods, services or personnel being supplied to one or more trust or organisation, in one or more specified location, should be supplied instead to another trust or organisation and/or in another specified location or locations. They may vary the quantities or schedules of deliveries in order to ensure an effective response to a Major Incident.

This power shall be exercised with discretion, following discussions with trusts affected when possible, in order to reflect overall NHS priorities.

## 16.3 Delegated Authority to Approve Payments to Staff

During a Major Incident the Hospital Incident Coordination has delegated authority to call in additional staff to assist in the management of the Incident. Such staff may be called in for work outside normal office hours. In the event of staff being required to work outside normal office hours they will be recompensed for all hours worked and will be entitled to repayment of travel costs at usual rates for the journey to the place at which they are asked to work.

Subsistence allowances will be paid where appropriate, if arrangements for the supply of meals etc. cannot be made.

## 16.4 Recording Financial Information

It is the responsibility of Gold and Silver Commanders to maintain adequate logs and records of all activity undertaken in respect of the response to a Major Incident. Where the action has financial implications, it is essential that the records are adequate to identify:

- The expenditure that has been incurred and for what item or service
- When and where the item or service is to be provided
- To whom the expenditure is payable – the company or organisations name and address, and a named individual as contact
- On whose behalf the expenditure was incurred, particularly if acting as an agent for a trust
- The relevant terms and conditions of sale
- When the bill is payable
- The name of the individual approving the expenditure at the time
- The date of the transaction

In order to provide an appropriate audit trail, copies of such information will be supplied as soon as possible to the Chief Finance Officer, or an officer nominated by the Director to oversee the financial implications of the Incident.

# 17. Recovery

## 17.1 Debriefing

### 17.1.1 Hot Debrief [25]

Within 2 hours of a Major Incident STAND DOWN a series of 'hot debriefs' will be held. The Gold Commander will have the responsibility for debriefing all director level and Gold Command staff and the appropriate Silver Incident Commanders will debrief all staff involved in the response.

A 'hot debrief' is:

- A process for learning lessons from the Incident;
- A forum for staff to express up to two immediate issues which may concern them;
- An opportunity to thank staff.

A 'hot debrief' may help the Trust identify staff that may need further support but should **NOT**:

- be allowed to become over-emotional or confrontational;
- be used to criticise individuals;
- be overly detailed;
- be used to provide any form of post Incident psychological support.

The hot debriefs should be minuted and last no more than an 30minutes. Once the hot debriefs have been conducted the emergency planning and resilience manager will organise a series of 'Cold' structured debriefs.

### 17.1.2 Cold debrief

The key aspects of a cold debrief are as follows;

- It should be held within 2 weeks of the Incident
- It should include key players within the Trust who were involved in the response to the Incident
- It should address organisational issues, not personal or psychological issues
- It should look for both strengths and weaknesses and ideas for future learning
- It provides an opportunity to thank staff and provide positive feedback
- It will be facilitated by the Emergency Planning and Resilience Team or an independent external person.

### 17.1.3 Multi-agency debrief

- If a multiagency debrief is convened, the key aspects are as follows;
- It should address organisational issues, not personal or psychological issues
- It should look for both strengths and weaknesses and ideas for future learning
- It provides an opportunity to thank staff and provide positive feedback
- it may be facilitated by a partner agency.

### 17.1.4 Post Incident

- Post Incident the following action will be undertaken;
- The Trust post Incident report will be completed by the Emergency Planning and Resilience Team
- Lessons identified from the Incident will be developed into an action plan
- Lessons identified will be shared with our partners
- The Trust Emergency Planning and Resilience Team will be responsible for collating and storing all the records, logs and reports associated with the Incident. At the same time the Trust Organisational

[25] A copy of the Hot Debrief Standard Operating Procedure is available in the Hospital Incident Coordination Centre or via ResilienceDirect

Resilience Group will meet to consider the implications of how the debrief and plan should be reconsidered in light of the lessons identified.

### 17.1.5 Post Incident report

The Trust Post Incident report, collated by the Emergency Planning and Resilience Team, signed off by the Executive Management Team will be sent to NHS England, Commissioners and/or partners as appropriate. The report will;

- Summarise the sequence of events
- Identify the individuals involved
- Describe the actions of staff
- Provide an accurate timeline
- Outline any lessons identified, along with action plans

## 17.2 Post Incident Psychosocial and Mental Health Support

After a Major Incident the Trust recognises that some members of patients, relatives and staff may become distressed in the short-term. However, for a small number of patients, relatives or staff this distress might become temporarily disabling, last for a longer time, or cause substantial mental health problems. Therefore, facilities for appropriate psychosocial support and clear pathways to specialist mental healthcare (for the few instances that these services might be required) will be made available within the Trust to support distressed persons.

The Trust will take a stepped approach to psychosocial support that initially relies on informal support provided by families, communities, and colleagues. This support will progress, according to need, to the Primary or Occupational Health and Social Care services and Voluntary agencies that can provide psychosocial first aid. Any person who does not recover from immediate and short-term distress of the Incident after the above measures then assessment and intervention services will be offered by the Trust through the usual referral pathways via the Staff Health and Well Being Service. Anyone assessed as requiring further primary or secondary mental healthcare services will be provided with them either directly by the Trust or in the case of staff through the Trust's Staff Health and Well Being Service.

## 17.3 Staff Post Incident Counselling Service

Information about counselling services is available from the Staff Health and Well Being Service, to whom staff can self-refer following a Critical / Major Incident. This service is available for all staff experiencing psychological distress for whatever reason.

## 17.4 Serious Incident Investigation

In the event of an Incident that severely or completely impedes the Trust's ability to carry out its business, damages Trust property, or causes significant legal, media or reputation implications for the Trust then the Incident is also classed as a Serious Incident and should be reported as such.

## 17.5 Incident Documentation

After a Major Incident all documents including logs, notes, post-its, flip charts, electronic documents, memos, and message pads must be retained. Documents are to be sent to the Emergency Planning and Resilience Team as soon as possible after stand-down.

## 17.6 Post Incident Recovery

Recovery is defined as the process of rebuilding, restoring and rehabilitating the community following an emergency, but it is more than simply the replacement of what has been destroyed and the rehabilitation of those affected. It is a complex social and developmental process rather than just a remedial process. There are four interlinked categories of impact that individuals and communities will need to recover from: Humanitarian (inc.

Health); Economic; Infrastructure; and Environmental. The manner in which recovery processes are undertaken is critical to their success. Recovery is best achieved when the affected community is able to exercise a high degree of self-determination.

The recovery phase should begin at the earliest opportunity following the onset of an emergency, running in tandem with the response to the emergency. It continues until the disruption has been rectified, demands on services have returned to normal levels, and the needs of those affected (directly and indirectly) have been met. While the response phase to an emergency can be relatively short, the recovery phase may endure for months, years or even decades.

Post-Incident recovery planning starts at the first Gold meeting where recovery issues are identified as part of the standing agenda[26] and will followed up at any subsequent Gold meetings. For large scale Incidents or those that may result in long term impacts (financial, reputational or to staff, patients or estate) the Gold Commander may request the establishment of a recovery group, chaired by an appropriate Executive to manage the recovery process separately with regular inputs in to the Gold Control Room. The Gold Commander (or recovery group should assess the disruption to the Trusts operational functions caused by the Incident, including any long-term implications and how to return to a 'new normality'[27]. This assessment will include:

- Effects on staffing (e.g. loss of staff through injury or sickness, impact of overtime worked by staff during the Incident on staffing levels);
- Support needs of staff affected by the Incident (including trauma support);
- Disruption caused to patient care;
- Disruption caused to other PAH functions;
- Damage inflicted to PAH property or property the Trust shares;
- Financial losses;
- Future provision of services in the short-, medium- and long-term. It should be considered that for Incidents such as mass casualty Incidents, the resulting injuries to patients could result in the requirement for long term inpatient and outpatient care over many months or potentially years.

The results of which will be passed to the Executive Management Team who will combine the results and conduct a strategic level initial post-Incident recovery action plan. Once the initial action plan has been agreed the executive management team will facilitate the transition to a 'new normality' across the Trust. Following an Incident stand down the Trust will host regular recovery meetings inviting the appropriate operational leads as necessary. The meeting will have a set agenda based around the initial assessment. If the business continuity arrangements have been invoked they will be used to inform the priority and timescales of the restoration and recovery of services which will happen on a staged basis dependant on criticality. In the case of "rising tide" Incidents that start and finish gradually (e.g. influenza pandemic), the main Trust Recovery meeting may be hosted, by an appropriate director, before the Incident stand down is issued.



[26] Available in Hospital Incident Coordination Centre pack
[27] It should be remembered that the Trust is not able to return to its previous state as any incident, regardless of size, will have an impact on the way the Trust operates, and will resulting in actions and learning.

# 18. Competency

## 18.1 National Occupational Standards

National Occupational Standards are the mandatory system used to define what is expected of competent individuals. Trusts must provide those people who are expected to undertake a command role with the training and exercise opportunities that are relevant to the role they will be performing.

Used as tools to assist in recruitment, appraisal, job evaluation and development of individuals, teams and organisation's, they ensure that all personnel are aware of their own role and what they need to be able to perform it in a competent manner. They allow for easy reference to team composition, task allocation and can provide organisation's with defense when competence is questioned.

Increasingly, in a litigious society it might prove useful to be able to claim competence with nationally recognised standards. NOS provide a framework for development and assessment.

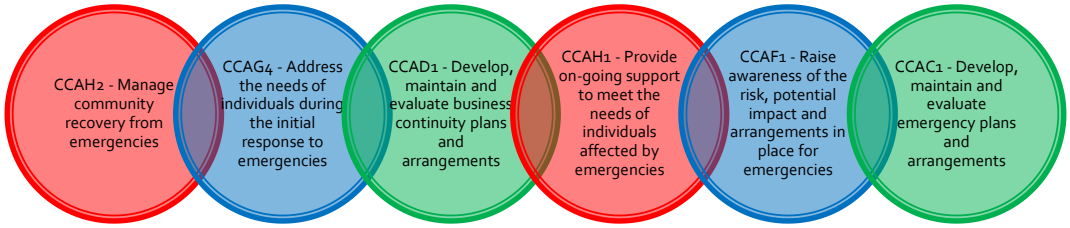
There are three main types of training within the workplace designed to meet an individual's development needs, continual professional development, progression and new roles (either expansion or change).

In all these cases, NOS accurately define and underpin roles and their desired outcomes.

### 18.1.1 Gold commander

The following represent the suite of standards that a Gold Commander is required to achieve. There are 9 mandatory standards and 6 optional ones.


Gold Commander Mandatory Suite of Standards

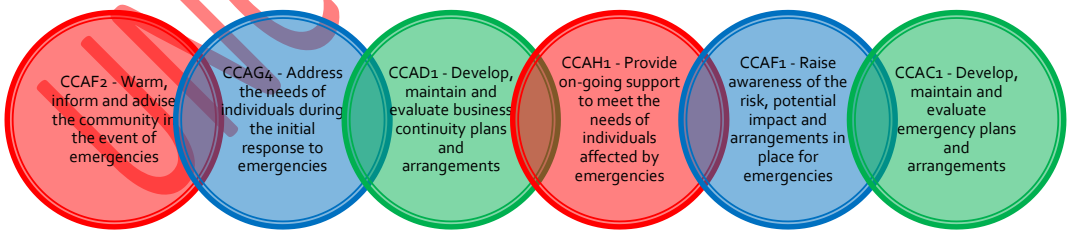



Gold Commander Optional Standards

### 18.1.2 Silver Commander

Working at the tactical level, the Silver Commander suite contains 8 mandatory and 6 optional standards. The Silver Commander must demonstrate competence against the standards through completion of their CPD.


Silver Commander Mandatory Suite of Standards

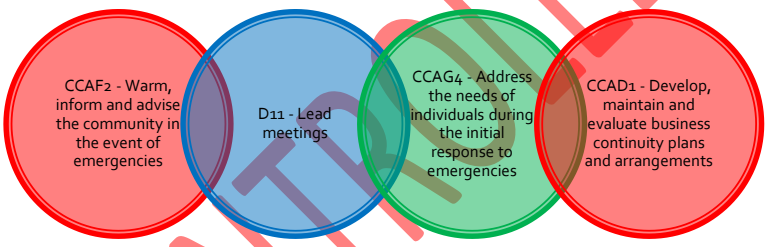



Silver Commander Optional Standards

### 18.1.3 Bronze Commander

The Bronze Commander suite contains 7 mandatory standards and 4 optional ones. The Bronze Commander must demonstrate competence against the standards through completion of their CPD.


*Bronze Commander Mandatory Suite of Standards*




Bronze Commander Optional Standards

As a Trust it is essential that we ensure that our Gold, Silver and Bronze Commanders are appropriately trained to ensure they meet the requirements of the National Occupational Standards. Failure to do so means we are unable to fulfill our requirements under the Civil Contingencies Act (2004) in terms of our duty to assess, plan and advise, and ultimately leave ourselves at risk of litigation.

# Action Cards

## Introduction to Action Cards

During a Major or Critical Incident members of Trust staff may be asked to perform a key role on behalf of the Trust, these roles might be different from their usual responsibilities so action cards have been developed to support staff in this situation.

At the request of the Hospital Incident Coordination Centre any member of Trust staff may be allocated an action card to perform a key role on behalf of the Trust. Usually this will be an On-call Member of staff with the relevant knowledge and experience, but it is acknowledged that this maybe not always be the case especially if they have been caught up in the Incident themselves. Once allocated it may be necessary for another member of staff to take over the action card role (because they are providing relief, or they have more localised appropriate experience) this can only happen after a full briefing has to been given, in writing, on the actions taken to-date and outstanding issues. Until this has taken place, the member of staff originally assigned to the action card will be considered as still in place and responsible for the actions associated with the role.

It may also become apparent that due to the nature of the Incident, that specialist advice is required and that staff from specialist areas may be contacted to attend the Incident Coordination Centre to provide advice and support Trust response.

All on-call staff should:

- Be familiar with the contents of their own action card;
- Use it from the moment they are contacted about an Incident;
- Carry their relevant On-Call Major Incident Packs containing their action card (when designated as on-call).

### Action Cards Summary

- Are role specific (not designed for designated individuals)
- Proves a useful checklist of actions to be considered
- Provide essential information needed to perform a specific role
- Help people focus on their role
- Give useful guidance
- Prevent important tasks being forgotten or delayed
- May remove the need to consult large or complex plans during an Incident
- May be used by other people who are required to perform a specific role during a Major Incident

### Action Card Criticality

| | | | |
|---|---|---|---|
| | Red | Essential Role | Used in all incidents |
| | Yellow | Emergency Dept Role | Used when incidents are related to the emergency department |
| | Green | Supporting Role | Used as required dependant on the incident |

# Action Card List

# A Command and Control Action Cards

| Action Card Number | Incident Role | Undertaken By | Page |
|---|---|---|---|
| **1** | Gold Commander | Executive On-Call | 62 |
| **2** | Silver Commander (Nurse) | Clinical Site Manager | 66 |
| **3** | Silver Commander (Manager) | Senior Manager On-Call | 71 |
| **4** | Tactical Advisor | Tactical Advisor On-Call | 76 |
| **5** | Switchboard | Switchboard Operator | 78 |
| **6** | Loggist | Any Trained Loggist | 80 |

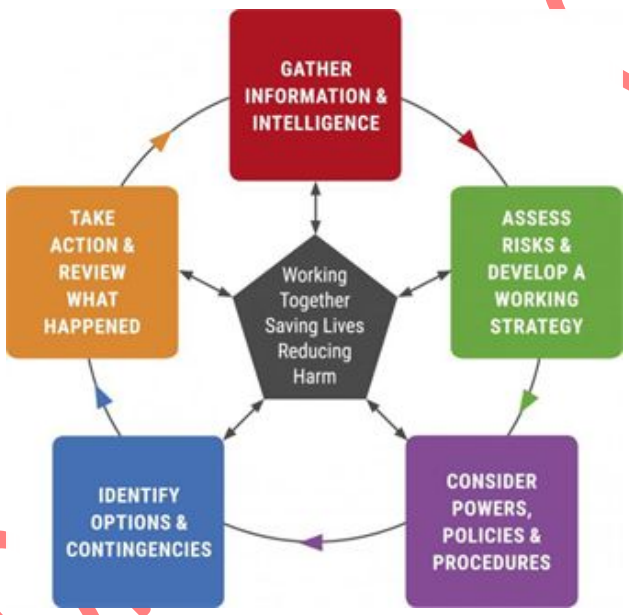
# Action Card 1 – Gold Commander

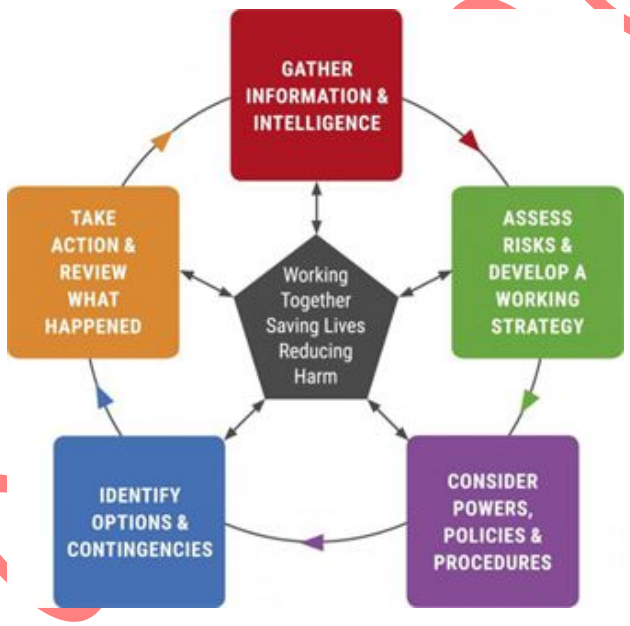
| | | |
|---|---|---|
| **Job Title** | Executive On-Call | **1** |
| **Incident Role** | Gold Commander | |

**Role Description**

The Gold Commander works at the strategic level and has overall responsibility for the command, response and recovery of an Incident. The Gold Commander will set the Trust's strategic aims (the Gold Strategy) for the Incident, providing a framework for the Silver Commanders to work within.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Ascertain situation by contacting Silver Commander (Nurse) and request METHANE Report and other any intelligence or information (sec. | | |
| 3 | Set initial Strategic Objectives using Decision Making Model   | | |
| 4 | Consider requesting Command Teleconference to enable discussions between:<br>• Gold Commander<br>• Silver Commander (Nurse)<br>• Silver Commander (Manager)<br>• Tactical Advisor | | |
| 5 | Maintain situational awareness by maintaining regular contact with Silver Commander (Nurse) | | |

| Major Incident / Critical Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Ascertain situation by contacting Silver Commander (Nurse) and request METHANE Report and other any intelligence or information | | |
| 3 | **If off site at time of declaration and prior to attending site**<br>Request Command Teleconference to enable discussions between:<br>• Gold Commander<br>• Silver Commander (Nurse)<br>• Silver Commander (Manager)<br>• Tactical Advisor | | |
| 4 | Provide regular updates to CEO, COO and Chairman | | |
| 5 | Set initial Strategic Objectives using Dynamic Decision Making Model ensuring the Strategy set allows the Silver Commanders to make justifiable decisions and implement tactical options to meet the strategy<br>  <br> | | |
| 6 | Gain assurance from Silver Commander (Nurse) that Risk Assessments have been carried out as appropriate (such as for capacity, capability, identified threats / hazards etc.) | | |
| 7 | Ensure that the following have been informed of the declared Incident:<br><br>NHS England Declared Major Incident<br>West Essex CCG Critical Incidents<br><br>And confirm on-going communication arrangements with them | | |
| 8 | Consider the need to cancel elective work, outpatient services etc under force majeure | | |

| Task | Description | ✓ | Time |
|---|---|---|---|
| 9 | Consider the need to establish a Gold Command Cell with:<br>• Strategic Advisor<br>• Medical Advisor<br>• Communications Lead<br>• HR Lead<br>• Finance Lead | | |
| 10 | Commence planning for recovery, including formation of a recovery cell (as required) | | |
| 11 | Continue to monitor, develop and communicate, the overall strategy for the Trust, both internally and externally, ensuring this is recorded and reviewed regularly | | |
| 12 | Confirm the command structure remains in place and is understood | | |
| 13 | Ensure interagency liaison is taking place | | |
| 14 | Ensure that an integrated media plan is created in conjunction with the Communications Lead | | |
| 15 | Agree the media strategy with other multi agency commanders and cascade to Silver Commanders and Communications Lead | | |
| 16 | Ensure there is a clear line of communication with the Hospital Incident Coordination Centre | | |
| 17 | Ensure longer term resources and Command and Control Resilience | | |
| 18 | Seek assurance that welfare arrangements are in place to identify and respond to any staff welfare needs arising as a result of the Incident | | |
| 19 | Give consideration to the needs of the wider health and social care economy | | |
| 20 | If the Incident is, or has the potential to be CBRNE / HazMat, consider discussions with the Tactical Advisor regarding requests for CBRNE Mass Prophylaxis via Ambulance HEOC / NBTS | | |
| 21 | Ensure that Incident debriefs are arranged:<br>• Hot debriefs<br>• Internal debriefs and action planning<br>• Inter-agency debriefs (as required) | | |
| 22 | Ensure that letters of appreciation are prepared as necessary for:<br>• Trust Staff<br>• Partner agencies | | |
| 23 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 24 | Attend the cold / structured debrief held after the Incident | | |

## Gold Strategy

| Strategy Description | |
|---|---|
| It is our intention to deal with an on-going Major Incident in an appropriate manner which promotes the saving of life, reduces humanitarian suffering and is compatible with the vision and values of the Trust.<br><br>Through effective co-ordination, sound planning and good leadership the Gold commander will: | |
| Task | Description |
| 1 | Maintain public confidence and minimise the impact of the occurrence by ensuring that the Trust is responding effectively to the Incident. |
| 2 | Ensure that the Trust response is co-ordinated and integrated with the wider health and other responding agencies where applicable. |
| 3 | Maintain effective capacity management within the Trust (expand). |
| 4 | Assess and identify any gaps in the response capability of the organisation for dealing with the Incident. |
| 5 | Through the identification and use of mutual aid, minimise the impact on the Trust. |
| 6 | So far as reasonably practicable, take all measures to safeguard the following people under the terms of health and safety legislation:<br>• Staff and other responders<br>• Local communities |
| 7 | Ensure public messages are co-ordinated with other agencies and partners. |
| 8 | Ensure effective Business Continuity and Recovery arrangements are in place across the organisation and review where necessary. |
| 9 | Create and maintain a well-documented auditable plan and decision log for the Incident at all levels of command. |

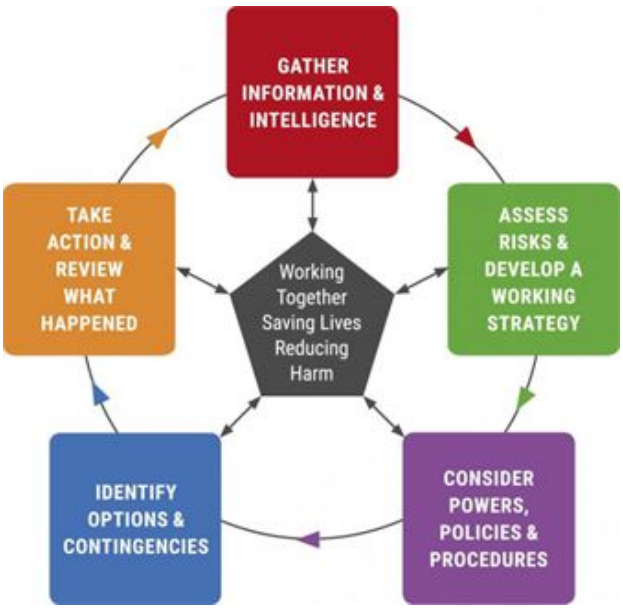
# Action Card 2 – Silver Commander (Nurse)

| | | |
|---|---|---|
| **Job Title** | Clinical Site Manager | **2** |
| **Incident Role** | Silver Commander (Nurse) | |

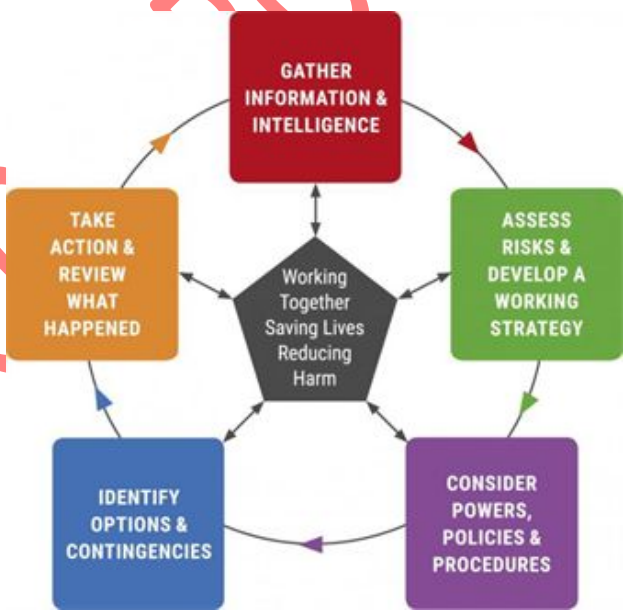
**Role Description**

The Silver Commander works at the Tactical level, their role is to take responsibility for developing the tactical plan for the use of resources. The tactical plan will be developed within the framework of the gold strategy and any available intelligence and associated risks. You will work in conjunction with Silver Commander (Manager)

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Ascertain situation by contacting Switchboard and request METHANE Report and other any intelligence or information such as that available from the Emergency Department | | |
| 3 | Provide an initial briefing to Gold Commander using IIMARCH model | | |
| 4 | Open Hospital Incident Coordination Centre and inform switchboard | | |
| 5 | Assume command of all assets operating within Princess Alexandra Hospital (including any external companies and voluntary services) | | |
| 6 | Confirm that a Tactical Advisor has been requested and is on route. | | |
| 7 | If requested by Gold Commander join Command Teleconference to enable discussions between:<br>• Gold Commander<br>• Silver Commander (Nurse)<br>• Silver Commander (Manager)<br>• Tactical Advisor | | |
| 8 | Use the Dynamic Decision Making Model set a Tactical plan which is justifiable and meets the requirements of the Gold strategy<br>  | | |

| Task | Description | ✓ | Time |
|---|---|---|---|
| 9 | Maintain situational awareness by maintaining regular contact with and providing briefings for Bronze Commanders | | |
| 10 | Manage the Incident until cancelled or declared | | |
| 11 | Undertake a Hot Debrief for the Hospital Incident Coordination Centre | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Ascertain situation by contacting Switchboard and request METHANE Report and other any intelligence or information such as that available from the Emergency Department | | |
| 3 | Activate Major Incident Declared DeskAlert Message | | |
| 4 | Provide an initial briefing to Gold Commander using IIMARCH model | | |
| 5 | Open Hospital Incident Coordination Centre and inform switchboard | | |
| 6 | Assume command of all assets operating within Princess Alexandra Hospital (including any external companies and voluntary services) | | |
| 7 | Confirm that a Tactical Advisor has been requested and is on route. | | |
| 8 | Ensure that appropriate Bronze Commander roles have been allocated and deployed as appropriate. | | |
| 9 | If Incident is likely to see large numbers of attenders, ensure that the designated receiving ward is being prepared to accept admissions (EAU) | | |
| 10 | If requested by Gold Commander join Command Teleconference to enable discussions between:<br>• Gold Commander<br>• Silver Commander (Nurse)<br>• Silver Commander (Manager)<br>• Tactical Advisor | | |
| 11 | Use the Dynamic Decision Making Model set a Tactical plan which is justifiable and meets the requirements of the Gold strategy<br>  | | |
| 12 | Maintain situational awareness by maintaining regular contact with and providing briefings for Bronze Commanders | | |
| 13 | Establish lines of communication with other agency Silver Commanders as appropriate | | |

| Task | Description | ✓ | Time |
|---|---|---|---|
| 14 | Ensure there are clear lines of communication between Silver and Bronze Commanders | | |
| 15 | In conjunction with the Tactical Advisor consider the need to request specialist assets or equipment | | |
| 16 | Ensure that staff are allocated (as appropriate to):<br>• A&E Triage Point<br>• Family and Friend Reception Centre<br>• Staff Holding Area<br>• Press Holding Area<br>• Decontamination area | | |
| 17 | Consider an early request for Mutual Aid and escalate to Gold Commander | | |
| 18 | Ensure effective deployment of:<br>• Resources<br>• Personnel<br>• Specialist assets | | |
| 19 | Liaise with the Tactical Advisor to ensure the Major Incident Plan is being followed or for specialist knowledge or advice | | |
| 20 | Liaise with Bronze Commanders to ensure functional roles are being undertaken | | |
| 21 | Liaise with Local Authority as required if there is a need for non-medical transport (such as buses) or there is a need for access to additional buildings etc. | | |
| 22 | Consider welfare arrangements for yourself, managers and staff if the Incident is likely to become protracted | | |
| 23 | Agree and initiate “Major Incident Stand Down” arrangements in conjunction with Gold Commander when appropriate | | |
| 24 | Ensure that a “hot debrief” is facilitated immediately after the Incident | | |
| 25 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 26 | Attend the cold / structured debrief held after the Incident | | |

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# Action Card 3 – Silver Commander (Manager)

| | | |
|---|---|---|
| **Job Title** | Senior Manager On-Call | **3** |
| **Incident Role** | Silver Commander (Manager) | |

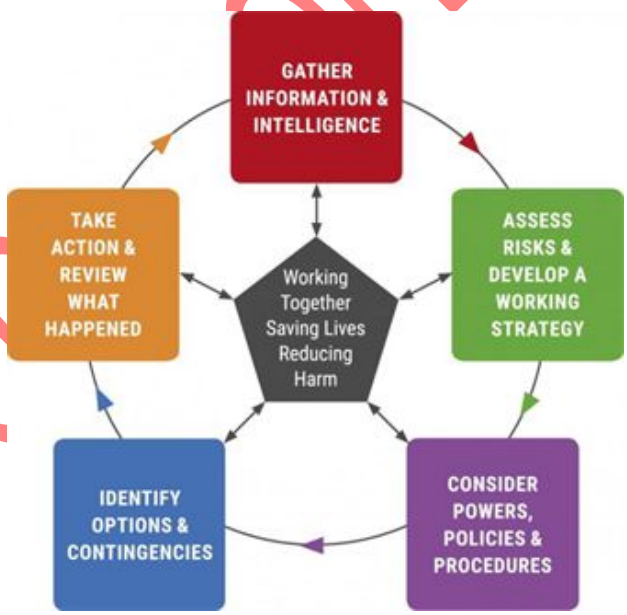
**Role Description**

The Silver Commander works at the Tactical level, their role is to take responsibility for developing the tactical plan for the use of resources. The tactical plan will be developed within the framework of the gold strategy and any available intelligence and associated risks. You will work in conjunction with Silver Commander (Nurse)

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Ascertain situation by contacting Silver Commander (Nurse) and request METHANE Report and other any intelligence or information such as that available from the Emergency Department | | |
| 4 | Make your way to the Hospital Incident Coordination Centre | | |
| 5 | Assume command of all assets operating within Princess Alexandra Hospital (including any external companies and voluntary services) | | |
| 6 | Confirm that a Tactical Advisor has been requested and is on route. | | |
| 7 | If requested by Gold Commander join Command Teleconference to enable discussions between:<br>• Gold Commander<br>• Silver Commander (Nurse)<br>• Silver Commander (Manager)<br>• Tactical Advisor | | |
| 8 | Use the Dynamic Decision Making Model set a Tactical plan which is justifiable and meets the requirements of the Gold strategy<br>  | | |

| | | | |
|---|---|---|---|
| 9 | Maintain situational awareness by maintaining regular contact with Bronze Commanders | | |
| 10 | Manage the Incident until cancelled or declared | | |
| 11 | Undertake a Hot Debrief for the Hospital Incident Coordination Centre | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Ascertain situation by contacting Switchboard and request METHANE Report and other any intelligence or information such as that available from the Emergency Department | | |
| 3 | Make your way to the Hospital Incident Coordination Centre | | |
| 4 | Assume command of all assets operating within Princess Alexandra Hospital (including any external companies and voluntary services) | | |
| 5 | Confirm that a Tactical Advisor has been requested and is on route. | | |
| 6 | Ensure that appropriate Bronze Commander roles have been allocated and deployed as appropriate. | | |
| 7 | If Incident is likely to see large numbers of attenders, ensure that the designated receiving ward is being prepared to accept admissions (EAU) | | |
| 8 | If requested by Gold Commander join Command Teleconference to enable discussions between:<br>• Gold Commander<br>• Silver Commander (Nurse)<br>• Silver Commander (Manager)<br>• Tactical Advisor | | |
| 9 | Use the Dynamic Decision Making Model set a Tactical plan which is justifiable and meets the requirements of the Gold strategy<br>  | | |
| 10 | Maintain situational awareness by maintaining regular contact with Bronze Commanders | | |
| 11 | Establish lines of communication with other agency Silver Commanders as appropriate | | |
| 12 | Ensure there are clear lines of communication between Silver and Bronze Commanders | | |

| Task | Description | ✓ | Time |
|---|---|---|---|
| 13 | In conjunction with the Tactical Advisor consider the need to request specialist assets or equipment | | |
| 14 | Ensure that staff are allocated (as appropriate to):<br>• A&E Triage Point<br>• Family and Friend Reception Centre<br>• Staff Holding Area<br>• Press Holding Area<br>• Decontamination area | | |
| 15 | Consider an early request for Mutual Aid and escalate to Gold Commander | | |
| 16 | Ensure effective deployment of:<br>• Resources<br>• Personnel<br>• Specialist assets | | |
| 17 | Liaise with the Tactical Advisor to ensure the Major Incident Plan is being followed or for specialist knowledge or advice | | |
| 18 | Liaise with Bronze Commanders to ensure functional roles are being undertaken | | |
| 19 | Liaise with Local Authority as required if there is a need for non-medical transport (such as buses) or there is a need for access to additional buildings etc. | | |
| 20 | Consider welfare arrangements for yourself, managers and staff if the Incident is likely to become protracted | | |
| 21 | Agree and initiate “Major Incident Stand Down” arrangements in conjunction with Gold Commander when appropriate | | |
| 22 | Ensure that a “hot debrief” is facilitated immediately after the Incident | | |
| 23 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 24 | Attend the cold / structured debrief held after the Incident | | |

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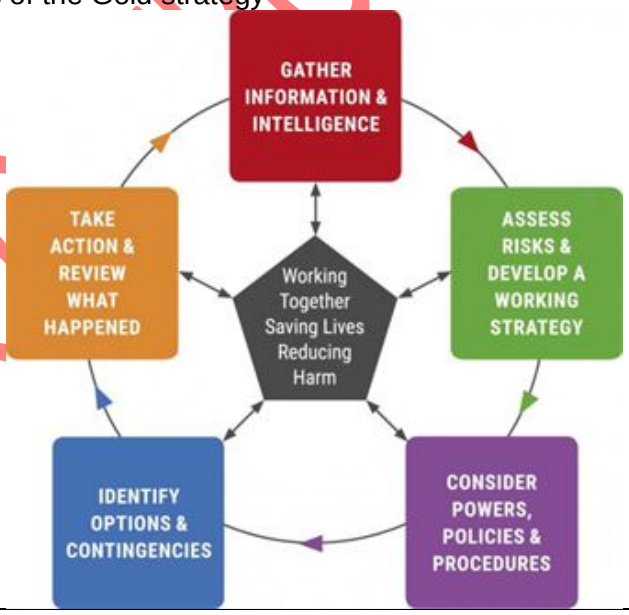
# Action Card 4 – Tactical Advisor

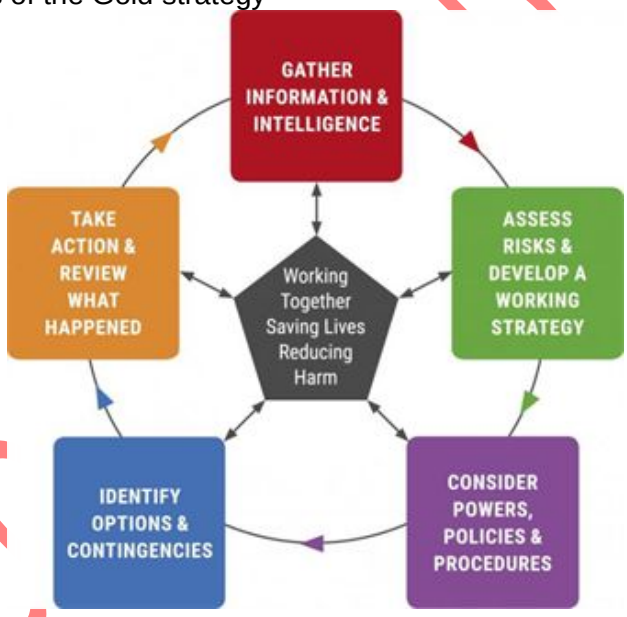
| | | |
|---|---|---|
| **Job Title** | On-Call Health, Safety and Resilience Officer | **4** |
| **Incident Role** | Tactical Advisor | |

**Role Description**

The Tactical Advisor works to support the Silver Commanders to develop the tactical plan for the use of resources and to provide specialist knowledge related to the Major Incident Plan, Specific Incidents, The Civil Contingencies Act and the availability of specialist resources. The Tactical Advisor may also be requested to support the Gold Commander, for which they would become the Strategic Advisor.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Ascertain situation by contacting Switchboard and request METHANE Report and other any intelligence or information such as that available from the Emergency Department | | |
| 3 | Ensure NHS England SitRep is completed | | |
| 4 | Make your way to the Hospital Incident Coordination Centre | | |
| 5 | If requested by Gold Commander join Command Teleconference to enable discussions between:<br>• Gold Commander<br>• Silver Commander (Nurse)<br>• Silver Commander (Manager)<br>• Tactical Advisor | | |
| 6 | Work with the Silver Commanders using the Dynamic Decision Making Model to set a Tactical plan which is justifiable and meets the requirements of the Gold strategy<br>  | | |
| 7 | Maintain situational awareness by maintaining regular contact with all Commanders | | |
| 8 | Provide specialist knowledge and guidance to assist commanders to manage the Incident until cancelled or declared | | |
| 9 | Take part in a Hot Debrief for the Hospital Incident Coordination Centre | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Ascertain situation by contacting Switchboard and request METHANE Report and other any intelligence or information such as that available from the Emergency Department | | |
| 3 | Ensure NHS England SitRep is completed | | |
| 4 | Make your way to the Hospital Incident Coordination Centre | | |
| 5 | If requested by Gold Commander join Command Teleconference to enable discussions between:<br>• Gold Commander<br>• Silver Commander (Nurse)<br>• Silver Commander (Manager)<br>• Tactical Advisor | | |
| 6 | Work with the Silver Commanders using the Dynamic Decision Making Model to set a Tactical plan which is justifiable and meets the requirements of the Gold strategy<br>  | | |
| 7 | Maintain situational awareness by maintaining regular contact with all Commanders | | |
| 8 | Consider<br>• Mutual Aid<br>• Other Specialist Advisors | | |
| 9 | Provide specialist knowledge and guidance to assist commanders to manage the Incident until cancelled or declared | | |
| 10 | Take part in a Hot Debrief for the Hospital Incident Coordination Centre | | |
| 11 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 5 – Switchboard Operator

| | | |
|---|---|---|
| **Job Title** | Switchboard Operator | **5** |
| **Incident Role** | Switchboard Operator | |

| **Role Description** |
|---|
| To ensure the rapid dissemination of information related to Incidents. |

| **Major Incident Stand By or Declared** | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | Receive emergency call via A2 line | | |
| 2 | Follow Switchboard Major Incident Report Form | | |
| **Internal Incident** | | | |
| 4 | Receive call via switchboard or 2222 | | |
| 5 | Follow Switchboard Internal Incident Report Form | | |

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# Action Card 6 – Loggist

| | | |
|---|---|---|
| **Job Title** | Any staff member trained as a loggist | **6** |
| **Incident Role** | Loggist | |

**Role Description**

The loggist will maintain the Incident log book on behalf of the commander they are allocated to, ensuring that information received, decisions and rationale for the decision being made.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Upon being requested make your way to the Hospital Incident Coordination Centre | | |
| 2 | On arrival collect a Loggist pack, and ensure it has all the equipment required for you to perform your task | | |
| 3 | Report to the Commander you have been requested to log for, and receive a briefing from them | | |
| 4 | **FOCUS ONLY ON YOUR ALLOCATED ROLE<br>DO NOT UNDERTAKE ANY OTHER TASKS** | | |
| 5 | You are responsible for capturing key information, events, all decisions and rationales during the Incident | | |
| 6 | Remain with the assigned Commander until stood down | | |
| 7 | Ensure the log is kept up to date, including ensuring each entry is initialled, timed and dated | | |
| 8 | Ensure any changes to the Command and Control Structure is recorded | | |
| 9 | Ensure the Commander signs the log as accurate, prior to them standing down or being relieved | | |
| 10 | Collate and cross reference (to the log) all additional documentations such as photographs, paperwork, notes etc | | |
| 11 | Ensure that all logs and additional documentation is handed to the Incident Commander, or Tactical Advisor before you leave | | |
| 12 | Take part in the Hot Debrief at the end of your shift / at the end of the Incident | | |
| 13 | Attend the cold / structured debrief held after the Incident | | |

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# B Emergency Department Action Cards

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# Action Card 7 – Bronze ED Nurse

| | | |
|---|---|---|
| **Job Title** | Nurse in Charge – ED | **7** |
| **Incident Role** | Bronze ED Nurse | |

**Role Description**

The Bronze ED Nurse works at the Operational level in conjunction with the Bronze ED Consultant and has responsibility for the Emergency Department for the duration of an Incident. The Bronze Commander will liaise with the Hospital Incident Coordination Centre, who will set the tactical parameters for the management of the Incident.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Take details of Incident from switchboard via the Red Line | | |
| 3 | Update yourself on the current position of the department in terms of patient activity, staffing levels, capacity and equipment | | |
| 4 | Contact the ED Consultant on-call and confirm they are on route to the department | | |
| 5 | Brief staff regarding the potential Incident, and prepare the department accordingly | | |
| 6 | Provide regular updates to the Hospital Incident Coordination Centre as to the position of the department via ext 2999 | | |
| 7 | Consider which staff will be allocated to ED Triage point | | |
| 8 | Ensure that paediatric ED staff are aware that there may be a need to open the P3 area within the Paediatric ED area | | |
| 9 | Undertake a Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Take details of Incident from switchboard via the Red Line | | |
| 3 | Update yourself on the current position of the department | | |
| 4 | Contact the ED Consultant on-call and confirm they are on route to the department | | |
| 5 | Brief staff regarding the potential Incident, and prepare the department accordingly | | |
| 6 | Provide regular updates to the Hospital Incident Coordination Centre as to the position of the department via ext 2999 | | |
| 7 | Allocate a member of reception staff to carry out the Major Incident Cascade if required | | |
| 8 | Designate staff to work in:<br>• Triage Point Ambulance Entrance<br>• P1 Area Resus<br>• P2 Area Majors<br>• P3 Area Minors or Fracture Clinic | | |
| 9 | Paediatric casualties should be treated in the same areas as all other patients | | |
| 10 | Ensure that the Triage Point Whiteboard is maintained | | |
| 11 | In conjunction with the ED Consultant, maintain an overview of the department in terms of:<br>• Staffing<br>• Capacity<br>• Patient Activity<br>• Resource Requirements<br>• Mutual aid requirements<br>And feed back to the hospital Incident coordination centre any requirements | | |
| 12 | In conjunction with the ED Consultant, review and as needed adjust staffing for the next 48 hours. | | |
| 13 | Ensure that a “hot debrief” is facilitated in the department after any shift changes, and immediately after the Incident | | |
| 14 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 15 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 8 – Bronze ED Consultant

| | | |
|---|---|---|
| **Job Title** | On-Call ED Consultant | **8** |
| **Incident Role** | Bronze ED Consultant | |

**Role Description**

The Bronze ED Consultant works at the Operational level in conjunction with the Bronze ED Nurse and has clinical responsibility for the Emergency Department for the duration of an Incident. The Bronze Commander will liaise with the Hospital Incident Coordination Centre, who will set the tactical parameters for the management of the Incident.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Contact ED Nurse in Charge (Bronze ED Nurse) for details of the Incident | | |
| 3 | Update yourself on the current position of the department in terms of patient activity, staffing levels, capacity and equipment | | |
| 4 | If not on site, make your way to site | | |
| 5 | Ensure medical staff are aware of the Incident, and consider contacting off duty ED Consultants, dependant on the intelligence you have received | | |
| 6 | Based on information received consider the need for any additional support or resources in the department | | |
| 7 | Ensure all patients in the department are reviewed and discharged or transferred as appropriate | | |
| 8 | Take part in the Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Contact ED Nurse in Charge (Bronze ED Nurse) for details of the Incident | | |
| 3 | Update yourself on the current position of the department in terms of patient activity, staffing levels, capacity and equipment | | |
| 4 | If not on site, make your way to site | | |
| 5 | Ensure medical staff are aware of the Incident, and consider contacting off duty ED consultants, dependant on the intelligence you have received | | |
| 6 | Consider the need to request teams to the Department:<br>• Crash Team<br>• Trauma Team<br>• Paediatric Team<br>• Medical Team | | |
| 7 | Consider the need for any specialist information or resources that may be required such as poisons unit, Public Health England, Trauma Specialists | | |
| 8 | Maintain an overview of clinical activity and provide clinical leadership, but DO NOT become actively involved in the treatment of patients | | |
| 9 | Ensure you are the only person authorising the discharge of patients from the department | | |
| 10 | In conjunction with the Bronze ED Nurse, maintain an overview of the department in terms of:<br>• Staffing<br>• Capacity<br>• Patient Activity<br>• Resource Requirements<br>• Mutual aid requirements<br>And feed back to the hospital Incident coordination centre any requirements | | |
| 11 | Paediatric casualties should be treated in the same areas as all other patients:<br>P1 A&E Resus<br>P2 A&E Majors<br>P3 A&E Minors (or Fracture Clinic if there are large numbers of casualties) | | |
| 12 | In conjunction with the Bronze ED Nurse, review and as needed adjust staffing for the next 48 hours. | | |
| 13 | Ensure that a “hot debrief” is facilitated in the department after any shift changes, and immediately after the Incident | | |
| 14 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 15 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 9 – Bronze Triage Nurse

| | | |
|---|---|---|
| **Job Title** | ED Nurse | **9** |
| **Incident Role** | Bronze Triage Nurse | |

**Role Description**

To undertake triage of patients arriving at the Emergency Department during a Major Incident, whether they are casualties from the Major Incident or standard ED arrivals.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Prepare to go to the Triage Point when requested by the Bronze ED Nurse | | |
| 3 | Take part in the Hot Debrief for the Emergency Department | | |

<table>
<tr><th colspan="4">Major Incident Declared</th></tr>
<tr><th>Task</th><th>Description</th><th>✓</th><th>Time</th></tr>
<tr><td>1</td><td>Maintain a comprehensive log of information received, decisions made and rationale throughout.</td><td></td><td></td></tr>
<tr><td>2</td><td>Collect Triage Kit from Major Incident Store, then base yourself at the Major Incident Triage Point at the Ambulance Entrance</td><td></td><td></td></tr>
<tr><td>3</td><td>Request that the Bronze ED nurse closes the main entrance to ED and directs all patients to the Ambulance Entrance</td><td></td><td></td></tr>
<tr><td>4</td><td>Carry out Secondary Triage on ALL patients arriving at the department and ensure all patients have a Triage Tag<br><br>GCS<br>13 – 15 4<br>9 – 12 3<br>6 – 8 2<br>4 – 5 1<br>3 0<br><br>+<br><br>Resp Rate<br>10 – 29 4<br>30 or more 3<br>6 – 9 2<br>1 – 5 1<br>0 0<br><br>+<br><br>Systolic BP<br>90 or more 4<br>76 – 89 3<br>50 – 75 2<br>1 – 49 1<br>0 0<br><br>=<br><br>10 or less = Priority 1<br>11 = Priority 2<br>12 = Priority 3</td><td></td><td></td></tr>
<tr><td>5</td><td>Stay focused on your role. DO NOT ATTEMPT TREATMENT OF CASUALTIES</td><td></td><td></td></tr>
<tr><td>6</td><td>Ensure the white board remains up to date in conjunction with receptionist</td><td></td><td></td></tr>
<tr><th>Task</th><th>Description</th><th>✓</th><th>Time</th></tr>
<tr><td>7</td><td>Ensure that each casualty has a Major Incident Documentation pack from the Major Incident Store</td><td></td><td></td></tr>
</table>

| | | | |
|---|---|---|---|
| 8 | Paediatric casualties should be treated in the same areas as all other patients:<br>P1 A&E Resus<br>P2 A&E Majors<br>P3 Paediatric ED | | |
| 9 | In collaboration with the East of England Ambulance Service Hospital Ambulance Liaison Officer ensure scheduled arrivals by priority group | | |
| 10 | Provide regular updates to the Bronze ED Nurse | | |
| 11 | Provide regular updates on numbers in the department to the Hospital Incident Coordination Centre via the designated hot line | | |
| 12 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 13 | Take part in the Hot Debrief at the end of your shift / at the end of the Incident | | |
| 14 | Attend the cold / structured debrief held after the Incident | | |

**Intentionally Blank**

# Action Card 10 – P1 Area Doctor

| | | |
|---|---|---|
| **Job Title** | Anaesthetic Consultant | **10** |
| **Incident Role** | P1 Area Doctor | |

**Role Description**

The P1 Area Doctor will manage and coordinate the treatment of Priority 1 casualties and the team allocated to work within Resus

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Receive briefing regarding potential Incident from either Bronze ED Nurse or Bronze ED Consultant | | |
| 2 | Remain within the Emergency Department until released by either Bronze ED Nurse or Bronze ED Consultant. | | |
| 3 | Take part in the Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | On being alerted to a declared Major Incident make your way to the Majors Nursing Station and receive a briefing from the Bronze ED Nurse or Bronze ED Consultant. | | |
| 2 | Make your way to Resus | | |
| 3 | Manage the staff within this area to treat the casualties from the Incident. If you require resources, staff, or need a patient moved to a higher or lower triage category, you should discuss this with the Bronze ED Consultant | | |
| 4 | No patients may be discharged from the Emergency Department without the consent of the Bronze ED Consultant during a Major Incident. | | |
| 5 | Ensure that the records are maintained as to the location of all patients in the P1, P2 and P3 areas | | |
| 6 | Provide regular updates to the Bronze ED Consultant | | |
| 7 | Take part in the Hot Debrief at the end of your shift / at the end of the Incident | | |
| 8 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 11 – P2 Area Doctor

| | | |
|---|---|---|
| **Job Title** | Surgical Consultant | **11** |
| **Incident Role** | P2 Area Doctor | |

**Role Description**

The P2 Area Doctor will manage and coordinate the treatment of Priority 1 casualties and the team allocated to work within Majors

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Receive briefing regarding potential Incident from either Bronze ED Nurse or Bronze ED Consultant | | |
| 2 | Remain within the Emergency Department until released by either Bronze ED Nurse or Bronze ED Consultant. | | |
| 3 | Take part in the Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | On being alerted to a declared Major Incident make your way to the Majors Nursing Station and receive a briefing from the Bronze ED Nurse or Bronze ED Consultant. | | |
| 2 | Make your way to Majors Area | | |
| 3 | Manage the staff within this area to treat the casualties from the Incident. If you require resources, staff, or need a patient moved to a higher or lower triage category, you should discuss this with the Bronze ED Consultant | | |
| 4 | No patients may be discharged from the Emergency Department without the consent of the Bronze ED Consultant during a Major Incident. | | |
| 5 | Ensure that the records are maintained as to the location of all patients in the P1, P2 and P3 areas | | |
| 6 | Provide regular updates to the Bronze ED Consultant | | |
| 7 | Take part in the Hot Debrief at the end of your shift / at the end of the Incident | | |
| 8 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 12 – P3 Area Doctor

| | | |
|---|---|---|
| **Job Title** | Orthopaedic Consultant | **12** |
| **Incident Role** | P3 Area Doctor | |

**Role Description**

The P3 Area Doctor will manage and coordinate the treatment of Priority 1 casualties and the team allocated to work within Paediatric ED

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Receive briefing regarding potential Incident from either Bronze ED Nurse or Bronze ED Consultant | | |
| 2 | Remain within the Emergency Department until released by either Bronze ED Nurse or Bronze ED Consultant. | | |
| 3 | Take part in the Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | On being alerted to a declared Major Incident make your way to the Majors Nursing Station and receive a briefing from the Bronze ED Nurse or Bronze ED Consultant. | | |
| 2 | Make your way to paediatric ED | | |
| 3 | Manage the staff within this area to treat the casualties from the Incident. If you require resources, staff, or need a patient moved to a higher or lower triage category, you should discuss this with the Bronze ED Consultant | | |
| 4 | No patients may be discharged from the Emergency Department without the consent of the Bronze ED Consultant during a Major Incident. | | |
| 5 | Ensure that the records are maintained as to the location of all patients in the P1, P2 and P3 areas | | |
| 6 | Provide regular updates to the Bronze ED Consultant | | |
| 7 | Take part in the Hot Debrief at the end of your shift / at the end of the Incident | | |
| 8 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 13 – ED Doctor

| | | |
|---|---|---|
| **Job Title** | ED Doctor / Any Doctor assigned to work within ED | **13** |
| **Incident Role** | ED Doctor | |

**Role Description**

The ED doctor works under the guidance of P1, P2, or P3 doctor in the area to which they are assigned, to treat casualties received from the Major Incident.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Receive briefing regarding potential Incident from either Bronze ED Nurse or Bronze ED Consultant | | |
| 2 | Remain within the Emergency Department until released by either Bronze ED Nurse or Bronze ED Consultant. | | |
| 3 | Take part in the Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | On being alerted to a declared Major Incident make your way to the Majors Nursing Station and receive a briefing from the Bronze ED Nurse or Bronze ED Consultant. | | |
| 2 | Make your way to your allocated working area:<br>P1 Resus<br>P2 Majors<br>P3 Paediatric ED | | |
| 3 | Work within this area to treat the casualties from the Incident. If you require resources, staff, or need a patient moved to a higher or lower triage category, you should discuss this with the Doctor in charge for that area | | |
| 4 | No patients may be discharged from the Emergency Department without the consent of the Bronze ED Consultant during a Major Incident. | | |
| 5 | Ensure that the records are maintained as to the location of all patients in the P1, P2 and P3 areas | | |
| 6 | Take part in the Hot Debrief at the end of your shift / at the end of the Incident | | |
| 7 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 14 – ED Nurse

| | | |
|---|---|---|
| **Job Title** | ED Nurse / Any Nurse assigned to work within ED | **14** |
| **Incident Role** | ED Nurse | |

**Role Description**

The ED nurse works under the guidance of P1, P2, or P3 doctor in the area to which they are assigned, to treat casualties received from the Major Incident.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Receive briefing regarding potential Incident from either Bronze ED Nurse or Bronze ED Consultant | | |
| 2 | Remain within the Emergency Department until released by either Bronze ED Nurse or Bronze ED Consultant. | | |
| 3 | Take part in the Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | On being alerted to a declared Major Incident make your way to the Majors Nursing Station and receive a briefing from the Bronze ED Nurse or Bronze ED Consultant. | | |
| 2 | Make your way to your allocated working area:<br>P1 Resus<br>P2 Majors<br>P3 Paediatric ED | | |
| 3 | Work within this area to treat the casualties from the Incident. If you require resources, staff, or need a patient moved to a higher or lower triage category, you should discuss this with the Doctor in charge for that area | | |
| 4 | No patients may be discharged from the Emergency Department without the consent of the Bronze ED Consultant during a Major Incident. | | |
| 5 | Ensure that the records are maintained as to the location of all patients in the P1, P2 and P3 areas | | |
| 6 | Take part in the Hot Debrief at the end of your shift / at the end of the Incident | | |
| 7 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 15 – Triage Receptionist

| | | |
|---|---|---|
| **Job Title** | ED Receptionist | **15** |
| **Incident Role** | Triage Receptionist | |

**Role Description**

The Triage Receptionist works alongside the Bronze Triage Nurse, and ensures that all patients received for the duration of the Incident receive a ED Major Incident Documentation Pack, along with logging their arrival on to the Triage Area white board, and updating the white board for any moves that are undertaken.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Receive briefing regarding potential Incident from either Bronze ED Nurse or Bronze ED Consultant | | |
| 2 | Remain within the Emergency Department until released by either Bronze ED Nurse or Bronze ED Consultant. | | |
| 3 | Take part in the Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | On being alerted to a declared Major Incident make your way to the Majors Nursing Station and receive a briefing from the Bronze ED Nurse or Bronze ED Consultant. | | |
| 2 | Make your way to the Ambulance Triage Area | | |
| 3 | Ensure that all casualties arriving have 2 numbered wrist bands, and a full set of documentation | | |
| 4 | Ensure the white board remains updated throughout the Incident, with the location of each patient | | |
| 5 | Liaise with the Hospital Incident Coordination Centre via the Hot Line telephone, to ensure their white board remains up to date | | |
| 6 | Take part in the Hot Debrief at the end of your shift / at the end of the Incident | | |
| 7 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 16 – ED Receptionist

| | | |
|---|---|---|
| **Job Title** | ED Receptionist | **16** |
| **Incident Role** | ED Receptionist | |

**Role Description**

The ED nurse works under the guidance of P1, P2, or P3 doctor in the area to which they are assigned, to treat casualties received from the Major Incident.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Receive briefing regarding potential Incident from either Bronze ED Nurse or Bronze ED Consultant | | |
| 2 | Remain within the Emergency Department until released by either Bronze ED Nurse or Bronze ED Consultant. | | |
| 3 | Take part in the Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | On being alerted to a declared Major Incident make your way to the Majors Nursing Station and receive a briefing from the Bronze ED Nurse or Bronze ED Consultant. | | |
| 2 | Make your way to your allocated working area:<br>P1 Resus<br>P2 Majors<br>P3 Paediatric Emergency Department | | |
| 3 | Ensure that all patients in the areas have numbered wristbands and documentation packs | | |
| 4 | Ensure the Triage Point white board is updated with the location of patients | | |
| 5 | Ensure that the records are maintained as to the location of all patients in the P1, P2 and P3 areas | | |
| 6 | Take part in the Hot Debrief at the end of your shift / at the end of the Incident | | |
| 7 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 17 – Paediatric Nurse

| | | |
|---|---|---|
| **Job Title** | ED Paediatric Nurse | **17** |
| **Incident Role** | Paediatric Nurse | |

**Role Description**

The Paediatric nurse works under the guidance of the Bronze ED Nurse, to treat paediatric casualties received from the Major Incident.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Receive briefing regarding potential Incident from the Bronze ED Nurse. | | |
| 2 | Update yourself on the current position of the department in terms of patient activity, staffing levels, capacity and equipment | | |
| 3 | Contact the Paediatric Consultant on-call and confirm they are on route to the department | | |
| 4 | Contact the Paediatric Manager On Call and ensure they are aware. | | |
| 5 | Brief staff regarding the potential Incident, and prepare the department accordingly | | |
| 6 | Provide regular updates to the Bronze ED Nurse as to the position of the department | | |
| 7 | Review capacity within Paediatric ED and available equipment | | |
| 8 | Undertake a Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | On being alerted to a declared Major Incident make your way to the Majors Nursing Station and receive a briefing from the Bronze ED Nurse. | | |
| 2 | Update yourself on the current position of the department in terms of patient activity, staffing levels, capacity and equipment | | |
| 3 | Contact the Paediatric Consultant on-call and confirm they are on route to the department | | |
| 4 | Contact the Paediatric Manager On Call and ensure they are aware. | | |
| 5 | Brief staff regarding the potential Incident, and prepare the department accordingly | | |
| 6 | Paediatric casualties should be treated in the same areas as all other patients:<br>P1 A&E Resus<br>P2 A&E Majors<br>P3 Paediatric ED | | |
| 7 | Provide regular updates to the Bronze ED Nurse as to the position of the department | | |
| 8 | Review capacity within Paediatric ED and available equipment | | |
| 9 | Confirm the status of expected paediatric casualties with the Bronze Triage Nurse | | |
| 10 | Undertake a Hot Debrief for the Emergency Department | | |
| 11 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 18 – Paediatric Consultant

| | | |
|---|---|---|
| **Job Title** | Paediatric Consultant | **18** |
| **Incident Role** | Paediatric Consultant | |

| **Role Description** |
|---|
| The paediatric Consultant will manage and coordinate the treatment of paediatric casualties within all areas. |

| **Major Incident Stand By** | | | |
|---|---|---|---|
| **Task** | **Description** | ✓ | **Time** |
| 1 | Receive briefing regarding potential Incident from Bronze ED Consultant. | | |
| 2 | Remain within the Emergency Department until released by either Bronze ED Consultant. | | |
| 3 | Take part in the Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | On being alerted to a declared Major Incident make your way to the Majors Nursing Station and receive a briefing from the Bronze ED Consultant. | | |
| 2 | Update yourself on the current position of the department in terms of patient activity, staffing levels, capacity and equipment | | |
| 3 | Manage the staff within this area to treat the casualties from the Incident. If you require resources, staff, or need a patient moved to a higher or lower triage category, you should discuss this with the Bronze ED Consultant | | |
| 4 | No patients may be discharged from the Emergency Department without the consent of the Bronze ED Consultant during a Major Incident. | | |
| 5 | Ensure that the records are maintained as to the location of all patients in the P1, P2 and P3 areas | | |
| 6 | Provide regular updates to the Bronze ED Consultant | | |
| 7 | Take part in the Hot Debrief at the end of your shift / at the end of the Incident | | |
| 8 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 19 – ED Porter

| | | |
|---|---|---|
| **Job Title** | ED Porter | **19** |
| **Incident Role** | ED Porter | |

| **Role Description** |
|---|
| To provide portering services within the Emergency Department |

| **Major Incident Stand By** | | | |
|---|---|---|---|
| **Task** | **Description** | ✓ | **Time** |
| 1 | Receive briefing regarding potential Incident from the Bronze ED Nurse | | |
| 2 | Remain within the ED until stood down by the Bronze ED Nurse | | |
| 3 | Take part in the Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | On being alerted to a declared Major Incident make your way to the Majors Nursing Station and receive a briefing from the Bronze ED Nurse. | | |
| 2 | Liaise with the Bronze ED Nurse as to the activities that need to be undertaken | | |
| 3 | Remain in the ED until stood down by the Bronze ED Nurse | | |
| 4 | Ensure that Bronze Porter remains updated as to the porting situation, such as if you require any additional assistance. | | |
| 5 | Provide regular updates to the Silver Nurse. | | |
| 6 | Take part in the Hot Debrief at the end of your shift / at the end of the Incident | | |
| 7 | Attend the cold / structured debrief held after the Incident | | |

# C Other Area / Roles Action Cards

**Intentionally Blank**

# Action Card 20 – Bronze Porter

| | | |
|---|---|---|
| **Job Title** | Portering Supervisor | **20** |
| **Incident Role** | Bronze Porter | |

**Role Description**

To operationally coordinate portering services across the Trust

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Contact the Silver Nurse (Clinical Site Manager) and receive a briefing on the Incident | | |
| 2 | Remain in contact with the Silver Nurse until stood down | | |
| 3 | Take part in the Hot Debrief for the Emergency Department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | On being alerted to a declared Major Incident make your way to the Hospital Incident Coordination Centre and receive a briefing from the Silver Nurse | | |
| 2 | Update yourself on the current position of the department in terms of staffing levels, capacity and equipment | | |
| 3 | Call the Facilities Manager On-Call to update them on the situation | | |
| 4 | As required follow the Portering Department Call in procedure to call in additional staff | | |
| 5 | Work with the Silver Nurse to coordinate porters as required to:<br>• Assist with lock down<br>• Undertake patient movements<br>• Undertake equipment movements<br>• Open areas out of hours, such as Parndon Hall, Restaurant etc.<br>• Assist with any other suitable operational issues | | |
| 6 | Provide regular updates to the Silver Nurse. | | |
| 7 | Ensure that a “hot debrief” is facilitated in the department after any shift changes, and immediately after the Incident | | |
| 8 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 9 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 21 – Bronze EAU Nurse

| | | |
|---|---|---|
| **Job Title** | Nurse in Charge – EAU | **21** |
| **Incident Role** | Bronze EAU Nurse | |

**Role Description**

The Bronze EAU Nurse works at the Operational level in conjunction with the Physician of the day and has responsibility for EAU for the duration of an Incident. The Bronze Commander will liaise with the Hospital Incident Incident Coordination Centre, who will set the tactical parameters for the management of the Incident.

**EAU is the designated receiving ward for Major Incident Patients**

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Take details of Incident from the Silver Nurse | | |
| 3 | Update yourself on the current position of the ward in terms of patient activity, staffing levels, capacity and equipment | | |
| 4 | Contact the Physician of the Day and confirm they are on route to the ward | | |
| 5 | Brief staff regarding the potential Incident, and prepare the ward accordingly | | |
| 6 | Provide regular updates to the Hospital Incident Coordination Centre as to the position of the ward via ext 2999 | | |
| 7 | Review which patients would be suitable for rapid discharge from the ward | | |
| 8 | Undertake a Hot Debrief for the Ward | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Take details of Incident from the Silver Nurse | | |
| 3 | Update yourself on the current position of the ward | | |
| 4 | Contact the Physician of the Day and confirm they are on route to the ward | | |
| 5 | Brief staff regarding the Incident, and prepare the department accordingly | | |
| 6 | Provide regular updates to the Hospital Incident Coordination Centre as to the position of the ward via ext 2999 | | |
| 7 | In conjunction with the Physician of the day, maintain an overview of the ward in terms of:<br>• Staffing<br>• Capacity<br>• Patient Activity<br>• Resource Requirements<br>• Mutual aid requirements<br>And feed back to the hospital Incident coordination centre any requirements | | |
| 8 | In conjunction with the Physician of the Day, review and as needed adjust staffing for the next 48 hours. Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 9 | Ensure that a “hot debrief” is facilitated in the department after any shift changes, and immediately after the Incident | | |
| 10 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 11 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 22 – Bronze ITU Nurse

| | | |
|---|---|---|
| **Job Title** | Nurse in Charge – ITU | **22** |
| **Incident Role** | Bronze ITU Nurse | |

**Role Description**

The Bronze ITU Nurse works at the Operational level in conjunction with the Intensive Care Consultant and has responsibility for ITU for the duration of an Incident. The Bronze Commander will liaise with the Hospital Incident Coordination Centre, who will set the tactical parameters for the management of the Incident.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Take details of Incident from the Silver Nurse | | |
| 3 | Update yourself on the current position of the department in terms of patient activity, staffing levels, capacity and equipment | | |
| 4 | Contact the Intensive Care Consultant and confirm they are on route to the department | | |
| 5 | Brief staff regarding the potential Incident, and prepare the department accordingly | | |
| 6 | Provide regular updates to the Hospital Incident Coordination Centre as to the position of the department via ext 2999 | | |
| 7 | Review which patients would be suitable to step down to a ward bed or suitable to transfer out | | |
| 8 | Undertake a Hot Debrief for the department | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | Maintain a comprehensive log of information received, decisions made and rationale throughout. | | |
| 2 | Take details of Incident from the Silver Nurse | | |
| 3 | Update yourself on the current position of the department in terms of patient activity, staffing levels, capacity and equipment | | |
| 4 | Contact the Intensive Care Consultant and confirm they are on route to the department | | |
| 5 | Brief staff regarding the Incident, and prepare the department accordingly | | |
| 6 | Provide regular updates to the Hospital Incident Coordination Centre as to the position of the ward via ext 2999 | | |
| 7 | In conjunction with the Intensive Care Consultant, maintain an overview of the ward in terms of:<br>• Staffing<br>• Capacity<br>• Patient Activity<br>• Resource Requirements<br>• Mutual aid requirements<br>And feed back to the hospital Incident coordination centre any requirements | | |
| 8 | In conjunction with the Intensive Care Consultant, review and as needed adjust staffing for the next 48 hours. Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 9 | Ensure that a “hot debrief” is facilitated in the department after any shift changes, and immediately after the Incident | | |
| 10 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 11 | Attend the cold / structured debrief held after the Incident | | |

# Action Card 23 – Medical Advisor

| | | |
|---|---|---|
| **Job Title** | Chief Medical Officer or Associate Medical Director | **23** |
| **Incident Role** | Medical Advisor | |

**Role Description**

The Medical Advisor works alongside the Silver Manager and Silver Nurse during mass casualty Incidents and reports to them to lead the tactical Incident response and to provide a clear Command and Control response within the Trust.

**Major Incident Stand By**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Make your way to the Hospital Coordination Centre at request of Silver Manager | | |
| 2 | Maintain a log of all decisions made – keep all notes to hand in at the end of Incident. | | |
| 3 | Liaise with the Silver Nurse and obtain a full briefing. Work in conjunction with the Silver Nurse for the triage, treatment and transportation (as required) of patients. Maintain dialogue with surrounding Trusts | | |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | Attend the Hospital Incident Coordination Centre at request of Silver Manager. | | |
| 2 | Maintain a log of all decisions made – keep all notes to hand in at the end of Incident. | | |
| 3 | Liaise with the Silver Nurse and obtain a full briefing. Work in conjunction with the Silver Nurse for the triage, treatment and transportation (as required) of patients. Maintain dialogue with surrounding Trusts | | |
| 4 | Have consideration for the Legal and Human Rights duties of the Trust during mass casualty Incidents in particular where Triage is enacted. | | |
| 5 | **DO NOT ATTEMPT TO UNDERTAKE TREAMENT OF PATIENTS** | | |
| 6 | Where doctors are unknown to the Trust, undertake appropriate ID checks (where mutual aid etc has been enacted) | | |
| 7 | Ensure that appropriate medical staff are in place | | |
| 8 | Arrange a relief briefing and hand over session (4hrs or 8hrs depending on the Incident) for staff that have been working in the HICC. | | |
| 9 | Maintain an overview of any pressure points, bottlenecks and weaknesses in the system i.e.<br>• Ambulances unable to offload<br>• Bed Pressures<br>• Lack of theatre capacity<br>• Lack of Specialist Capacity (i.e. Critical Care, Paediatrics)<br>• Lack of transport for discharged/transferred patients<br>• Lack of supplies equipment and staff | | |
| 10 | Provide (or facilitate the provision of) technical medical advice | | |
| 11 | Arrange a 'hot' debrief session for staff after handover or at the end of the Incident. | | |
| 12 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 13 | Attend cold debrief session | | |

# Action Card 24 – Bronze Theatre Nurse

| | | |
|---|---|---|
| **Job Title** | Theatre Nurse In Charge | **24** |
| **Incident Role** | Bronze Theatres | |

**Role Description**

The Bronze Theatre Nurse ensures that all operating theatres become operational. The role provides support to the Emergency Department and reports to the Silver Nurse

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Assess current patient activity and staffing levels within Theatres with a Consultant Anaesthetist, identify patients who could be discharged home immediately if required. | | |
| 2 | Review the current resources available within the department | | |
| 3 | Ensure that at least two theatres are ready within 1 hour | | |
| 4 | Work with the Theatre Teams to clear Theatres urgently | | |
| 5 | Consider moving patients to wards as soon as appropriate | | |
| 6 | Arrange for further supplies to be delivered if required via Hospital Incident Coordination Centre | | |
| 7 | Liaise with Bronze ED Nurse to ensure transfer and acceptance of casualties from ED. | | |
| 8 | Maintain regular contact with the Hospital Incident Coordination Centre (EX 2999) at 30-minute intervals or sooner as the situation changes. Provide information on patients received in to theatres and to plan further operating lists. | | |
| 9 | Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 10 | Plan for the possibility of receiving multiple casualties in to theatres and the use of the Post Anaesthetic Recover Unit as ICU or resuscitation areas. | | |
| 11 | Ensure that a “hot debrief” is facilitated in the department after any shift changes, and immediately after the Incident | | |
| 12 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 13 | Attend the cold / structured debrief held after the Incident | | |

**Intentionally Blank**

# Action Card 25 – Bronze Relatives

| | | |
|---|---|---|
| **Job Title** | Member of Patient Experience Team | **25** |
| **Incident Role** | Bronze Relatives | |

**Role Description**

The Bronze Relative liaison is allocated by the Silver Manager to manage relatives and friends arriving at the hospital.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to the Hospital Coordination Centre for initial briefing from Silver Manager | | |
| 2 | Collect Bronze Relatives Pack and clipboard from Silver Manager | | |
| 3 | Maintain a log of all information – keep all notes to hand in at the end of the Incident or when relieved of post. | | |
| 4 | Go to the Main Restaurant (request Facilities On-Call Manager or Portering Supervisor to open doors if out of hours). Ensure that large signs are in place to direct relatives and friends to holding areas. | | |
| 5 | Advise the security team that you are ready to receive relatives/friends in the holding area. | | |
| 6 | As relatives and friends arrive record their details (name, contact number, and details of their friend/relative). | | |
| 7 | Arrange for a private area to be made available for distressed relatives/friends. | | |
| 8 | Keep relatives and friends informed of the situation. | | |
| 9 | Liaise with the Hospital Incident Coordination Centre at all times and follow instructions. | | |
| 10 | Relatives/friends may see the casualty only when informed by the Silver Manager | | |
| 11 | Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 12 | Be aware of press/media posing as relatives. Direct all such persons to the Press area in Pardon Hall | | |
| 13 | Complete a hand over briefing when relived of post. Attend the ‘hot’ debrief session held in the Hospital Coordination Centre. | | |
| 14 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 15 | Attend ‘cold’ debrief session. | | |

**Intentionally Blank**

# Action Card 26 – Bronze Staff Coordinator

| | | |
|---|---|---|
| **Job Title** | Any suitable staff member identified by Silver Manager | **26** |
| **Incident Role** | Bronze Staff Coordinator | |

**Role Description**

The Bronze Staff Coordinator logs in/out all staff and volunteers that report to the Physio Gym. The Staff Coordinator is to direct staff/volunteers to appropriate roles under the guidance of the HICC Senior Nurse or Tactical (Silver) Commander. The Staff Coordinator reports to the Silver Manager

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to the Hospital Incident Coordination Centre for initial briefing from the Silver Manager | | |
| 2 | Collect hand held radio, action cards and clipboard from Hospitals Incident Coordination Centre. | | |
| 3 | Maintain a log of all decisions made – keep all notes to hand in at end of Incident or when relived of post. | | |
| 4 | Go the Physio Gym, Cardiac Corridor, Ground Floor, PAH | | |
| 5 | Ensure that large signs are in place to direct staff to the holding area | | |
| 6 | As staff arrive record their details (name role department) and give them an ID label if they do not have their staff ID badge. | | |
| 7 | If staff have action cards for their role give them their action cards and if they leave log them out of the area | | |
| 8 | All other staff are to remain with you until you are advised by the Hospital Incident Coordination Centre to send them to another location (or to go home and return to relieve current shift) | | |
| 9 | Liaise with the Hospital Incident Coordination Centre at all times and follow instructions | | |
| 10 | Where required, undertake coordination of calling in of additional staff, using cascade sheets available on wards and in departments | | |
| 11 | Complete a handover briefing when relived of post | | |
| 12 | Attend the 'hot' debrief session held in the Hospital Incident Coordination Centre | | |
| 13 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 14 | Attend 'cold' debrief session | | |

**Intentionally Blank**

# Action Card 27 – Bronze Medical Doctor

| | | |
|---|---|---|
| **Job Title** | Physician of the day (Registrar in their absence) | **27** |
| **Incident Role** | Bronze Medical Doctor | |

**Role Description**

To provide medical leadership to the HICC and rapid progression of patient through EAU to either admission or discharge. The Physician of the day reports to the Silver Doctor.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Attend the Hospital Incident Coordination Centre to receive first briefing from Tactical (Silver) Commander.<br>• **Objective 1:** Rapid progression of patients through EAU to either admission or discharge<br>• **Objective 2:** Lead the medical team to review and discharge patients to increase the number of beds available in areas outside of EAU<br>**EAU is the designated receiving ward and should be cleared as soon as possible, ensure that all alternative pathways are considered** | | |
| 2 | Review the current resources available in EAU. Liaise with Hospital Incident Coordination Centre (ext 2999) to provide an overview of beds available | | |
| 3 | Aim for rapid discharge from EAU or admission in conjunction with the Bronze EAU Nurse | | |
| 4 | Liaise with Consultant Physician colleagues to ensure as many patients as possible are identified for discharge. Where necessary go to wards and sanction discharges. | | |
| 5 | Review and as needed adjust staffing for the next 48 hours. Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 6 | Maintain regular contact with Silver Doctor and rapidly escalate any queries or concerns | | |
| 7 | Ensure that a "hot debrief" is facilitated in the department after any shift changes, and immediately after the Incident | | |
| 8 | Compile a report of your involvement in the Incident and forward to the Emergency Planning and Resilience Team along with your Incident log and associated documents | | |
| 9 | Attend 'cold' debrief session held after the Incident. | | |

**Intentionally Blank**

# Action Card 28 – Bronze Pharmacist

| | | |
|---|---|---|
| **Job Title** | Chief Pharmacist / On Call Pharmacist | **28** |
| **Incident Role** | Bronze Pharmacist | |

**Role Description**

To manage the Pharmacy Department during a Major Incident, to provide a pharmacy service to the hospital and Incident (as require). The Bronze Pharmacist reports to Silver Doctor.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to Hospital Incident Coordination Centre for initial briefing from Silver Manager | | |
| 2 | **Normal Working Hours** – Assess current department activity and staffing levels. | | |
| 3 | **Out of Hours** – Go to the Department, deactivate security alarms, and prepare for use if required. Inform Hospital Incident Coordination Centre when Pharmacy Department is ready to dispense to patients being discharged | | |
| 4 | Arrange the following:<br>• Top Up / Provide additional TTA's for A&E and EAU<br>• Top Up ED with IV Fluids and other drugs as needed<br>• Top UP Controlled Drugs in Resus<br>• Top UP Theatres as required | | |
| 5 | Review and as needed adjust staffing for the next 48 hours. Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 6 | Liaise with the Clinical Site Manager/Manager and Senior Nurse to ensure that medicines are dispensed quickly and appropriately for patients who are being discharged from wards | | |
| 7 | Review staffing levels for the next 24/48 hours to ensure the department is covered | | |
| 8 | Complete hand over brief when relived of post | | |
| 9 | Ensure that a "hot debrief" is facilitated in the department after any shift changes, and immediately after the Incident | | |
| 10 | Attend 'cold' debrief session | | |
| 11 | Following stand down of Incident ensure that all areas in the department are secured before leaving | | |

**Intentionally Blank**

# Action Card 29 – Bronze Estates

| | | |
|---|---|---|
| **Job Title** | Estates | **29** |
| **Incident Role** | Bronze | |

**Role Description**

To call key estates staff and provide estates support as required. The Bronze Estates staff reports to Silver Manager.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to the Hospital Incident Coordination Centre for initial debriefing from Silver Manager | | |
| 2 | Maintain a log of all decisions made – keep all notes to hand in at the end of Incident or when relieved of post | | |
| 3 | Review and as needed adjust staffing for the next 48 hours. Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 4 | Ensure security measures are in place, liaise with the Security Team to resolve any issues | | |
| 5 | Liaise with the Hospital Incident Coordination Centre at all times | | |
| 6 | Liaise with the on-call Facilities Manager providing support if required | | |
| 7 | Assess all areas of the site and identify any weakness paying particular attention to health and safety issues | | |
| 8 | Complete a hand over briefing when relived of post | | |
| 9 | If possible attend 'hot' debrief session held in HICC | | |
| 10 | Attend 'cold' debrief session | | |

**Intentionally Blank**

# Action Card 30 – Bronze Facilities

| | | |
|---|---|---|
| **Job Title** | Facilities | **30** |
| **Incident Role** | Bronze | |

**Role Description**

To call key Facilities staff and provide Facilities support as required. The Bronze Facilities staff reports to Silver Manager.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to the Hospital Incident Coordination Centre for initial debriefing from Silver Manager | | |
| 2 | Maintain a log of all decisions made – keep all notes to hand in at the end of Incident or when relieved of post | | |
| 3 | Follow the Facilities Major Incident cascade protocol to call in key members of staff as required (see reverse for Telephone Cascade guide) | | |
| 4 | Ensure security measures are in place, liaise with the Security Team to resolve any issues | | |
| 5 | Liaise with the Hospital Incident Coordination Centre at all times, unless sent elsewhere by Tactical (Silver) Commander | | |
| 6 | Liaise with the on-call Estates Manager providing support if required | | |
| 7 | Assess all ward supply areas and identify any low stock that may be required (blankets, sheets, pillows etc). | | |
| 8 | Complete a hand over briefing when relived of post | | |
| 9 | If possible attend 'hot' debrief session held in HICC | | |
| 10 | Attend 'cold' debrief session | | |

**Intentionally Blank**

# Action Card 31 – CSSD Lead

| | | |
|---|---|---|
| **Job Title** | CSSD Lead | **31** |
| **Incident Role** | Bronze CSSD | |

**Role Description**

To manage CSSD during a Major Incident and to provide a CSSD service to the Hospital and Incident (as required).

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to the Hospital Incident Coordination Centre for initial debriefing from Silver Manager | | |
| 2 | **Normal Working Hours** – Assess current department activity and staffing levels with shift supervisors.<br><br>**Out of Hours** – Go to department, deactivate security alarms and prepare for use if required. Inform Hospital Incident Coordination Centre when CSSD is ready to support Theatres and Emergency Department. | | |
| 3 | Follow the CSSD telephone cascade process to call in staff as required (see reverse for Telephone Cascade guide) | | |
| 4 | Report any staffing shortfall to the Hospital Incident Coordination Centre | | |
| 5 | Liaise with Silver Manager to ensure appropriate supplies are available | | |
| 6 | Review staffing levels for the next 24/48 hours to ensure the department is covered. | | |
| 7 | Complete hand over briefing when relived of post | | |
| 8 | Attend 'hot' debrief session held in HICC | | |
| 9 | Attend 'cold' debrief session | | |
| 10 | Following stand down of Incident ensure that all areas in that department are secured before leaving | | |

**Intentionally Blank**

# Action Card 32 – Mortuary Lead

| Job Title | Mortuary Lead | 32 |
|---|---|---|
| Incident Role | On-Call Mortuary Technician | |

**Role Description**

To manage the Mortuary Department during a Major Incident and to maintain mortuary services during the Incident. The Mortuary Lead reports to the Silver Manager

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to the Hospital Incident Coordination Centre for initial debriefing from Silver Manager | | |
| 2 | Inform the Consultant Histopathologist | | |
| 3 | Follow the Mortuary Department telephone cascade process to call in staff as required (see reverse for Telephone Cascade guide) | | |
| 4 | Report any staffing shortfall to the Hospital Incident Coordination Centre (ext 2999) | | |
| 5 | Ensure body bags are available for use as requested | | |
| 6 | Ensure that mortuary space and facilities is adequate (if more storage is required contact approved provider) | | |
| 7 | Liaise with the Coroners Office with regard to management of bodies/post mortem investigation | | |
| 8 | Review and as needed adjust staffing for the next 48 hours. Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 9 | Attend 'hot' debrief session held in HICC | | |
| 10 | Attend 'cold' debrief session | | |
| 11 | Following stand down of Incident ensure that all areas in that department are secured before leaving | | |

**Intentionally Blank**

# Action Card 33 – Bronze Radiographer

| | | |
|---|---|---|
| **Job Title** | Radiographer | **33** |
| **Incident Role** | Radiographer | |

**Role Description**

The Bronze radiologist role will manage the X-ray Department during a Major Incident and reports to the Silver Manager. The role is to provide a diagnostic imaging service to the Incident.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to the Emergency Department and receive briefing from the Bronze ED Nurse | | |
| 2 | **Normal Working Hours** – Assess current patient activity and staffing levels within the X-ray department with the On Call Consultant Radiologist. Based on situational awareness consider the cancellations of elective work and / or redeployment of staff in conjunction with the Hospital Incident Coordination Centre. | | |
| 3 | **Out of Hours** – Go to the department, deactivate security alarms and prepare for use if required. Inform Bronze ED Lead Nurse when X-ray Department and CT Scanner are operational. Confirm on-call radiologist is on route to the department. | | |
| 4 | Review and as needed adjust staffing for the next 48 hours. Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 5 | Complete hand over brief when relived of post | | |
| 6 | If possible attend a 'hot' debrief session held in HICC | | |
| 7 | Attend 'cold' debrief session | | |
| 8 | Following stand down of Incident ensure that all areas in the department are secured before leaving | | |

**Intentionally Blank**

# Action Card 34 – Security

| | | |
|---|---|---|
| **Job Title** | Security | **34** |
| **Incident Role** | Security | |

**Role Description**

The Bronze Security role reports to the Silver Manager and must manage the Security of the site during a Major Incident. The Bronze security must also ensure the security of the Emergency Department during a Major Incident.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to the Hospital Incident Coordination Centre for initial briefing from the Silver Manager | | |
| 2 | Base yourself in the Security Office | | |
| 3 | **If requested to do so:** Commence a lockdown of the hospital site | | |
| 4 | Review and as needed adjust staffing for the next 48 hours. Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 5 | Work closely with the Silver Manager with regards managing security arrangements for casualties relatives/friends. | | |
| 6 | Liaise with the Silver Manager over access for media/press to Press Area and any expected VIP visits. | | |
| 7 | Instigate one way traffic flow through site. | | |
| 8 | Maintain security across the hospital site | | |
| 9 | Complete a handover briefing when relieved of your post. | | |
| 10 | If possible attend a 'hot' debrief session held in HICC | | |
| 11 | Attend 'cold' debrief session | | |
| 12 | Following stand down of Incident ensure that all areas are secured | | |

**Intentionally Blank**

# Action Card 35 – Hospital Chaplain

| | | |
|---|---|---|
| **Job Title** | Chaplain | **35** |
| **Incident Role** | Chaplain | |

**Role Description**

The Hospital Chaplin provides access for casualties, relatives and friends to religious and emotional support as requested. The Hospital Chaplain reports to the Silver Manager.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to the Hospital Incident Coordination Centre for initial briefing from Silver Manager | | |
| 2 | Contact other local religious leaders and update them on the situation | | |
| 3 | Go to the Main Restaurant and liaise with Bronze Relatives Coordinator. | | |
| 4 | Go to Emergency Department and offer your services/support to any casualties, relatives and staff as necessary. | | |
| 5 | Keep a record of all casualties, relatives and staff advised. | | |
| 6 | Arrange a private area to be made from available for distressed relatives/friends with the Bronze Relatives Coordinator. | | |
| 7 | Liaise with the Hospital Incident Coordination Centre at all times and follow instructions. | | |
| 8 | Be aware of media/press posing as relatives. Direct all such persons to the press area in Pardon Hall. | | |
| 9 | Attend debriefing sessions in the Emergency Department to provide support to staff as necessary. | | |
| 10 | If possible attend a 'hot' debrief session held in HICC | | |
| 11 | Attend 'cold' debrief session | | |

**Intentionally Blank**

# Action Card 36 – Communications Lead

| | | |
|---|---|---|
| **Job Title** | Head of Communications | **36** |
| **Incident Role** | Communications Lead | |

**Role Description**

The Communications Lead reports to Gold Commander and must manage all media liaison. The Communications Lead must release information to the press according to Trust policy.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to the Hospital Incident Coordination Centre for initial briefing from the Silver Manager | | |
| 2 | With the Gold Commander, agree the first and subsequent press releases regarding the incident. Locate key staff to represent the Trust during briefings.<br><br>Press briefing: to be held on the hour or two hours depending on resources/capacity.<br><br>Staff briefing: internal briefings for staff at half past the hour/every two hours depending on resources/capacity. | | |
| 3 | Liaise with Bronze Press to manage press/media arriving on site | | |
| 4 | Liaise with Head of Security to ensure members of the press/media do not access controlled areas | | |
| 5 | As required liaise with Communications Teams at:<br>• Department of Health<br>• NHS England<br>• Trust Development Authority<br>• Clinical Commissioning Groups | | |
| 6 | Co-ordinate any VIP visits to site. | | |
| 7 | Ensure any press releases are signed off by the Gold Commander | | |
| 8 | If possible attend a 'hot' debrief session held in HICC | | |
| 9 | Attend 'cold' debrief session | | |

**Intentionally Blank**

# Action Card 37 – Bronze Press

| | | |
|---|---|---|
| **Job Title** | Communications Manager | **37** |
| **Incident Role** | Bronze Press | |

**Role Description**

The Bronze Press role reports to the Communications Lead to manage the Hospital Media Centre and to release information to the press following instructions from the Communications Lead.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to the Hospital Incident Coordination Centre for initial briefing from Silver Manager | | |
| 2 | Liaise with Communications Lead to manage press/media arriving on the site. | | |
| 3 | Go to the Hospital Media Centre and ensure that signs to direct the media/press are in place (contact Hospital Incident Coordination Centre for help if required). | | |
| 4 | Liaise with the Hospital Incident Coordination Centre to ensure members of the press/media do not access controlled areas. | | |
| 5 | Liaise with Communications Lead at all times. | | |
| 6 | Assist in the coordination of any VIP visits to the site. | | |
| 7 | If possible attend a 'hot' debrief session held in HICC | | |
| 8 | Attend 'cold' debrief session | | |

**Intentionally Blank**

# Action Card 38 – On-Call Haematology

| | | |
|---|---|---|
| **Job Title** | Transfusion Laboratory Manager / On Call Haematology | **38** |
| **Incident Role** | Transfusion Laboratory Manager / On Call Haematology | |

**Role Description**

To manage the Blood Transfusion Department during a major incident, to provide blood products to the hospital and incident (as require). The Bronze Transfusion BMS reports to Silver Doctor.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Report to Hospital Control Room for initial briefing from Silver Manager | | |
| 2 | **Normal Working Hours** – Assess current department activity and staffing levels. | | |
| 3 | **Out of Hours** – Contact Transfusion Laboratory Manager or deputy, and prepare for use if required. | | |
| 4 | Arrange the following:<br>• Contact National Blood Service and inform of incident<br>• Top Up blood products if required<br>• Top UP emergency O negative units if required<br>• Contact Transfusion Practitioner<br>• Contact department leads | | |
| 5 | Review and as needed adjust staffing for the next 48 hours. Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 6 | Review staffing levels for the next 24/48 hours to ensure the department is covered | | |
| 7 | Complete hand over brief when relived of post | | |
| 8 | Ensure that a “hot debrief” is facilitated in the department after any shift changes, and immediately after the incident | | |
| 9 | Attend ‘cold’ debrief session | | |
| 10 | Following stand down of incident ensure that all areas in the department are secured before leaving | | |

**Intentionally Blank**

# Action Card 39 – Runner

| Job Title | Allocated Staff Member/s | 39 |
|---|---|---|
| Incident Role | Runner | |

| Role Description |
|---|
| To relay information between the Hospital Incident Control and all areas within the Hospital site. |

| Major Incident Declared | | | |
|---|---|---|---|
| **Task** | **Description** | **✓** | **Time** |
| 1 | Report to the Hospital Incident Coordination Centre for initial briefing from Silver Manager | | |
| 2 | Write down all messages including:<br>• Time<br>• Who from<br>• Who for<br>• Time delivered<br>• Any response | | |
| 3 | Deliver messages from point to point in a quick and effective manner | | |
| 4 | Do not get side-tracked into other issues or tasks – direct all queries to the Hospital Incident Coordination Centre. | | |
| 5 | Keep all messages – do not throw any away and hand in to the Hospital Incident Coordination Centre once the Incident has stood down or when you are relived of your role. | | |
| 6 | Carry out handover briefing when relieved of post. | | |
| 7 | If possible attend a 'hot' debrief session held in HICC | | |
| 8 | Attend 'cold' debrief session | | |

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# Action Card 40 – Ward / Dept Manager

| | | |
|---|---|---|
| **Job Title** | Ward / Department Manager / Person in Charge | **40** |
| **Incident Role** | Ward / Department Manager / Person in Charge | |

**Role Description**

To manage the ward / department during a Major Incident.

**Major Incident Declared**

| Task | Description | ✓ | Time |
|---|---|---|---|
| 1 | Await a briefing from the Hospital Incident Coordination Centre via a runner or senior staff member | | |
| 2 | **DO NOT CONTACT SWITCHBOARD OR USE BLEEP SYSTEM UNLESS URGENT** | | |
| 3 | Assess the ward / department and maintain an overview of the in terms of:<br>• Staffing<br>• Capacity<br>• Patient Activity<br>• Resource Requirements<br>• Mutual aid requirements<br>And feed back to the hospital Incident coordination centre any requirements | | |
| 4 | **WARDS**<br>• Review patients and arrange discharge where possible<br>• Prepare to receive patients | | |
| 5 | **CLINICAL DEPARTMENTS**<br>• Review staffing, and consider who could assists wards or departments<br>• Review patients currently in department and those expected<br>• Review what non-essential work can cease | | |
| 6 | **NON-CLINICAL DEPARTMENTS**<br>• Review what non-essential work can cease<br>• Consider how staff can work differently to support the Incident | | |
| 7 | Review and as needed adjust staffing for the next 48 hours. Report any staffing shortfall to the Silver Manager in the Hospital Incident Coordination Centre. | | |
| 8 | Complete hand over brief when relived of post | | |
| 9 | If possible attend a 'hot' debrief session held in HICC | | |
| 10 | Attend 'cold' debrief session | | |

**Intentionally Blank**

**Trust Board – 04.06.20**

3.1

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Agenda item:** | 3.1 | | | | | | | |
| **Presented by:** | Sharon McNally – Director of Nursing & Midwifery | | | | | | | |
| **Prepared by:** | Sarah Webb – Deputy Director of Nursing and Midwifery | | | | | | | |
| **Date prepared:** | May 2020 | | | | | | | |
| **Subject / title:** | Abridged Report on Nursing and Midwifery and Care Staff Levels (Hard Truths) and an Update to Nursing and Midwifery Workforce Position | | | | | | | |
| **Purpose:** | Approval | | Decision | | Information | x | Assurance | x |
| **Key issues:** | This paper sets out an abridged version of the regular nursing and midwifery retrospective staffing report for the month of April 2020 and provides an update to the workforce position (part B).<br><br>The fill rate for overall RN/RM in month has increased to 99.7% which is an increase of 9.5%. Fill rates have been affected by the continued reconfiguration of the Trusts bed base in relation to Covid.<br><br>The overall nursing vacancy position remained stable in April at 8% and the Band 5 rate to 4.3% as due to Covid 19 any significant recruitment activity is on hold and staff are choosing not to leave or transfer employment at this time. Revised recruitment and retention trajectory is being developed based on the changed landscape of international travel. | | | | | | | |
| **Recommendation:** | The Board is asked to note the information within this report | | | | | | | |

| **Trust strategic objectives:** please indicate which of the five Ps is relevant to the subject of the report | Patients | People | Performance | Places | Pounds |
|---|---|---|---|---|---|
| | x | x | x | | x |

| | |
|---|---|
| **Previously considered by:** | QSC.22.05.20<br>WFC.01.06.20 |
| **Risk / links with the BAF:** | BAF: 2.1 Workforce capacity<br>All Health Groups have both recruitment and retention on their risk registers |
| **Legislation, regulatory, equality, diversity and dignity implications:** | NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data.<br>NHS Improvement letter: 22.4.16<br>NHS Improvement letter re CHPPD: 29/6/18 |
| **Appendices:** | Appendix 1: Ward level fill rates<br>Appendix 2: Registered fill rates by month. RAG rated<br>Appendix 3: Ward staffing exception reports |

## 1.0 PURPOSE

To update and inform the Committee on actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff in April 2020. To provide an update on plans to reduce the nursing vacancy rate over 2019/20.

## 2.0 BACKGROUND

The report is collated in line with The National Quality Board recommendations (June, 2016).

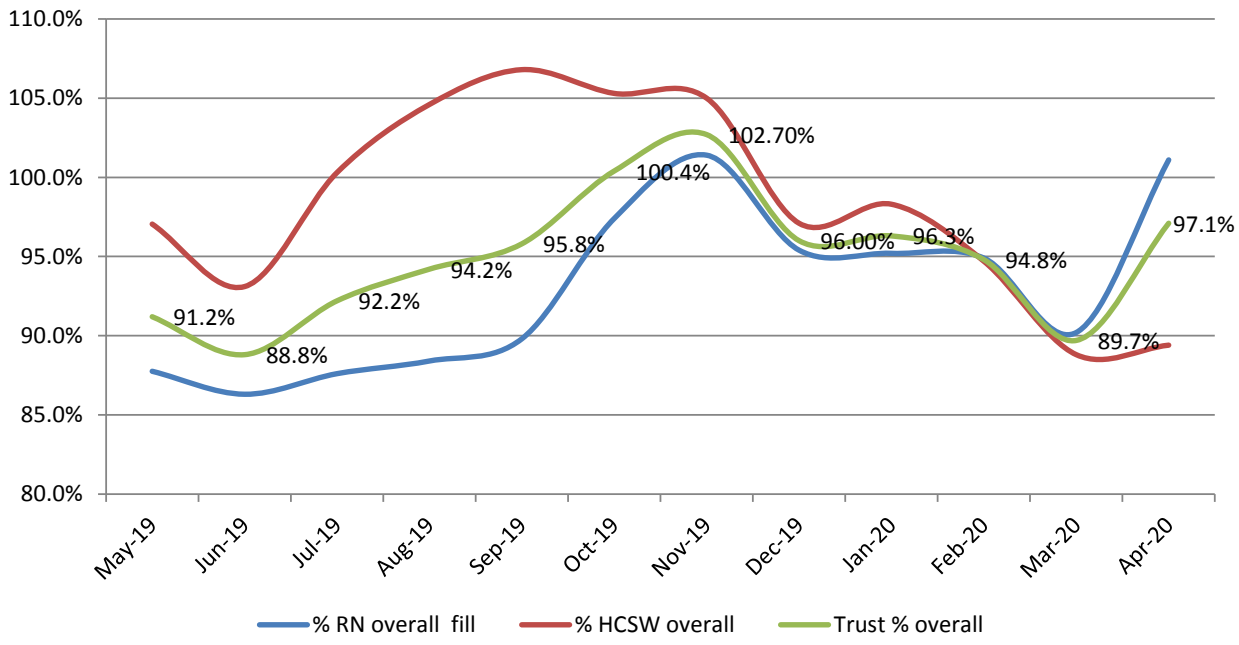
## 3.0 ANALYSIS

3.1 This report provides an analysis based on the actual coverage in hours against the agreed static demand templates for the calendar month of April 2020.

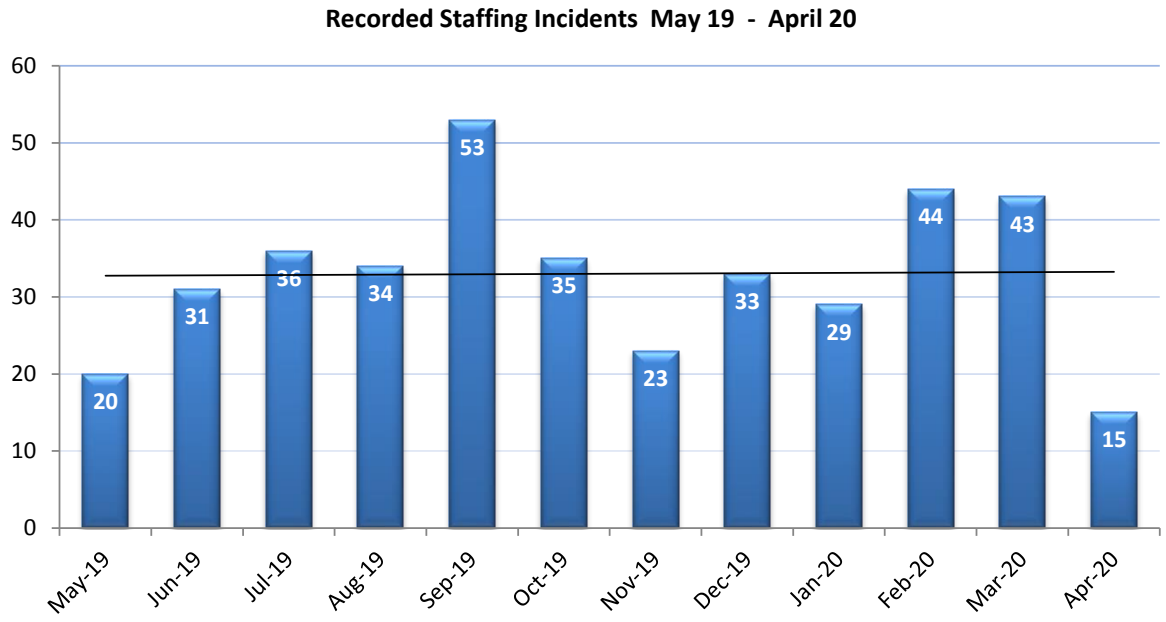
3.2 The summary position for the Trust Safer Staffing Fill rates for April 2020. The fill rate for overall RN/RM in month has increased to 101.1% which is an increase of 10.9% against March.

3.3 Fill rates were supported in month by redeployment of nurses from closed inpatient wards and outpatients, redeployment of nurses from non-clinical roles to wards and additional staff such as nurses working at The Rivers hospital and 3rd year students working as HCSW on extended placements. Due to the high volume of individual staff and ward and bed moves and additional staff not all of whom have been captured on Health roster but have been recorded locally manually an accurate breakdown by ward area has not been possible.

| Trust average | Days RM/RN | Days Care staff | Nights RM/RN | Nights care staff | Overall RM/RN | Overall care staff | Overall ALL staff |
|---|---|---|---|---|---|---|---|
| In Patient Ward average April 20 | 107.4% | 101.% | 93.6% | 75.5% | 101.1% | 89.4% | 97.1% |
| ED average April 20 | 91.4% | 81.5% | 89.1% | 68.6% | 90.3% | 7.6% | 85.0% |



3.3 Datix reports: The trend in reports completed in relation to nursing and midwifery staffing is included below and shows a large decrease in April. The impact of significantly improved fill rates across the wards is likely to be the main factor in the reduction in staffing Datix reports, this needs to be monitored going forward. All incidents continue to be reviewed by the safety and quality review process.




3.4 Bank and Agency fill rates:

The use of NHSP continues to support the clinical areas to maximise safer staffing. The Trust has worked with NHSP to increase the availability of resource, and are working in partnership to improve this further. The table below shows that there was a large decrease in registered demand (↓1517 shifts) in April compared to March, While NHSP filled 777 less bank shifts and 231 less agency shifts the overall fill rate remained static at 68.8%. Work continues to reduce the temporary staffing spend.

The HCSW demand shows a corresponding reduction in demand (↓ 830 shifts) and a reduction in overall fill rate reduced by 4.9% against March.

**RN temporary staffing demand and fill rates:** ***(April 2020 data supplied by NHSP 6.5.2020)***

| Last YTD Month & Year | Shifts Requested | NHSP Filled Shifts | % NHSP Shift | Agency Filled Shifts | % Agency Filled Shifts | Overall Fill Rate | Unfilled Shifts | % Unfilled Shifts |
|---|---|---|---|---|---|---|---|---|
| December 19 | 3891 | 1703 | 42.3% | 1020 | 27.9% | 70.2% | 1168 | 29.8% |
| January 20 | 4324 | 1903 | 44.0% | 993 | 23.0% | 67.0% | 1428 | 33.0% |
| February 20 | 4332 | 2276 | 52.5% | 939 | 21.7% | 74.2% | 1,117 | 25.8% |
| March 20 | 5001 | 2461 | 49.32% | 945 | 18.9% | 68.1% | 1,595 | 31.9% |
| April 20 | 3484 | 1684 | 48.3% | 714 | 20.5% | 68.8% | 1086 | 31.2% |
| April 19 | 3949 | 1666 | 42.2% | 1354 | 34.3% | 76.5% | 929 | 23.5% |

**HCA temporary staffing demand and fill rates:** ***(April 2020 data supplied by NHSP 6.5.2020)***

| Last YTD Month & Year | Shifts Requested | NHSP Filled Shifts | % NHSP Shift | Agency Filled Shifts | % Agency Filled Shifts | Overall Fill Rate | Unfilled Shifts | % Unfilled Shifts |
|---|---|---|---|---|---|---|---|---|
| December 19 | 2689 | 1805 | 68.5% | 0 | 0% | 68.5% | 884 | 31.5% |
| January 20 | 2732 | 1855 | 67.9% | 0 | 0% | 67.9% | 877 | 32.1% |
| February 20 | 2773 | 1910 | 68.9% | 0 | 0% | 68.9% | 863 | 31.1% |
| March 20 | 3182 | 2037 | 64.0 % | 0 | 0 % | 64.0 % | 1,145 | 36.0 % |
| April 20 | 2352 | 1391 | 59.1% | 0 | 0% | 59.1% | 961 | 40.9% |
| April 19 | 2156 | 1723 | 79.9% | 0 | 0% | 79.9% | 433 | 20.1% |

**B: Workforce:**

**Nursing Recruitment Pipeline**

The overall nursing vacancy rate in April remained static at 8.4%. International nurse recruitment remains on hold due to Covid 19 travel restrictions but those overseas nurses who joined the Trust in March have been invited to join the temporary NMC nursing register,

Although apprenticeship programmes have been put on hold by University and Colleges we welcomed 6 Degree Nurse Apprenticeships in April. These Apprentice nurses will commence work for the first 6 months of their 4 year training programme as health care support workers and have been deployed to wards across the Trust.

The extended programme for final year nurses and midwives has enabled student nurses and midwives to join the Trust and work in the capacity of students working to the level of HCSW. There are 8 student midwives who have joined the Trust who are due to complete their training in September. It is hoped that these students will take up full time posts at the Trust which will have a significant impact on the maternity vacancy rates.

A revised recruitment and retention programme is being developed for 2020/21 to take into account the impact of Covid 19 restrictions.

## 4.0 RECOMMENDATION

The Board is asked to receive the information describing the position regarding nursing and midwifery recruitment, retention and vacancies and note the plan to review and make further recommendations to improve the trajectory.

**Author:** Sarah Webb, Deputy Director of Nursing and Midwifery

**Date: 14th May 2020**

The Princess Alexandra Hospital NHS Trust

**Trust Board – 04.06.20**

3.2

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Agenda item:** | 3.2 | | | | | | | |
| **Presented by:** | Marcelle Michail –Acting Chief Medical Officer | | | | | | | |
| **Prepared by:** | Nicola Tikasingh – Mortality Matron | | | | | | | |
| **Date prepared:** | 18th May 2020 | | | | | | | |
| **Subject / title:** | Mortality Review Process | | | | | | | |
| **Purpose:** | Approval | | Decision | X | Information | X | Assurance | X |
| **Key issues:** | The purpose of this paper is to provide an update of the mortality review process including implementation of the new Structured Judgement Reviews. | | | | | | | |
| **Recommendation:** | The Board is asked to note the update. | | | | | | | |

| **Trust strategic objectives:** please indicate which of the five Ps is relevant to the subject of the report | Patients | People | Performance | Places | Pounds |
|---|---|---|---|---|---|
| | X | X | X | | |

| | |
|---|---|
| **Previously considered by:** | QSC.22.05.20 |
| **Risk / links with the BAF:** | Quality Improvement has the potential to support the mitigation of a number of risks in the organisation, but to highlight one specifically:<br>1.1 Inconsistent Outcomes |
| **Legislation, regulatory, equality, diversity and dignity implications:** | *'Learning from Deaths'* - National Quality Board, March 2017 |
| **Appendices:** | None |

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The Princess Alexandra Hospital NHS Trust

3.2

## 1.0 Purpose/issue

The purpose of this paper is to provide an update of the mortality review process including implementation of the new Structured Judgement Reviews (SJR).

## 2.0 Background

The PAHT has shown significantly high mortality data. The trust has implemented the Medical Examiner (ME) process; the Structured Judgement Review (SJR) process and appointed a Matron for Quality and Mortality to improve learning from deaths and reduce Hospital Standardised Mortality Ratios (HSMR) data.

**Dr Foster Data:**
(Please note that there is no update to the Dr Foster data this month due to delay in Dr Foster reporting)

Reporting data for January - December 2019 (1 month lag)
**HSMR: 121.8 (Significantly high)**
PAH is 1 of 6 Trusts within the peer group of 15 that sit within the 'higher expected'.

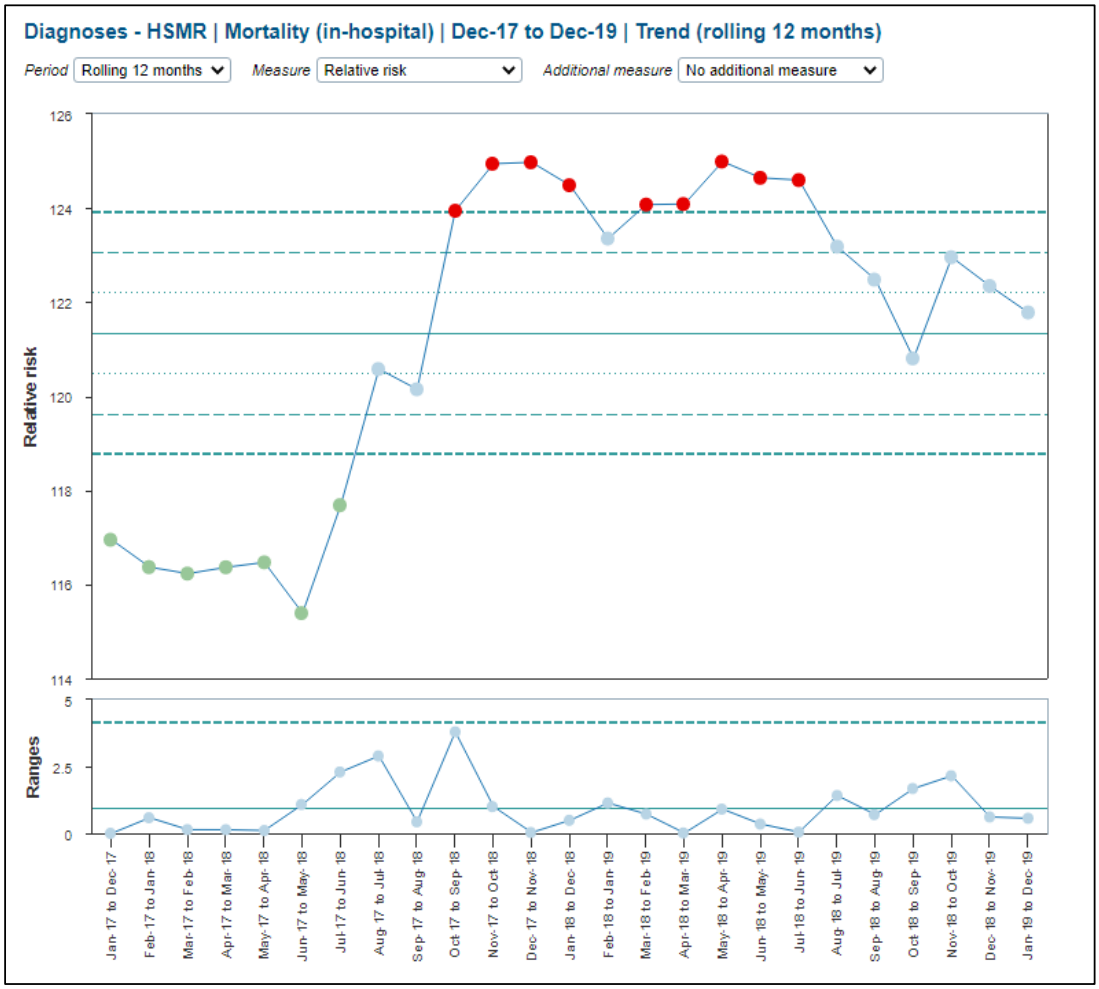
5 outlying groups (Jan – Dec 2019)
- Acute Bronchitis
- Acute and Unspecified Renal Failure
- Pneumonia
- Aspiration pneumonitis

6 outlying groups for October 2019:
- Pneumonia
- Urinary Tract Infections
- Acute and Unspecified Renal Failure
- Aspiration pneumonia food/vomitus
- Cardiac Dysrhythmias
- Septicaemia

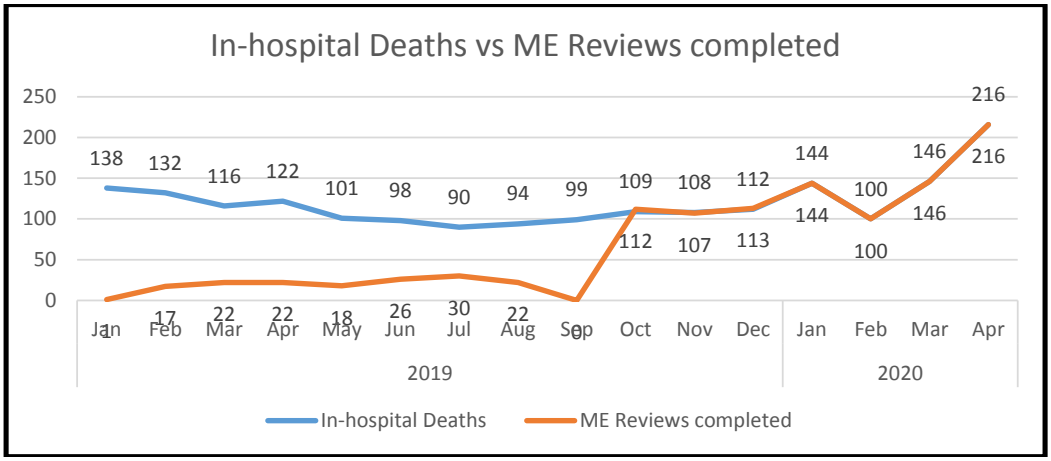
Reporting data for January - December 2019 (1 month lag)
**SHMI: 116.25 (higher than expected)**

There are 6 key outlying groups (significantly higher than expected deaths)
- Oesophageal disorders
- Other injuries and conditions due to external causes
- Acute bronchitis
- Acute and Unspecified Renal Failure
- Pneumonia
- Aspiration pneumonia food/vomitus

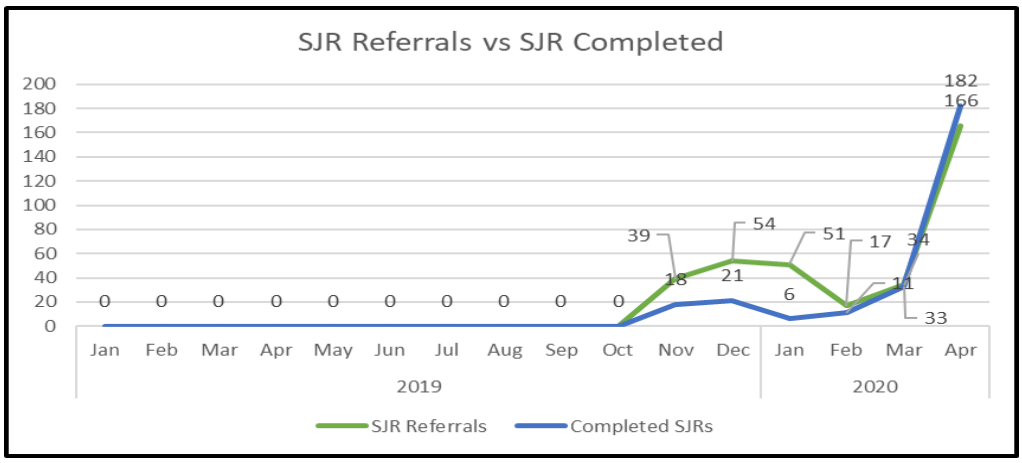
Comorbidity Coding: The Trust retains a high proportion of admitted patient spells with no comorbidity compared to nationally.
Comorbidity profile changes as the LOS increases.
A Quality improvement project is currently underway to improve admission documentation of co-morbidities.

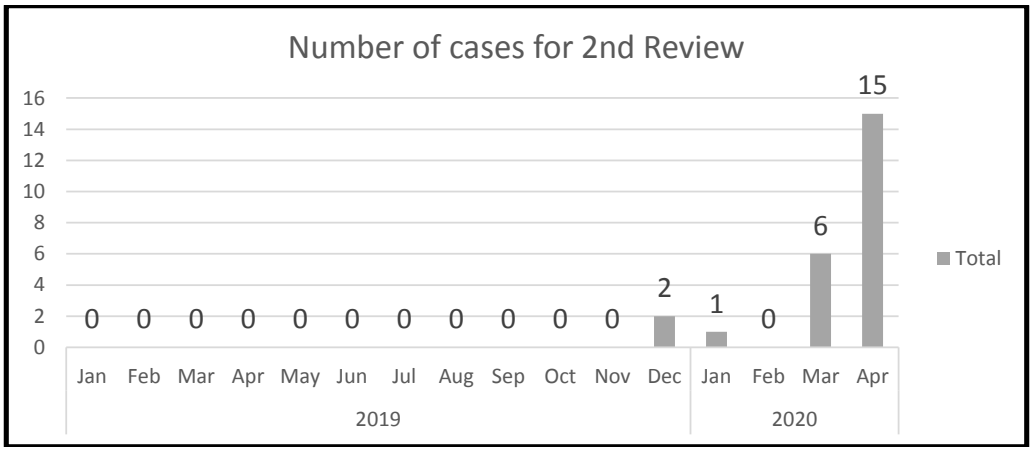



The charts below highlight the total number of in-patient deaths by month verses number of ME reviews. This shows a significant increase of deaths due to the COVID-19 pandemic.




The Structured Judgement Review (SJR) process continues to be implemented across the trust for adult deaths. Data below reflects progress made and referrals to specialities.




Team of SJR champions completing SJR's for all COVID-19 deaths and mandatory cases referred. Daily reports sent to the Matron for Mortality and Quality.

15 cases were referred to the second tier panel – all of these were for suspected hospital acquired COVID-19. No cases received an avoidability score of 1 or 2; no escalation required.

All COVID-19 cases have been referred for a SJR; including the mandatory SJR referrals.

Themes of reviews include:

- Need to improve utilisation of End of life pathways
- Need to improve prescription/ administration of Anticipatory medication
- Need to ensure appropriate admissions from care homes
- Need to understand reasons behind high morbidity/ mortality within 2-24 hours of admission.
- Good completion of DNA CPR and TEP forms in ED
- Families and NOK kept up to date with care and treatment plan
- Need to improve timeliness of referrals to specialist teams
- Need to minimise/ understand the rationale for multiple bed and ward moves
- Need to minimise readmission rates
- Need to improve record keeping including: risk assessments and fluid management

## 3.0 Successes

SJR champion team undertaking reviews daily and within 72 hours of patient's deaths. Weekly report:

Weekly mortality review meetings in place to enable quick learning and feedback to teams. Clarity forms – ME and SJR form updated and live.

All ITU deaths reviewed with the following themes:

- Quick referrals to ITU
- Good daily plans documented by clinical teams
- Patients admitted with multiple comorbidities
- 1 case escalated as a Serious Incident due to mismanagement of Diabetes – The management of Diabetic Ketoacidosis (DKA) has been reviewed with clear contingency management in place for situations where a pump may not be available
- 2 cases referred for a second review due to delays in referral to ITU – these have been logged as incidents and have been referred to the Serious Incident Group (SIG)

## 4.0 Work in Progress

- All patients referred to other tertiary centres to have a SJR completed.
- Mortality and Morbidity documentation to be revised and standardised across the trust.
- Long term review of Office space required to undertake the mortality process has been delayed due to current pandemic.
- Clinical coding review to assess impact on data collection.
- Work within the Quality First Team to review, identify and implement mortality improvement work.
- Development of process for all departments to ensure that learning from deaths in being undertaken and sharing is filtered to all clinical staff.
- Terms of Reference reviewed for the Operational and Strategic Mortality Review Group. Operational group to be held fortnightly (until learning from deaths is embedded) and Strategic group monthly.

## 5.0 Recommendation

The Board is asked to note the update and the following work in progress:

- Mortality dashboard continues to be developed
- Continue to collate themes from SJR's to assist with clinical improvements
- M&M documentation and process to be reviewed with the M&M speciality leads.
- Mortality improvement work to be linked with learning from deaths
- Clear and standardised process in place for local learning from deaths

**Author:** Nicola Tikasingh, Matron for Quality and Mortality
**Date:** 18th May 2020

NHS
The Princess Alexandra Hospital
NHS Trust

# Integrated Performance Report
# April 2020

The purpose of this report is to provide the Board of Directors with an analysis of quality performance.
The report covers performance against national and local key performance indicators.

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**Contact:**

Lance McCarthy, Chief Executive Officer
Andy Morris, Chief Medical Officer
Sharon McNally, Director of Nursing
Trevor Smith, Deputy CEO & Chief Financial Officer
Stephanie Lawton, Chief Operating Officer
Jim McLeish, Director of Quality Improvement
Ogechi Emeadi, Director of People
Michael Meredith, Director of Strategy

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# Trust Objectives

The Princess Alexandra Hospital NHS Trust

**Our Patients**
Continue to improve the quality of care we provide **our patients**, improving our CQC rating.

**Our People**
Support **our people** to deliver high quality care within a culture that improves engagement, recruitment and retention and improvements in our staff survey results.

**Our Places**
Maintain the safety of and improve the quality and look of **our places** and work with our partners to develop an OBC for a new build, aligned with the development of our local Integrated Care Alliance.

**Our Performance**
Meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators.

**Our Pounds**
Manage **our pounds** effectively to achieve our agreed financial control total for 2019/20.

# 5Ps

## In this month

NHS
The Princess Alexandra Hospital
NHS Trust

### Patients




### Performance




### People



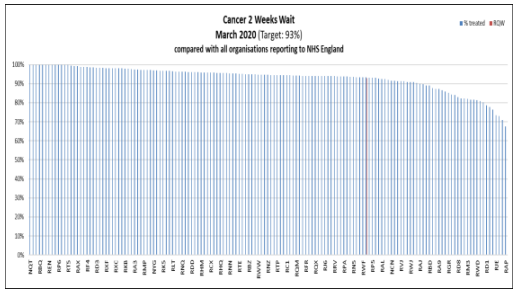

### Pounds

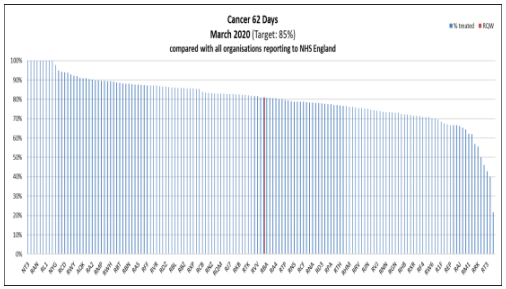


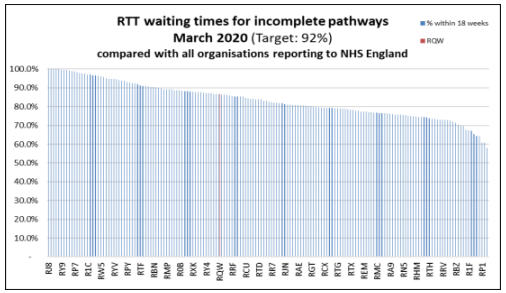

### Places

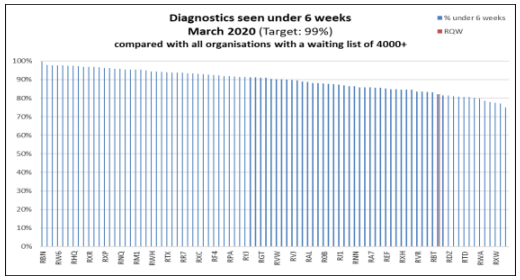
## National Benchmarking
Compared with all organisations reporting to NHS England

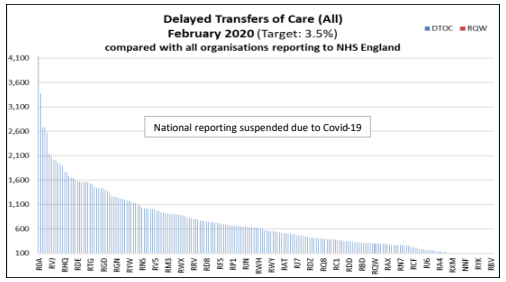
The Princess Alexandra Hospital NHS Trust

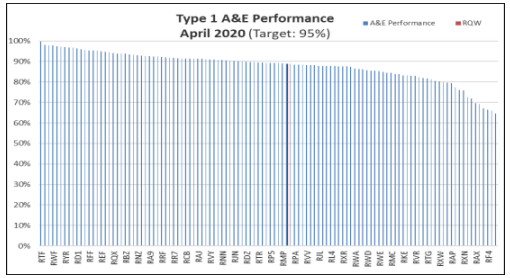


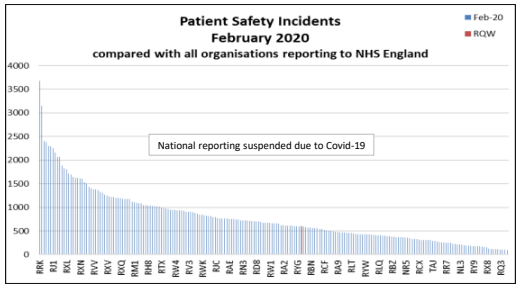



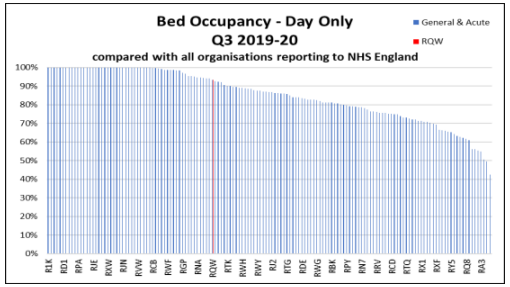



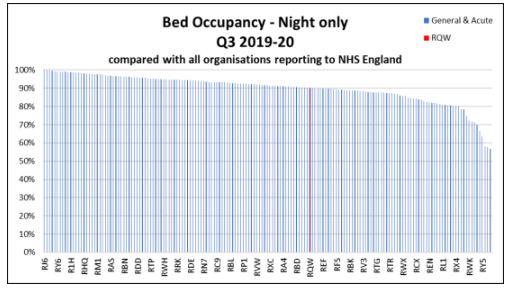

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Data Source: NHS England Statistics/Public Health England/Dr Foster

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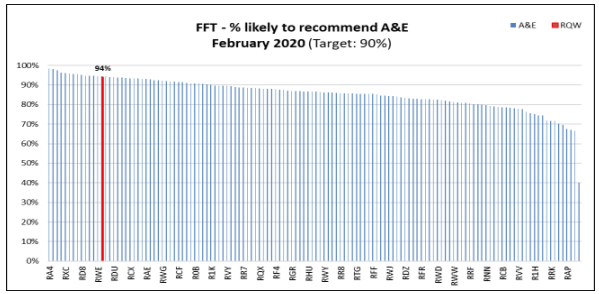
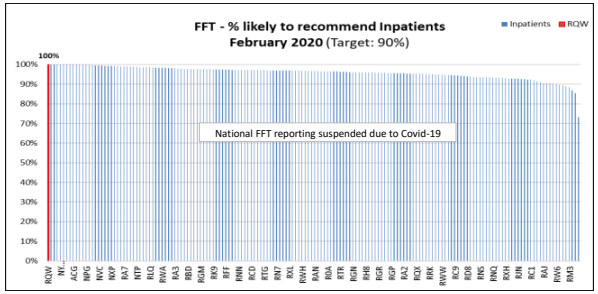
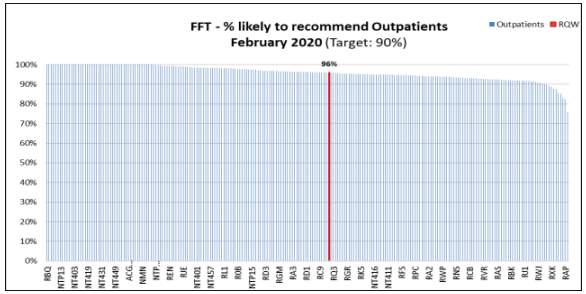
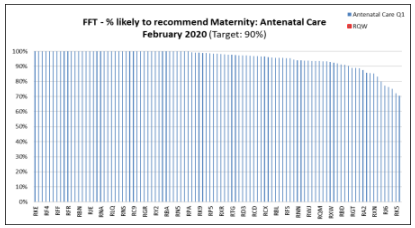
## National Benchmarking
Compared with all organisations reporting to NHS England

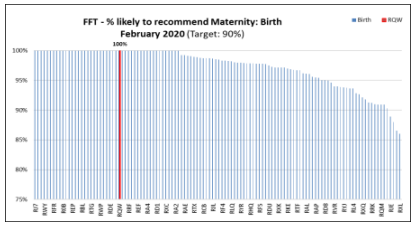
NHS
The Princess Alexandra Hospital
NHS Trust

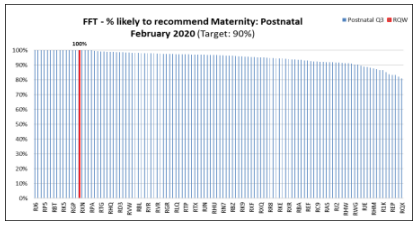


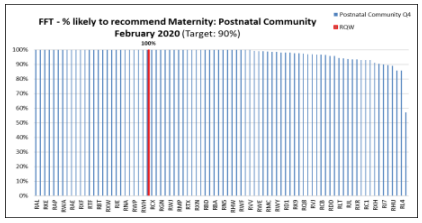



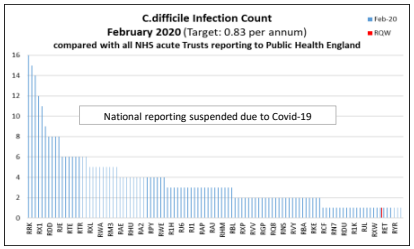



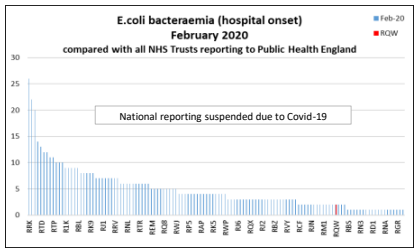



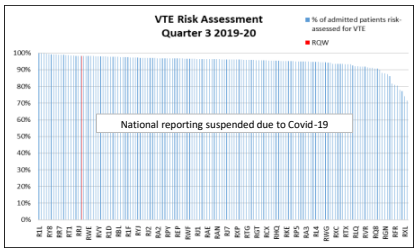



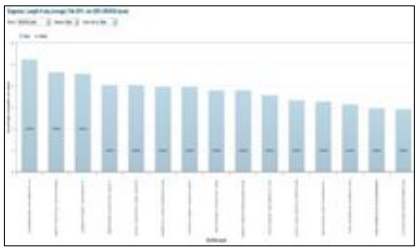



Your future | Our hospital

Data Source: NHS England Statistics/Public Health England/Dr Foster

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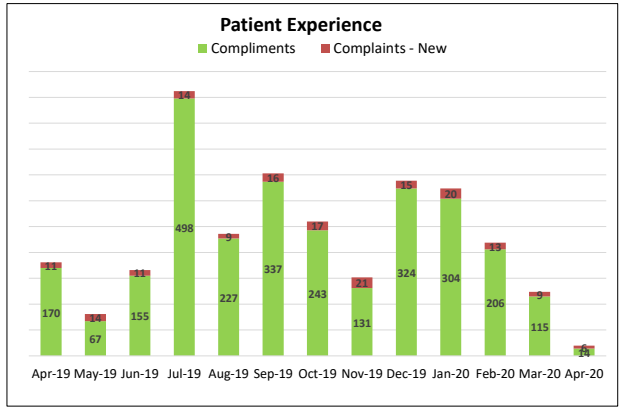
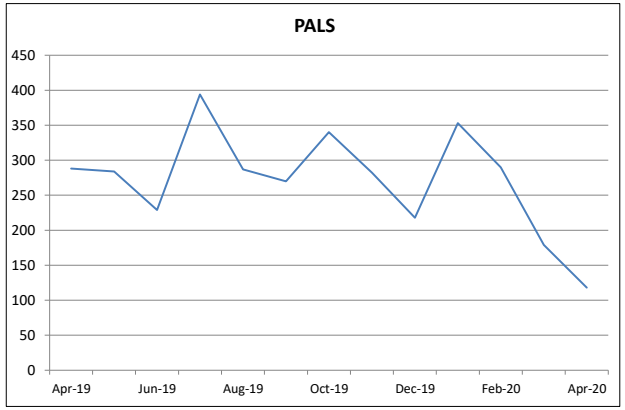
# Patient Experience

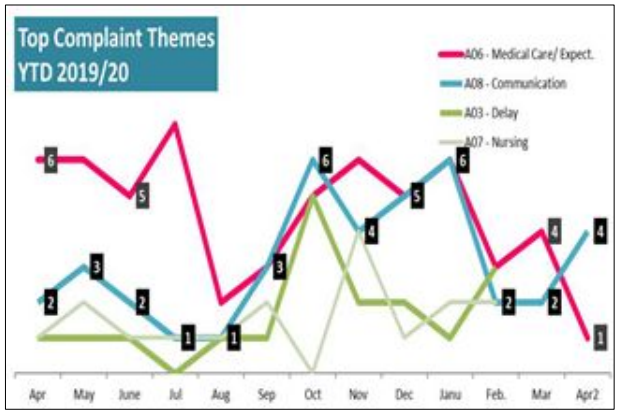
## 1 Our Patients Summary 1.1 Patient Experience

NHS The Princess Alexandra Hospital NHS Trust

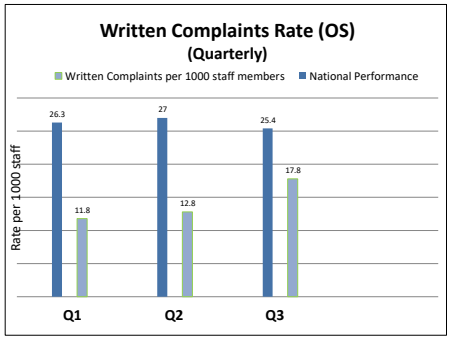



| PALS converted to Complaints | |
|---|---|
| Apr-19 | 1 |
| May-19 | 2 |
| Jun-19 | 2 |
| Jul-19 | 1 |
| Aug-19 | 1 |
| Sep-19 | 4 |
| Oct-19 | 2 |
| Nov-19 | 3 |
| Dec-19 | 4 |
| Jan-20 | 6 |
| Feb-20 | 3 |
| Mar-20 | 1 |
| Apr-20 | 0 |

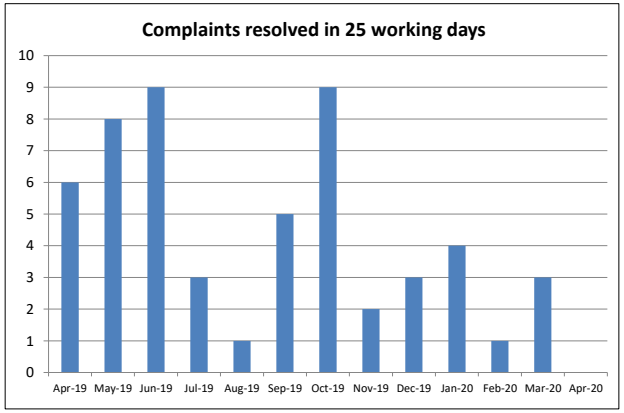


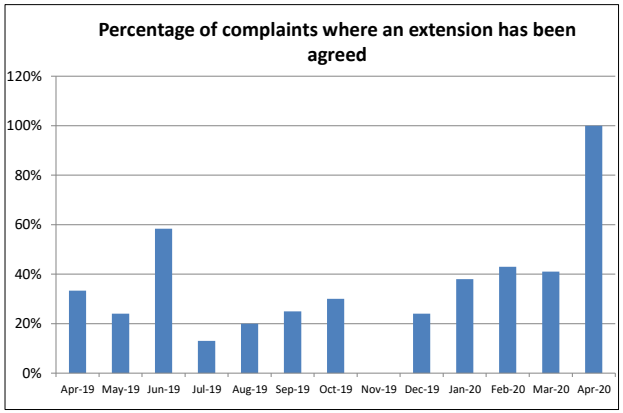


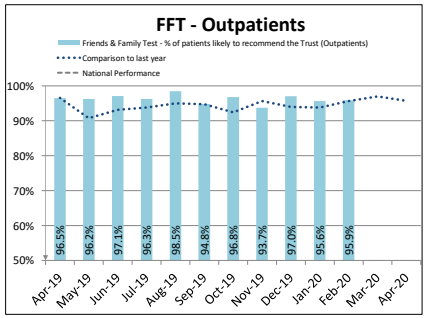


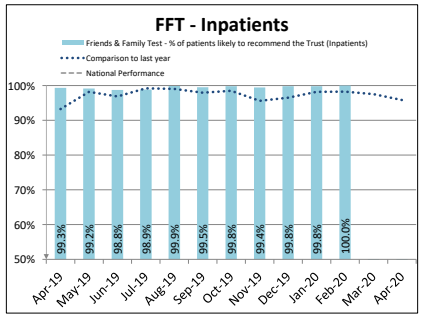

**National collection suspended due to Covid-19**

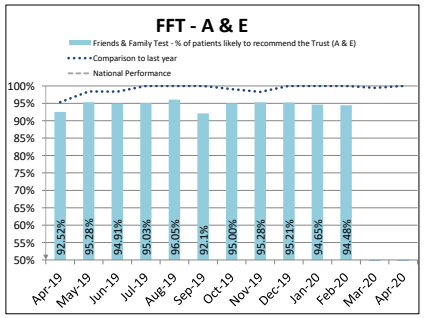
# Patient Experience

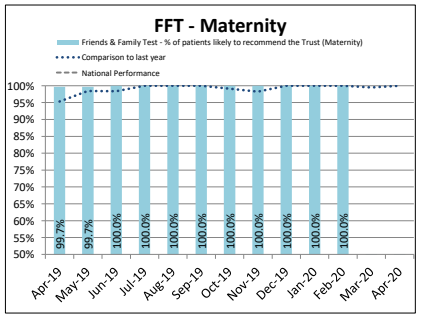



**FFT national collection suspended due to Covid-19**

# Patient Safety

## 1 Our Patients Summary 1.3 Patient Safety

NHS The Princess Alexandra Hospital NHS Trust

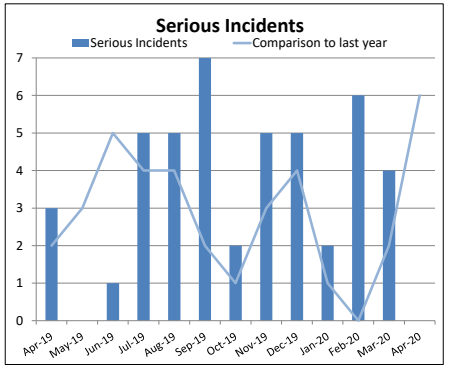
**Incidents**

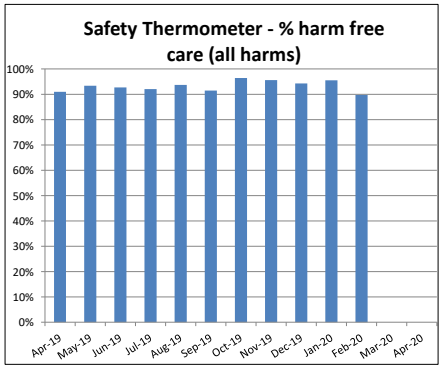
576 incidents were reported at PAH in April, 366 no harm 63.6%, 181 minor harm 31.4%, comprising 95% of all incidents.
20 moderate harm 3.4%, 8 severe harm 1.4%, 1 death 0.2%.
The majority of incidents have been reported in Zone B (38.2%), our non COVID positive wards.

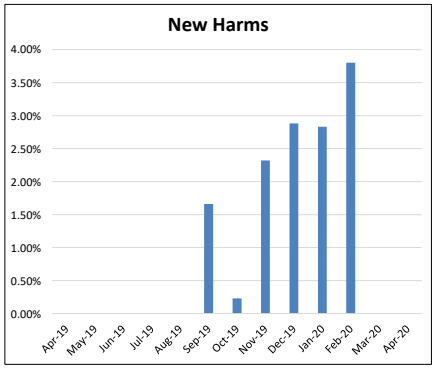
2 Serious incidents were reported externally in month.
- Self-harm resulting in death
- Allegation of assault: both police and safeguarding investigations are on-going

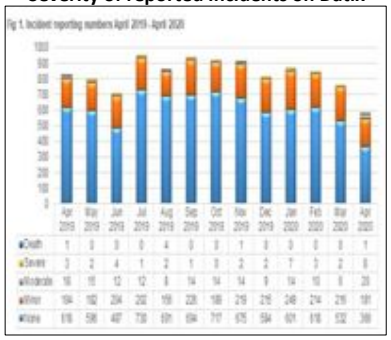
For all incidents the final grading will be confirmed upon conclusion of the investigations.

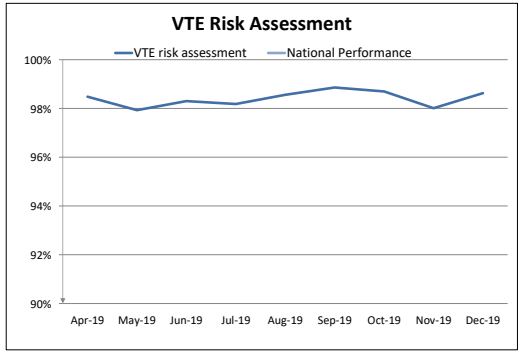
Four National Safety Alerts breached in April 2020 are as follows:
- MDA.2019.037 – Prismaflex Haemofiltration Systems: Trust Patient Safety & Quality Group in January 2020, agreed that until Baxter Technical are in a position to provide the required system update, the Trust is unable to comply. Baxter Technical advise they will have an IT solution to resolve the issues in this alert during July 2020.
- NatPSA.2020.002 – Interruption of High Flow Nasal Oxygen: Alert was issued on 1.4.2020 with a deadline of 8.4.2020. This alert was closed as compliant on 1.5.2020.
- NHSEI.2020.002 – Oxygen Usage: Alert was issued on 6.4.2020 with a deadline of the 10.04.2020. This alert was closed as compliant on 16.4.2020.
- NatPSA.2020.003 – Blood Control Safety Cannula & Needle Thoracostomy for Tension Pneumothorax: Alert was issued on 2.4.2020 with a deadline of the 9.4.2020. Procurement confirmed where products used on 15.04.2020. Products used across paediatrics & action taken to remove this stock. Action Plan & closure to this alert was completed on 12.5.2020.

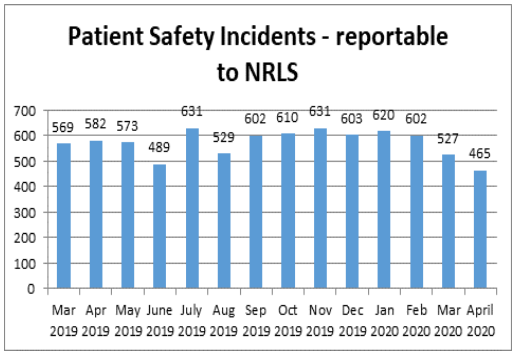


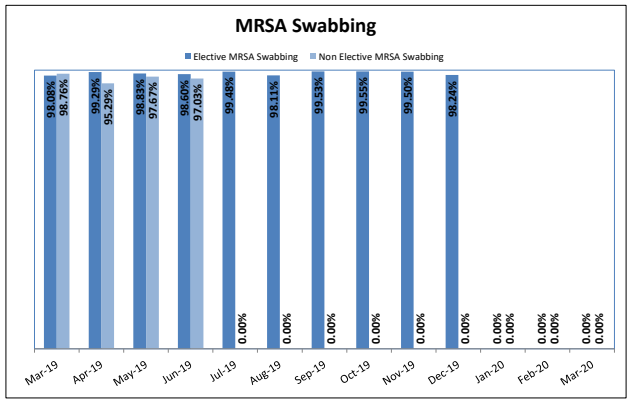



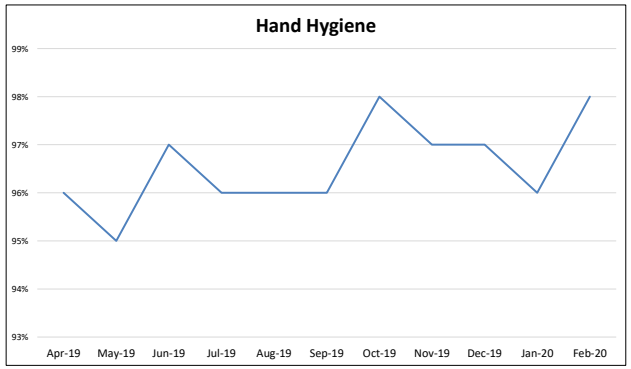




# Infection Control




| MSSA | |
|---|---|
| Apr-19 | 0 |
| May-19 | 1 |
| Jun-19 | 1 |
| Jul-19 | 0 |
| Aug-19 | 0 |
| Sep-19 | 0 |
| Oct-19 | 0 |
| Nov-19 | 0 |
| Dec-19 | 0 |
| Jan-20 | 1 |
| Feb-20 | 2 |
| Mar-20 | 1 |
| Apr-20 | 1 |

| C-DIFF (New categories including community from April 2019) | | | | | |
|---|---|---|---|---|---|
| | Hospital Responsible | | Community Responsible | | |
| Month | Hospital onset healthcare associated | Community onset healthcare associated (Acute Admission within last 4 wks) | Community onset indeterminate association (Acute Admission within last 12 wks) | Community onset community associated (No acute contact within 12 wks) | Total |
| Apr-19 | 2 | 1 | 1 | 0 | 4 |
| May-19 | 1 | 1 | 1 | 0 | 3 |
| Jun-19 | 0 | 1 | 0 | 2 | 3 |
| Jul-19 | 1 | 0 | 0 | 5 | 6 |
| Aug-19 | 0 | 0 | 1 | 2 | 3 |
| Sep-19 | 1 | 1 | 0 | 0 | 2 |
| Oct-19 | 1 | 0 | 1 | 2 | 4 |
| Nov-19 | 3 | 0 | 0 | 1 | 4 |
| Dec-19 | 4 | 0 | 3 | 0 | 7 |
| Jan-20 | 1 | 2 | 1 | 1 | 5 |
| Feb-20 | 1 | 1 | 0 | 0 | 2 |
| Mar-20 | 1 | 0 | 0 | 2 | 3 |



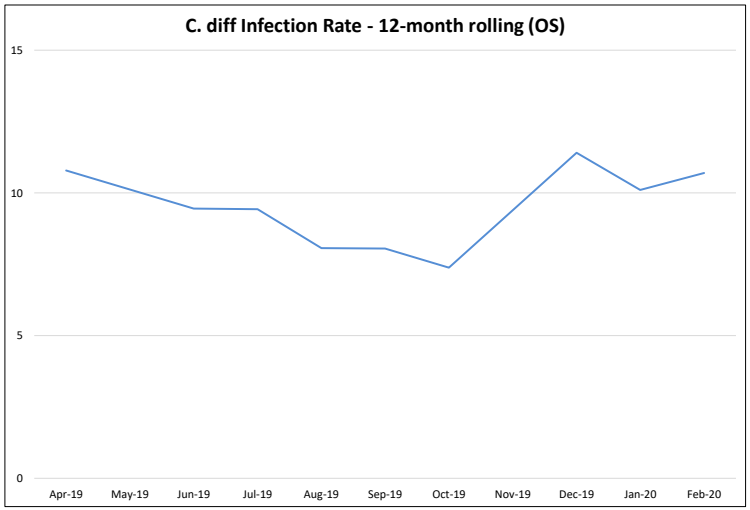

| E Coli | |
|---|---|
| Apr-19 | 2 |
| May-19 | 1 |
| Jun-19 | 2 |
| Jul-19 | 0 |
| Aug-19 | 2 |
| Sep-19 | 3 |
| Oct-19 | 0 |
| Nov-19 | 0 |
| Dec-19 | 1 |
| Jan-20 | 0 |
| Feb-20 | 2 |
| Mar-20 | 0 |
| Apr-20 | 1 |

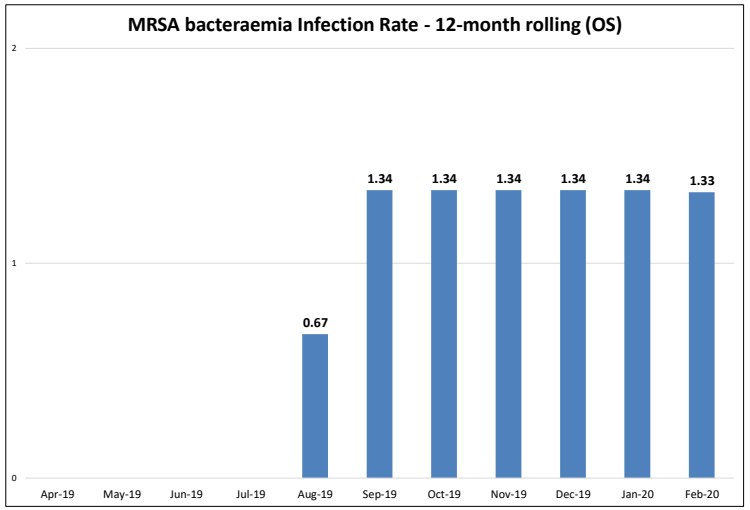
| Klebsiella | |
|---|---|
| Apr-19 | 0 |
| May-19 | 0 |
| Jun-19 | 1 |
| Jul-19 | 0 |
| Aug-19 | 0 |
| Sep-19 | 0 |
| Oct-19 | 0 |
| Nov-19 | 0 |
| Dec-19 | 1 |
| Jan-20 | 0 |
| Feb-20 | 0 |
| Mar-20 | 1 |
| Apr-20 | 1 |

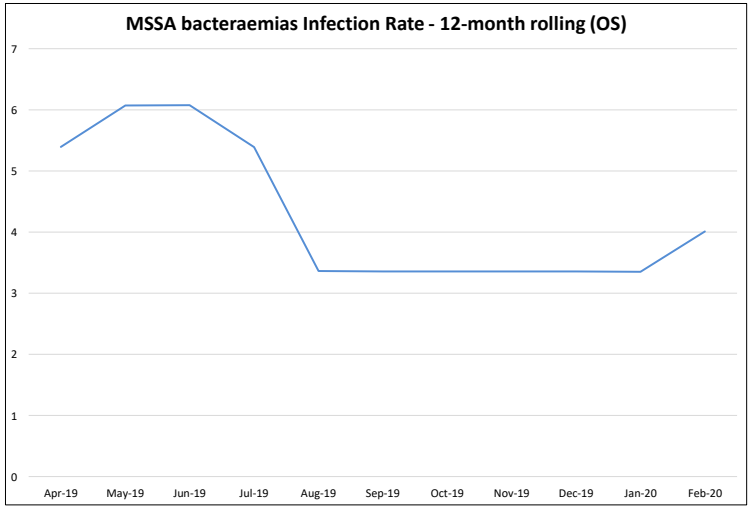
| Pseudomonas | |
|---|---|
| Apr-19 | 0 |
| May-19 | 0 |
| Jun-19 | 0 |
| Jul-19 | 0 |
| Aug-19 | 0 |
| Sep-19 | 1 |
| Oct-19 | 2 |
| Nov-19 | 0 |
| Dec-19 | 0 |
| Jan-20 | 0 |
| Feb-20 | 0 |
| Mar-20 | 0 |
| Apr-20 | 0 |

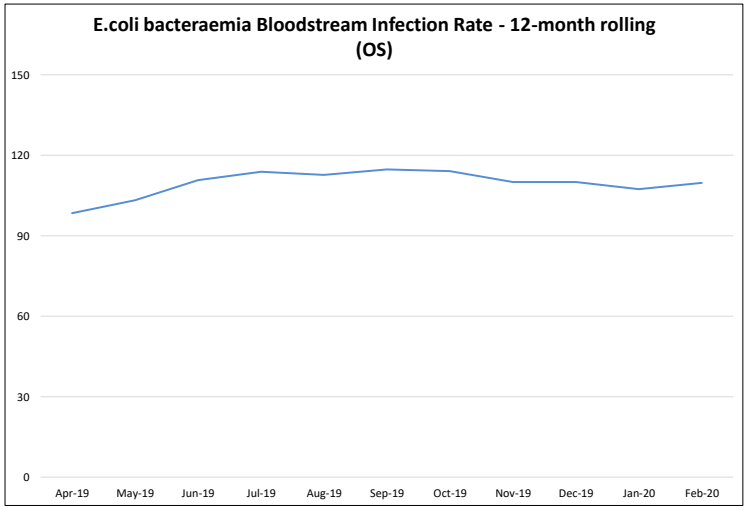
# Infection Control

*The following are the latest published data available.*

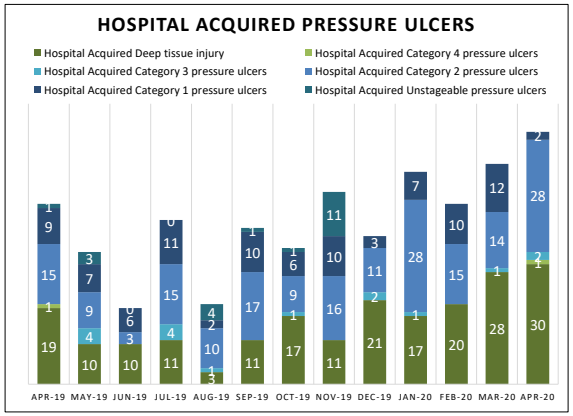


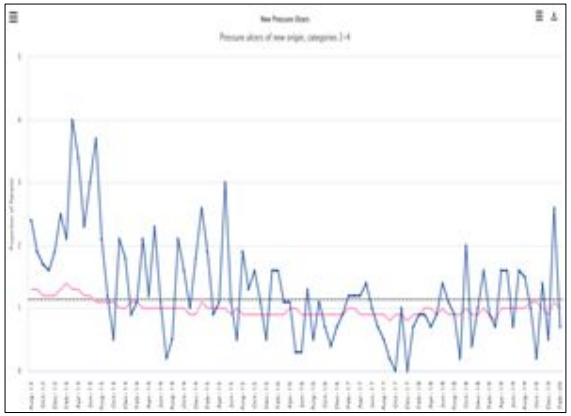



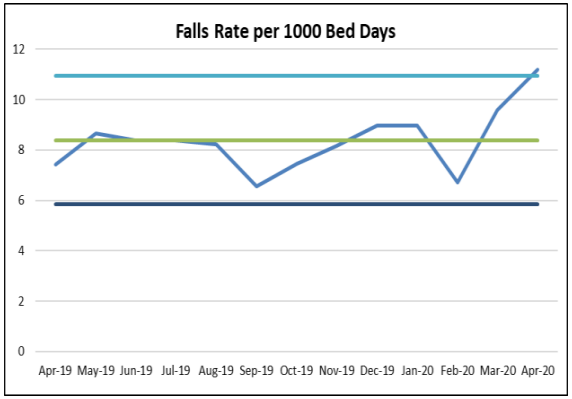



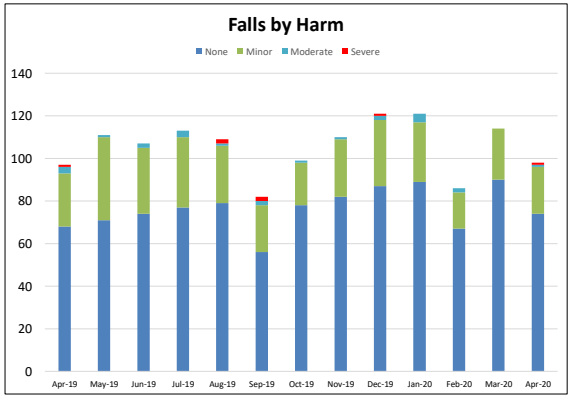



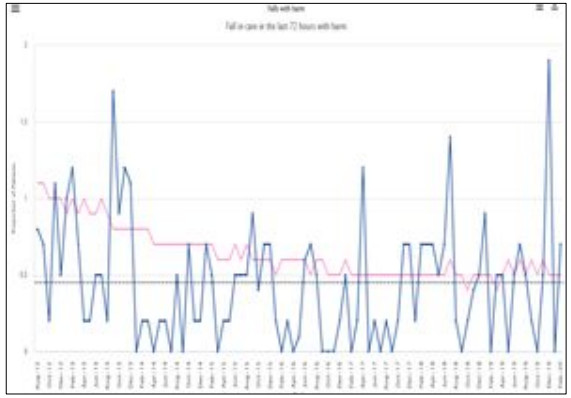

*(Rolling 12-month count/rolling 12-month average occupied bed days per 100,000 beds.)*


HOSPITAL ACQUIRED PRESSURE ULCERS
Hospital Acquired Deep tissue injury
Hospital Acquired Category 4 pressure ulcers
Hospital Acquired Category 3 pressure ulcers
Hospital Acquired Category 2 pressure ulcers
Hospital Acquired Category 1 pressure ulcers
Hospital Acquired Unstageable pressure ulcers
APR-19 MAY-19 JUN-19 JUL-19 AUG-19 SEP-19 OCT-19 NOV-19 DEC-19 JAN-20 FEB-20 MAR-20 APR-20




Falls Rate per 1000 Bed Days
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20


Falls by Harm
None
Minor
Moderate
Severe
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20

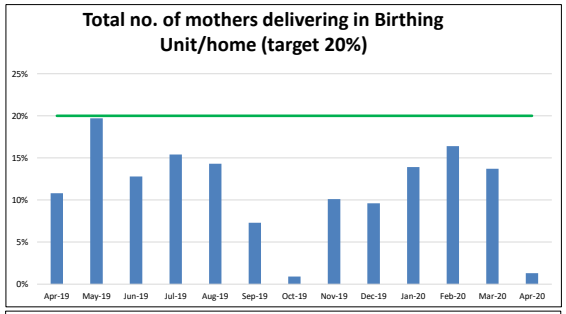


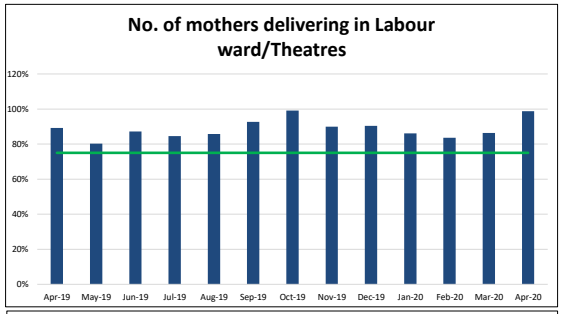
# Family & Women's Service

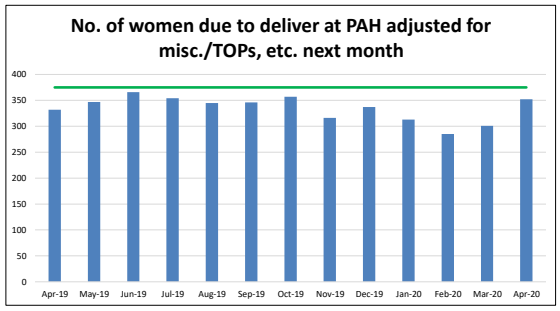
## 2 Our Patients Summary 1.7 Family & Women's Service

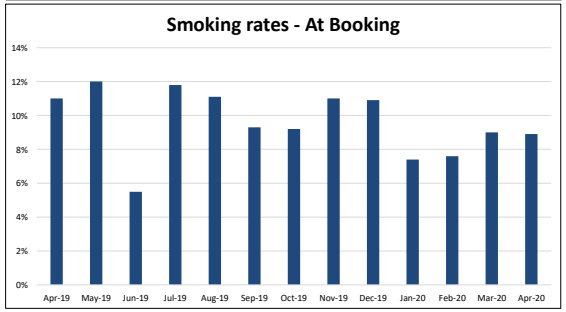
NHS The Princess Alexandra Hospital NHS Trust

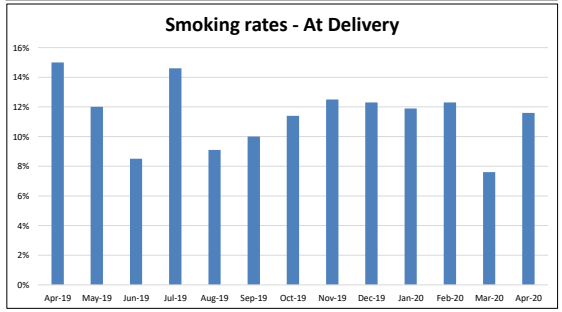
The overall C Section rate for March 2020 was has remained lower than the average rate for the financial year, representing a significant downwards trend for both February & March 2020 (25.4% for Feb & 27.0% for March 2020, compared to an average of 31.0% for April 2019 to March 2020).
The rate of Post-Partum haemorrhage over 1500mls remains higher than expected. Previous audits of the risk factors for PPH and regular case reviews have been conducted. The results were presented at the December 2019 FAWS Audit Meeting.
A much larger audit is now being conducted in order to understand the reasons why the Post-Partum haemorrhage over 1500mls remains high despite the introduction of new & ongoing measures such as risk assessments and active management of any risks at the onset of labour.

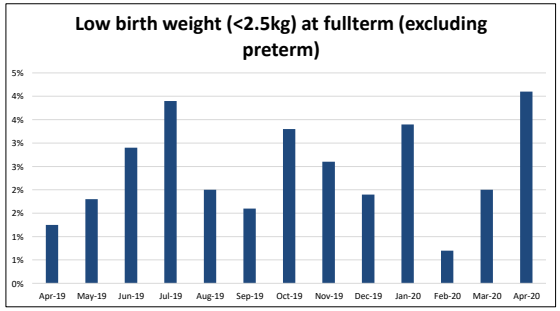


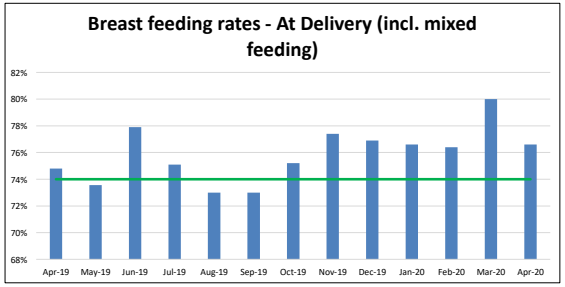



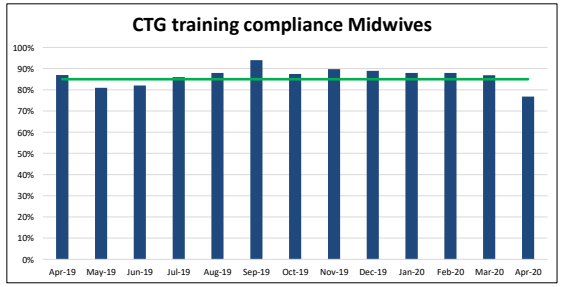



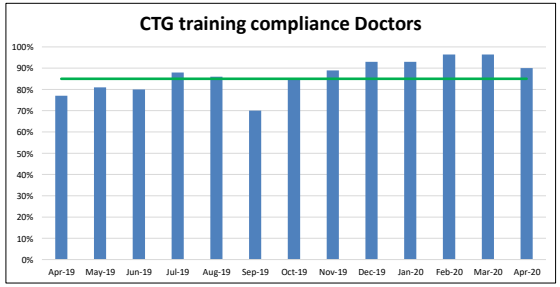



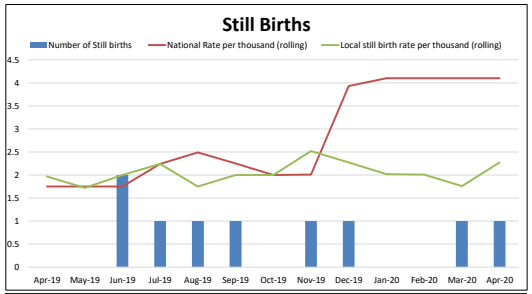



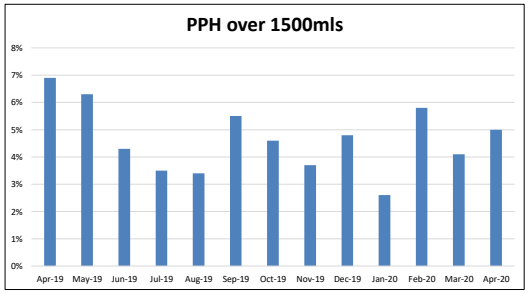



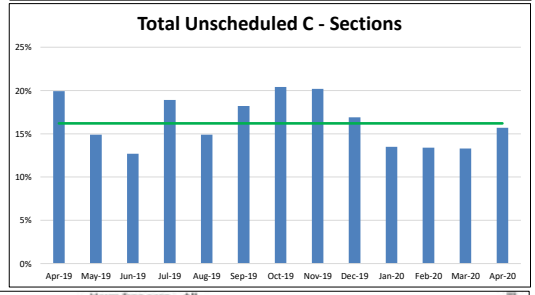



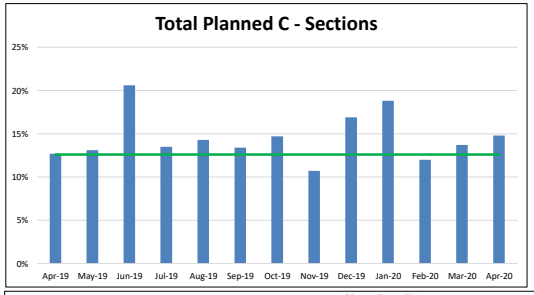
# Family & Women's Service

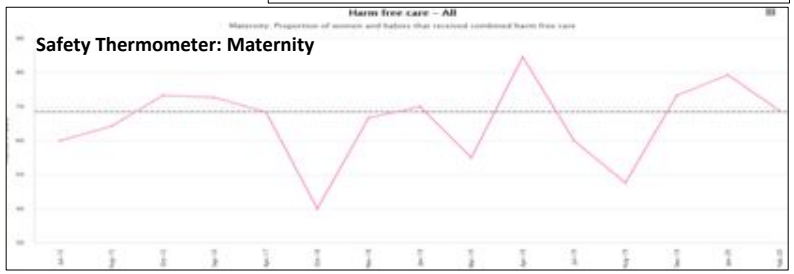


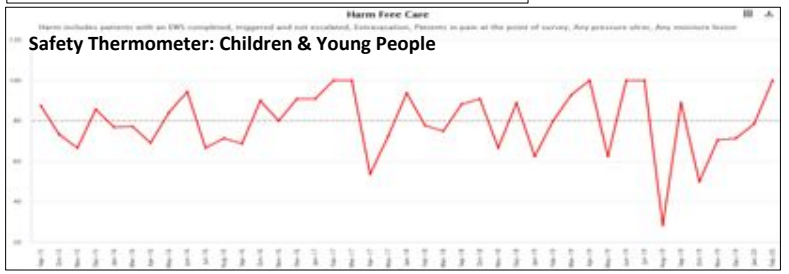


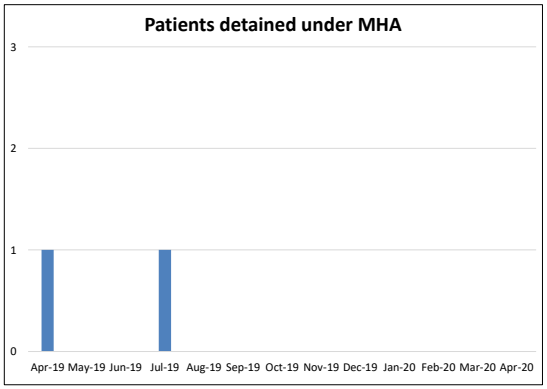



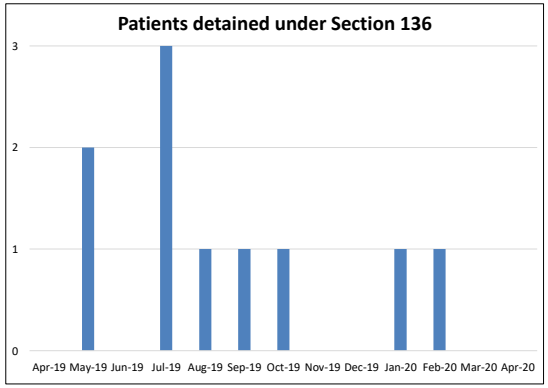



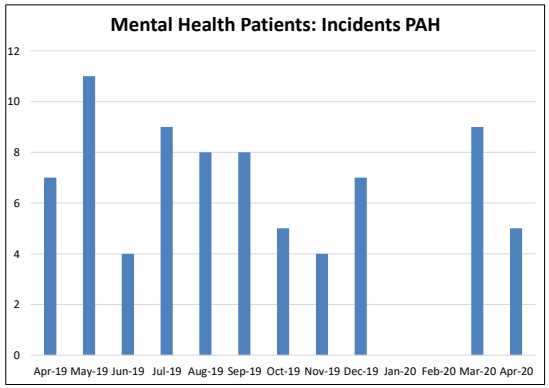
# Mental Health

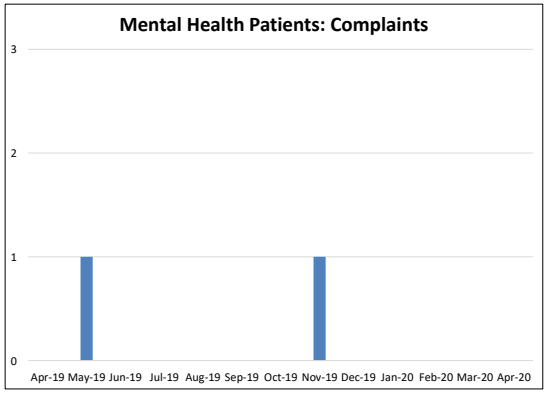


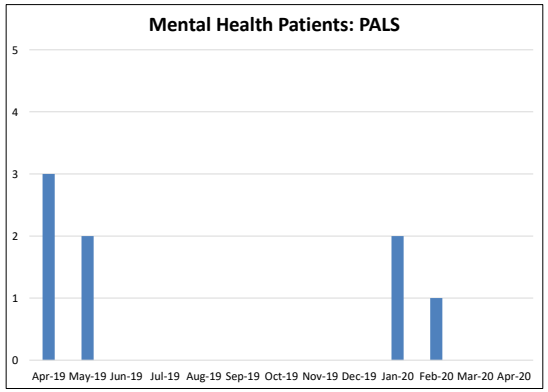


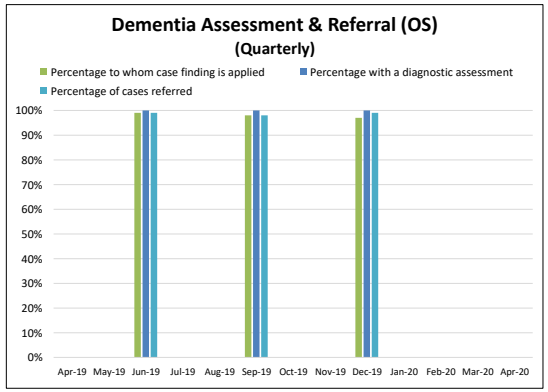


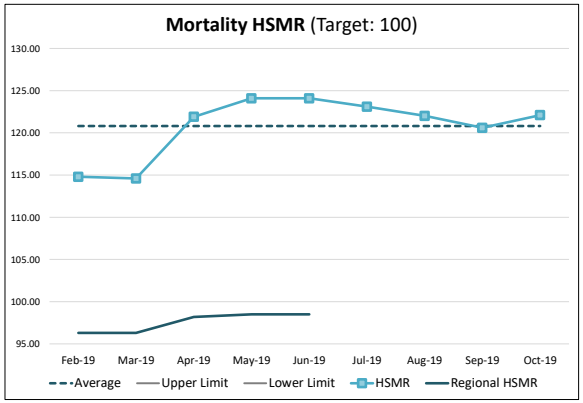



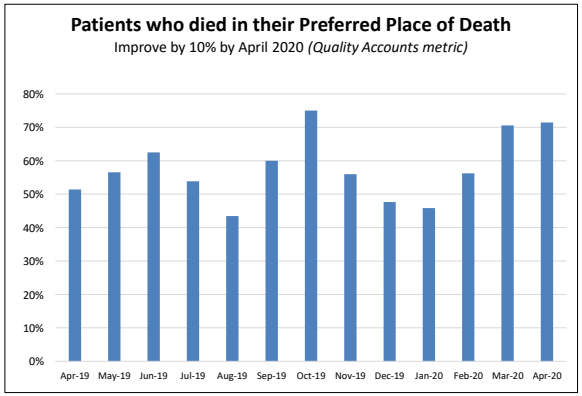




**DAR national collection suspended due to Covid-19**

# Mortality

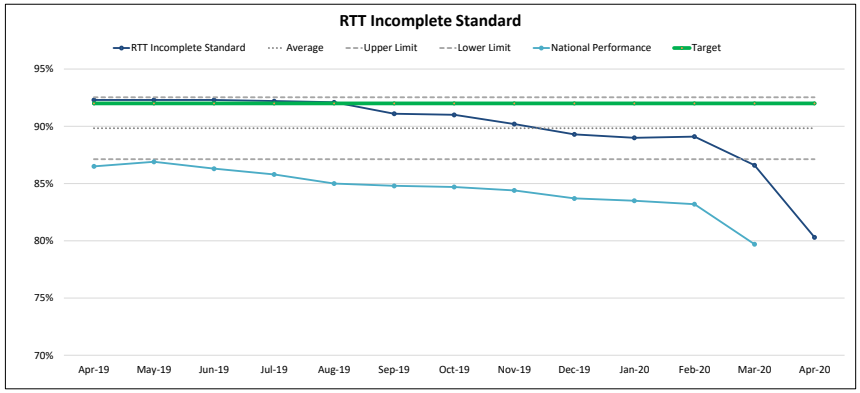


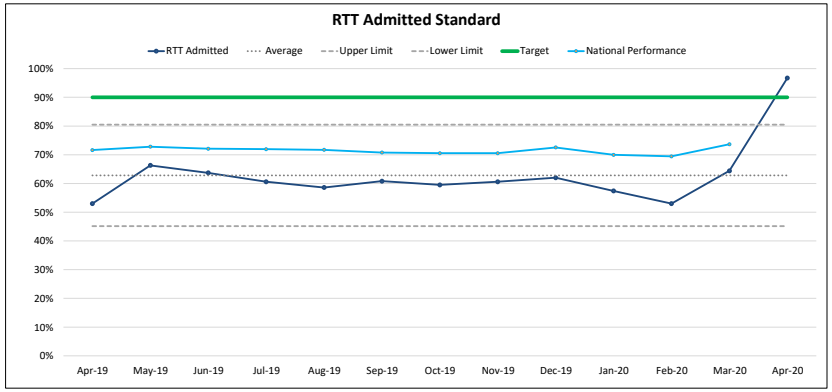



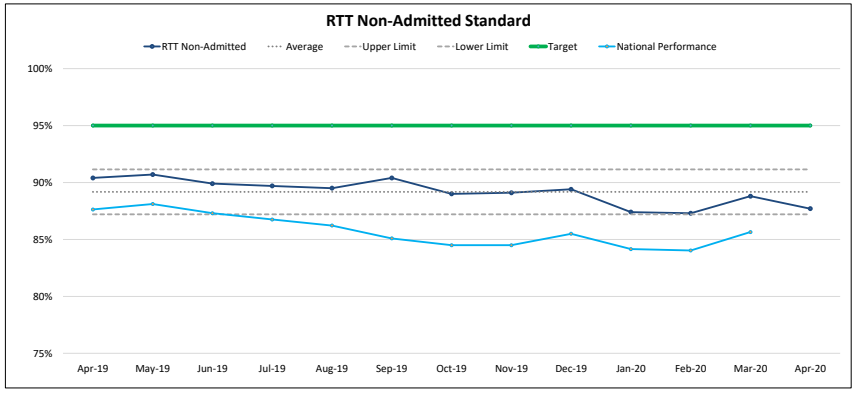

| Mortality SHMI | |
|---|---|
| Apr-19 | |
| May-19 | 111.4 |
| Jun-19 | 111.8 |
| Jul-19 | 112.1 |
| Aug-19 | 111.0 |
| Sep-19 | N/A |
| Oct-19 | 111.2 |
| Nov-19 | N/A |
| Dec-19 | N/A |
| Jan-20 | N/A |
| Feb-20 | N/A |
| Mar-20 | |
| Apr-20 | |

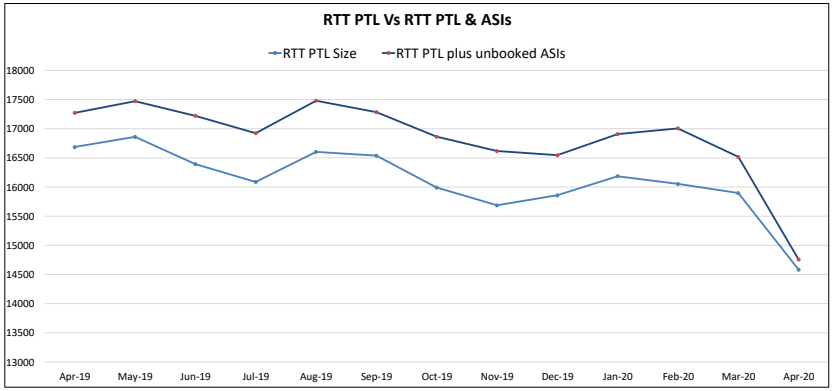
| Mortality Outlier Alerts (QA) | |
|---|---|
| May 17 - Apr 18 | 4 |
| Jun 17 - May 18 | 4 |
| Jul 17 - Jun 18 | 4 |
| Aug 17 - Jul 18 | 6 |
| Sep 17-Aug 18 | 6 |
| Oct 17 - Sep 18 | 9 |
| Nov 17 - Oct 18 | 8 |
| Jan 18 - Dec 18 | 7 |
| Feb 18 - Jan 19 | 6 |
| Mar 18 - Feb 19 | 7 |
| Jul 18 - Jun 19 | 7 |
| Aug 18 - Jul 19 | 6 |
| Sep 18 - Aug 19 | 5 |
| Oct 18 - Sep 19 | 5 |
| Nov 18 - Oct 19 | 6 |

# RTT


RTT Incomplete Standard
RTT Incomplete Standard
Average
Upper Limit
Lower Limit
National Performance
Target
95%
90%
85%
80%
75%
70%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20


RTT Admitted Standard
RTT Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20

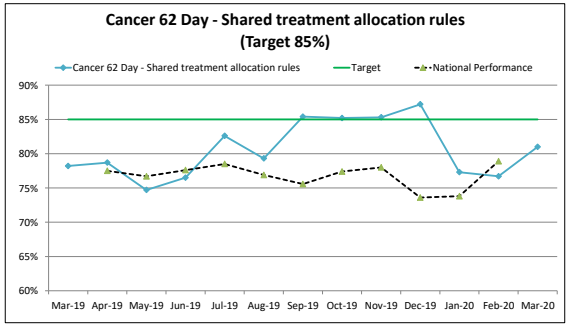

RTT Non-Admitted Standard
RTT Non-Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
95%
90%
85%
80%
75%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20

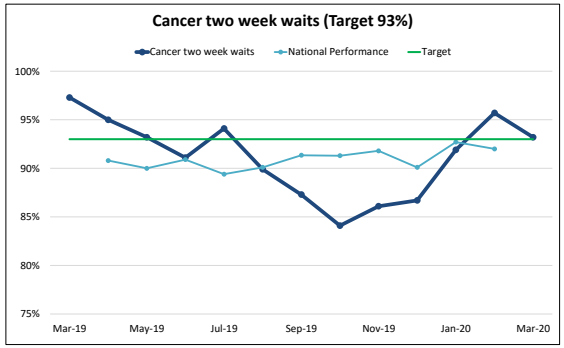

RTT PTL Vs RTT PTL & ASIs
RTT PTL Size
RTT PTL plus unbooked ASIs
18000
17500
17000
16500
16000
15500
15000
14500
14000
13500
13000
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20

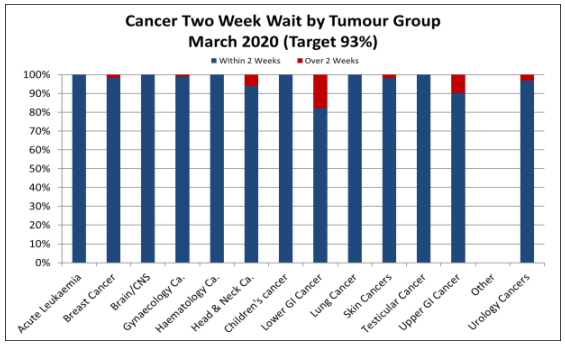
# Cancer

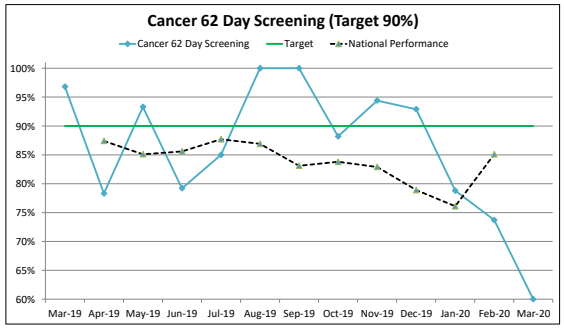
| | Cancer 2 week waits - breast symptomatic | Cancer 31 Day First | Cancer 31 Day Subsequent Drug | Cancer 31 Day Subsequent Surgery |
|---|---|---|---|---|
| Mar-19 | 97.70% | 97.40% | 100.00% | 100.00% |
| Apr-19 | 91.00% | 100.00% | 100.00% | 100.00% |
| May-19 | 92.60% | 97.80% | 92.90% | 75.00% |
| Jun-19 | 76.10% | 98.10% | 100.00% | 100.00% |
| Jul-19 | 95.70% | 99.00% | 100.00% | 100.00% |
| Aug-19 | 97.50% | 98.90% | 100.00% | 100.00% |
| Sep-19 | 99.10% | 99.10% | 100.00% | 100.00% |
| Oct-19 | 99.10% | 100.00% | 100.00% | 100.00% |
| Nov-19 | 97.60% | 100.00% | 100.00% | 100.00% |
| Dec-19 | 95.10% | 97.90% | 100.00% | 100.00% |
| Jan-20 | 98.50% | 94.40% | 100.00% | 100.00% |
| Feb-20 | 98.60% | 96.90% | 100.00% | 100.00% |
| Mar-20 | 98.80% | 97.10% | 100.00% | 100.00% |

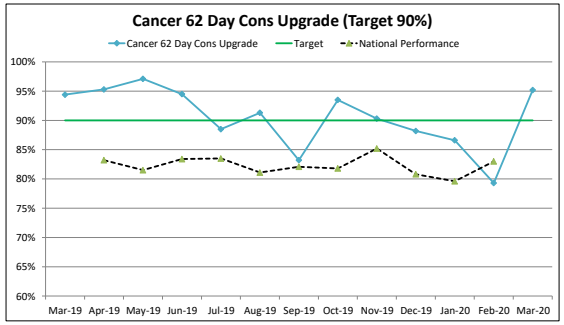
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

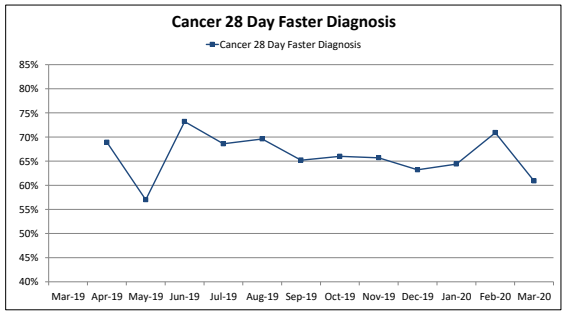


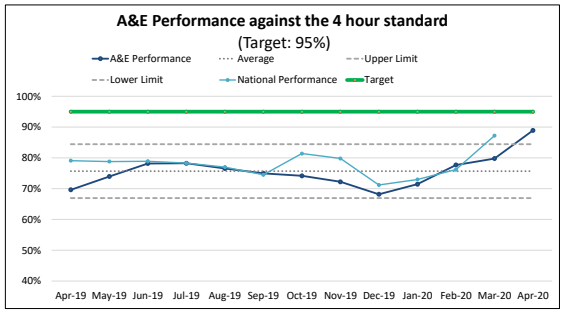



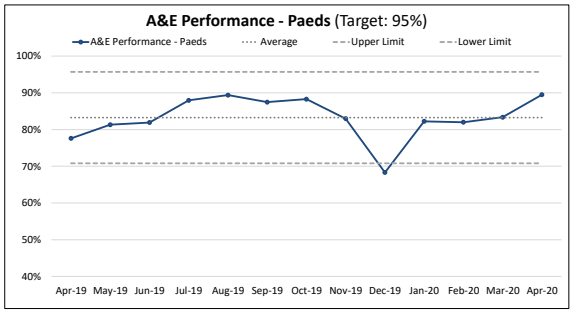



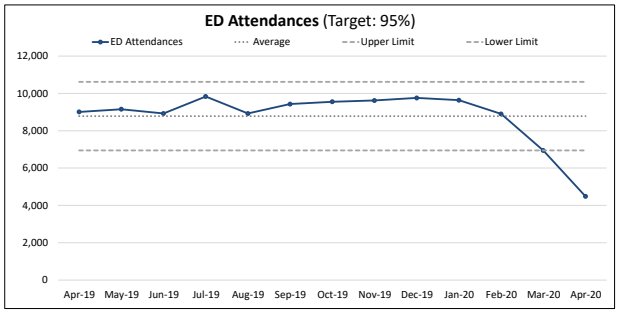



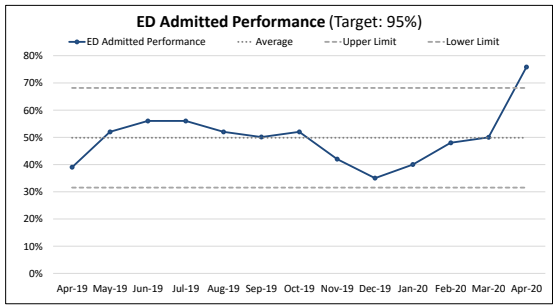
ED

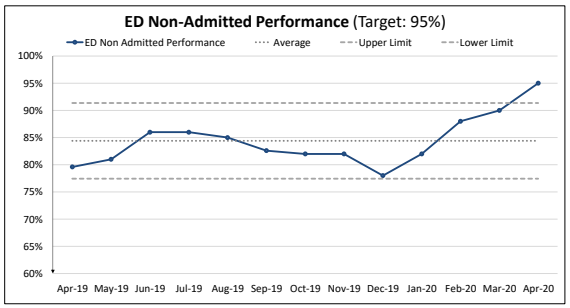




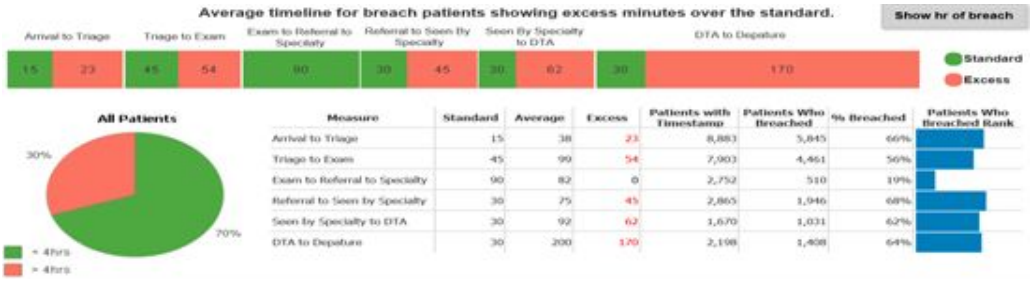



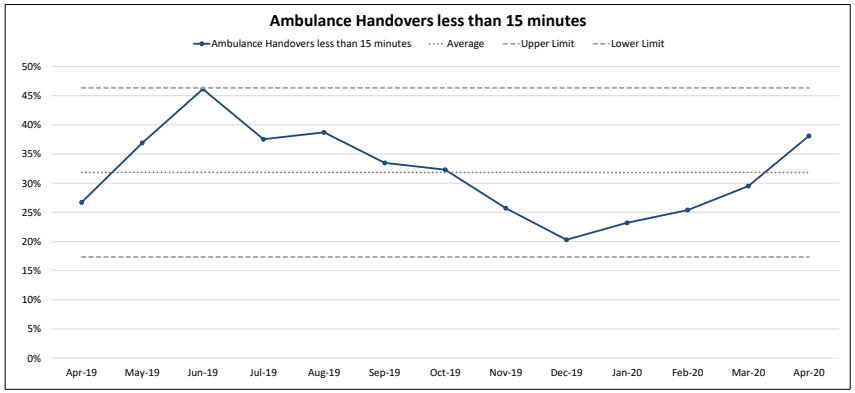



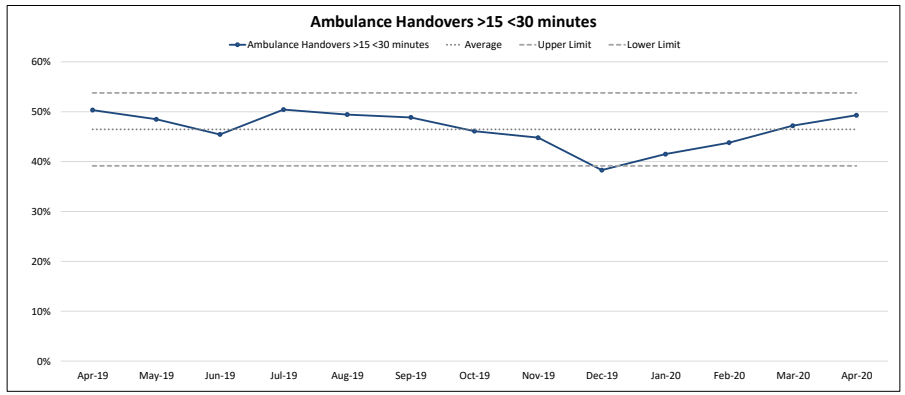

**ED Internal Professional Standards**

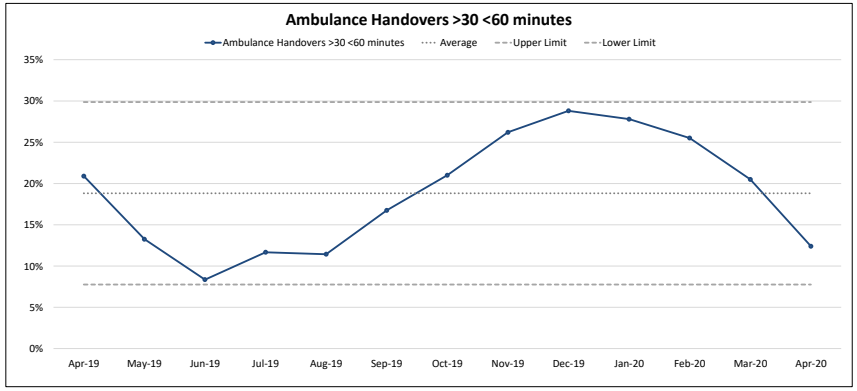
| | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Arrival to Triage - Average Wait (Minutes) | 38 | 33 | 26 | 46 | 34 | 39 | 35 | 38.63 | 46 | 43 | 38.09 | 31 | 26 |
| Triage to Exam - Average Wait (Minutes) | 99 | 99 | 91 | 90 | 93 | 102 | 108 | 102 | 104 | 91 | 76 | 60 | 41 |
| Exam to Referral to Specialty - Average Wait (Minutes) | 82 | 80 | 82 | 81 | 83 | 84 | 88 | 96 | 99 | 103 | 97 | 97 | 88 |
| Referral to Seen by Specialty - Average Wait (Minutes) | 75 | 69 | 67 | 65 | 79 | 70 | 78 | 98 | 90 | 87 | 77 | 74 | 54 |
| Seen by Specialty to DTA - Average Wait (Minutes) | 93 | 72 | 78 | 73 | 74 | 84 | 87 | 96 | 105 | 99 | 87 | 91 | 66 |
| DTA to Departure - Average Wait (Minutes) | 197 | 147 | 120 | 115 | 108 | 120 | 116 | 217 | 249 | 169 | 134 | 157 | 110 |

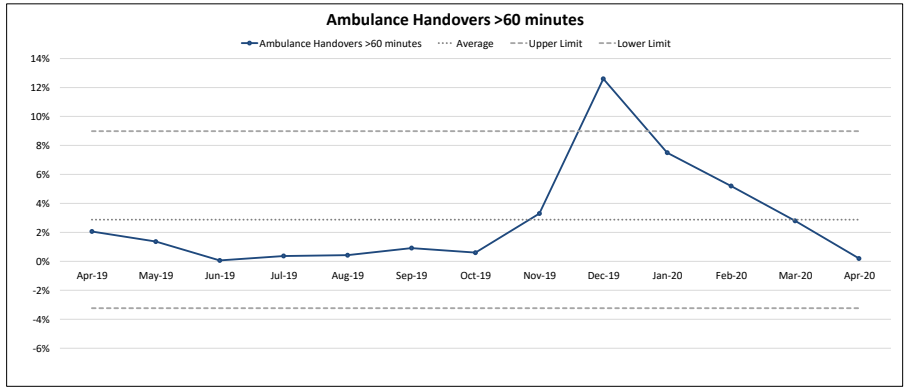


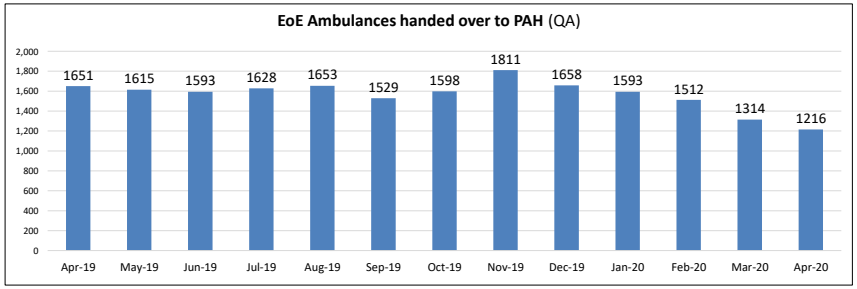
# Ambulance


Ambulance Handovers less than 15 minutes
Ambulance Handovers less than 15 minutes
Average
Upper Limit
Lower Limit
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20

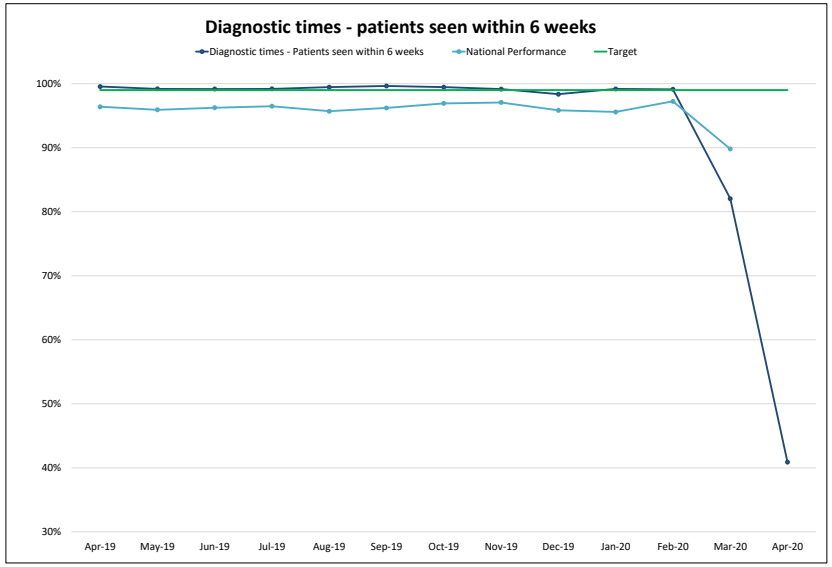

Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
60%
50%
40%
30%
20%
10%
0%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20

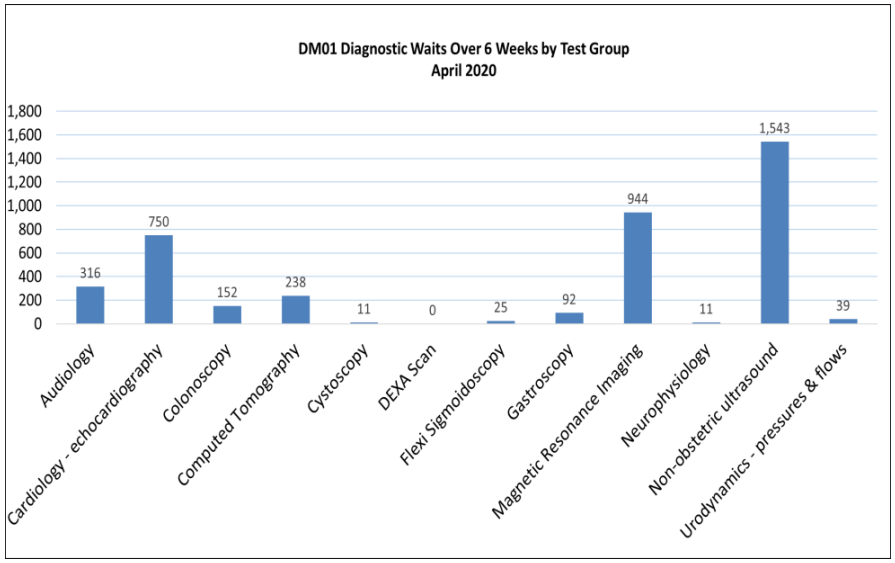

Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
35%
30%
25%
20%
15%
10%
5%
0%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20


Ambulance Handovers >60 minutes
Ambulance Handovers >60 minutes
Average
Upper Limit
Lower Limit
14%
12%
10%
8%
6%
4%
2%
0%
-2%
-4%
-6%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20


EoE Ambulances handed over to PAH (QA)
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1651
1615
1593
1628
1653
1529
1598
1811
1658
1593
1512
1314
1216
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20

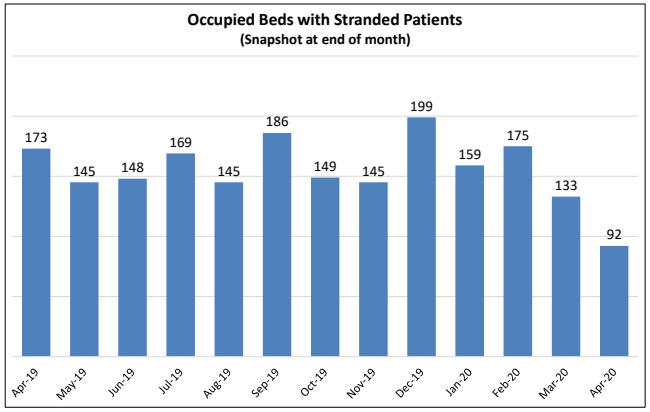
# Diagnostics

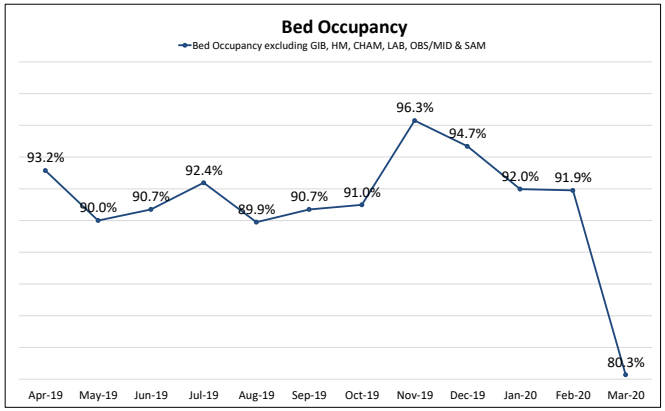


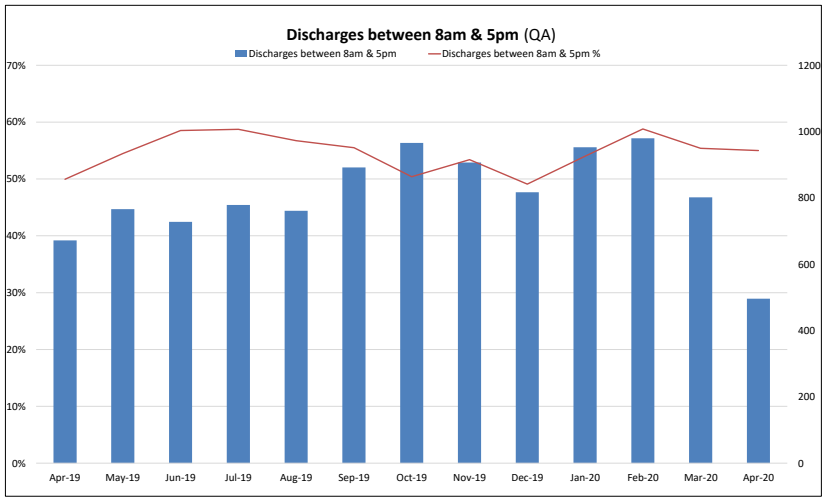

| Test | % of Total Cohort - April 20 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Magnetic Resonance Imaging (MRI) | | 100.00% | 100% | 100% | 100% | 100% | 100% | 100% | 99.79% | 99.84% | 100.00% | 100.00% | 78.41% | 33.52% |
| Computed Tomography (CT) | | 99.73% | 99% | 100.00% | 100.00% | 99% | 100% | 100% | 99.81% | 100.00% | 100.00% | 99.48% | 85.30% | 58.75% |
| Non-Obstetric Ultrasound | | 99.76% | 99.92% | 99.92% | 100.00% | 99.86% | 100% | 100% | 99.92% | 100.00% | 100.00% | 99.89% | 83.23% | 39.20% |
| DEXA | | 100% | 100.00% | 100% | 100% | 100% | 100% | 100% | 100.00% | 100.00% | 100.00% | 100.00% | - | - |
| Audiology - Audiology Asessments | | 99.58% | 99% | 99% | 100% | 100% | 100% | 100% | 100.00% | 98.76% | 98.40% | 100.00% | 68.82% | 23.42% |
| Cardiology - Echocardiography | | 100% | 100.00% | 100.00% | 100.00% | 100% | 100% | 98% | 100.00% | 100.00% | 99.87% | 96.38% | 74.02% | 37.55% |
| Neurophysiology | | 100% | 100% | 83% | 50% | 66.67% | 67% | 86% | 93% | 97% | 94% | 89% | 49% | 42.11% |
| Urodynamics | | 87% | 89.66% | 92.59% | 90.00% | 95.24% | 95% | 89% | 92.00% | 88.57% | 81.82% | 80.56% | 91.11% | 30.36% |
| Colonoscopy | | 96.76% | 90.71% | 88.11% | 84.62% | 94.81% | 99% | 99% | 89.14% | 74.72% | 88.52% | 97.94% | 93.58% | 62.56% |
| Flexi Sigmoidoscopy | | 98% | 90% | 93.10% | 89.66% | 92.86% | 100% | 94% | 94.59% | 69.05% | 94.64% | 95.56% | 87.18% | 48.98% |
| Cystoscopy | | 100.00% | 90.91% | 92% | 95.65% | 94% | 100% | 96% | 92.00% | 86.21% | 81.82% | 100.00% | 93.75% | 64.52% |
| Gastroscopy | | 95.35% | 92.52% | 88.46% | 88.79% | 96.83% | 99% | 99% | 89.57% | 83.16% | 89.09% | 99.15% | 92.07% | 58.37% |

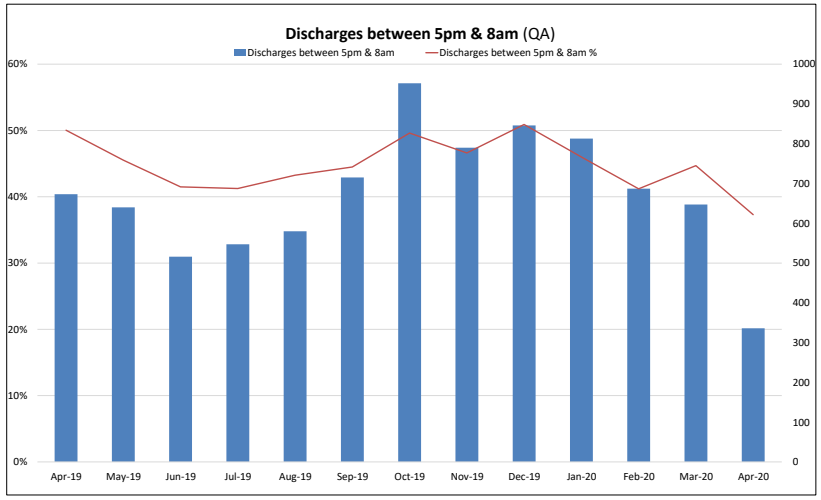
# Stranded Patients

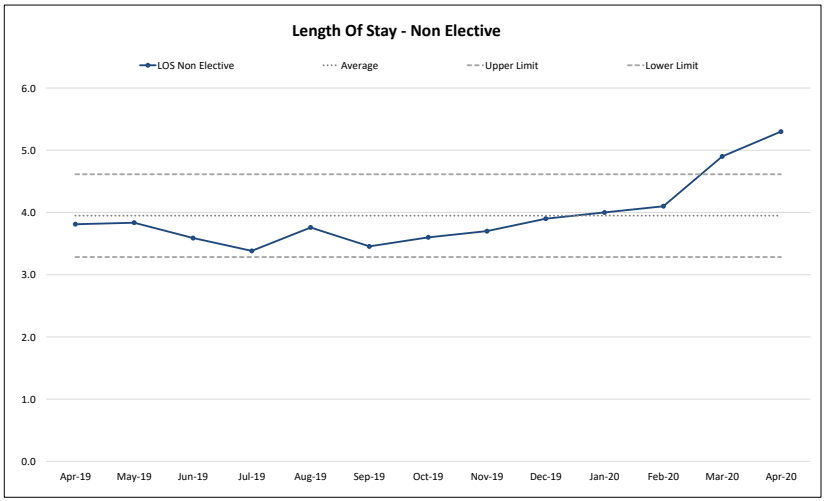


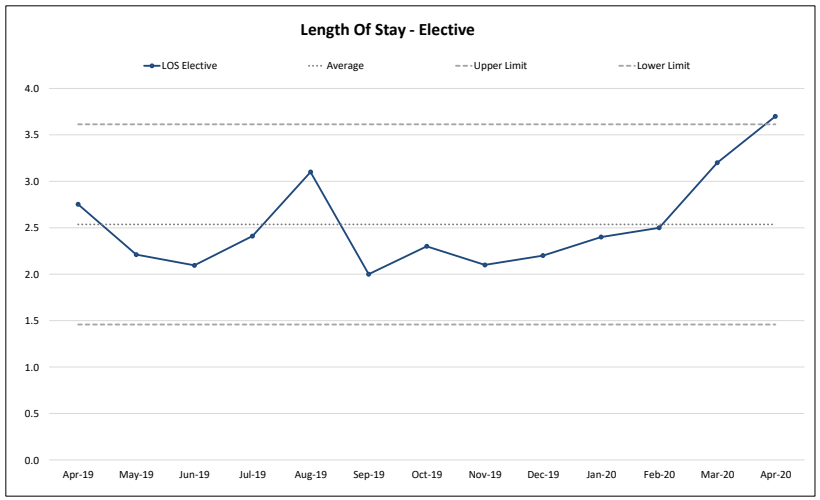



# Discharges & LOS



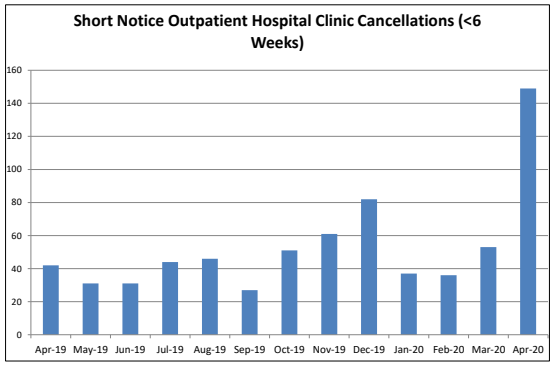



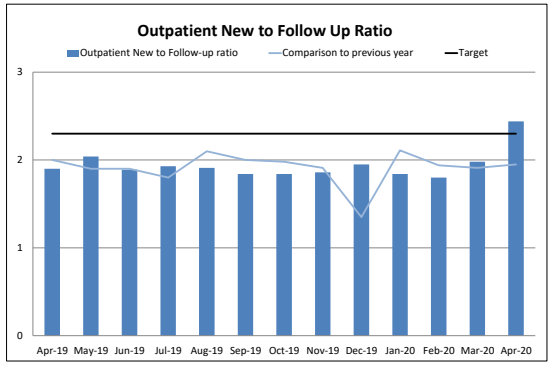



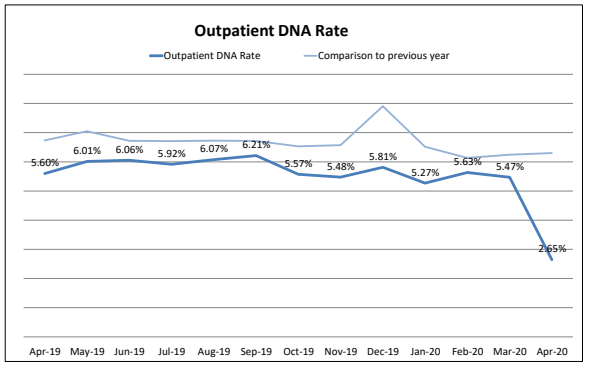



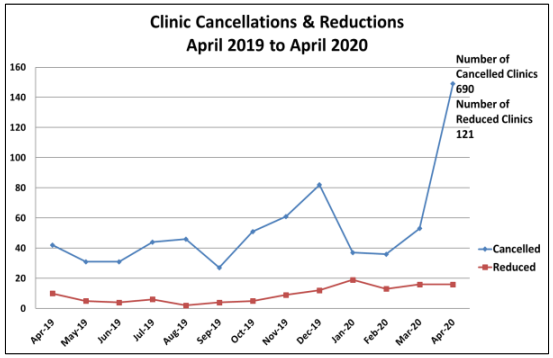
# Outpatients & Cancelled Operations

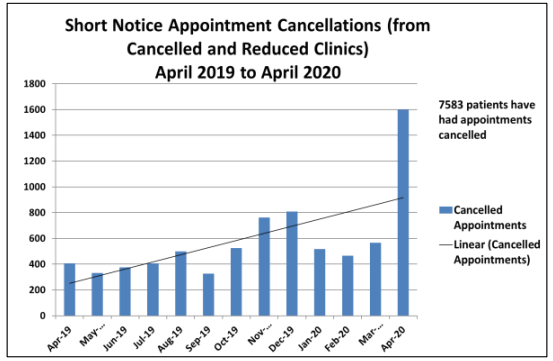


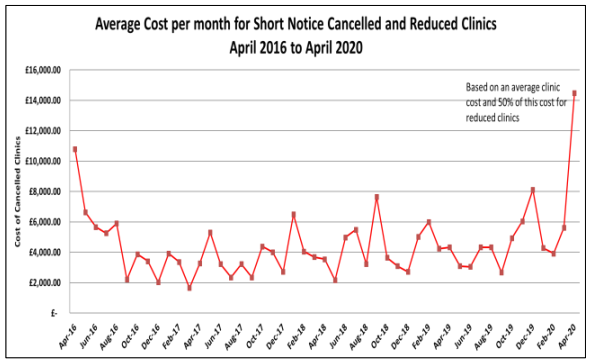



**DNA Rate for Follow Up Appointments per Specialty for April**

| Specialty & Performing Unit | Accident & Emergency | AHP Episode | Anticoagulant Service | Breast Surgery | Cardiology | Chemical Pathology | Clinical Haematology | Clinical Oncology | Colorectal Surgery | Community Midwifery | Dermatology | Diabetic Medicine | Dietetics | Endocrinology | ENT | Gastroenterology | General Medicine | General Surgery | Gynaecology | Haematology | Medical Oncology | Medicine for the Elderly | Neonatology | Neurology | Obstetrics | Ophthalmology | Optometry | Oral Surgery | Orthoptics | Paediatric Diabetic Medicine | Paediatrics | Physiotherapy | Respiratory Medicine | Rheumatology | Trauma & Orthopaedics | Urology | Vascular Surgery | Well Baby | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DNA Rate | 0.0% | 0.0% | 0.0% | 3.2% | 2.8% | 4.8% | 0.0% | 0.0% | 0.0% | 5.1% | 1.8% | 1.1% | 5.7% | 0.7% | 1.7% | 4.4% | 0.0% | 0.0% | 1.1% | 0.4% | 0.3% | 0.0% | 0.0% | 1.5% | 2.8% | 2.6% | 0.0% | 0.0% | 19.9% | 0.0% | 7.4% | 2.3% | 6.0% | 1.5% | 2.0% | 1.9% | 1.2% | 4.9% | 2.7% |

# Workforce Indicators Summary

**Agency Spend** 8.20%
**Bank Spend** 11.90%

**Staff In Post**
3286
WTE


**Training**
91%

**Sickness**
6.8%


9.1%

**Turnover**
11%

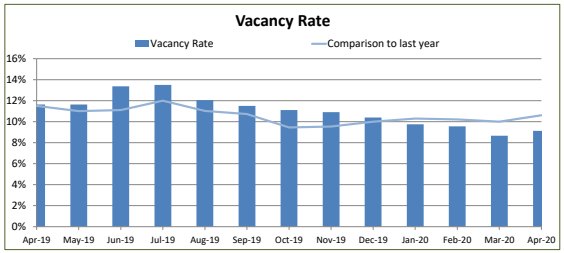

**Medical** 100%
**Non-Medical** 83%

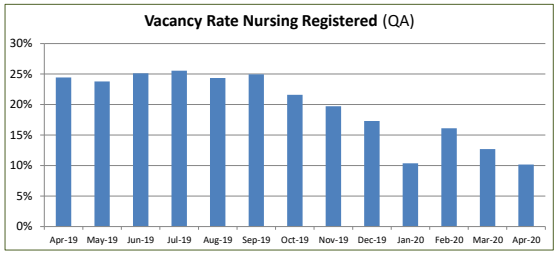
Scorecard

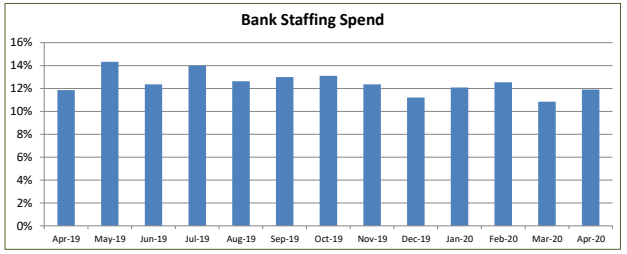
| People Measures as at 30 April 2020 | Trust Target | Trust | CCCS | FAWS | Medicine HCG | Surgery HCG | Estates & Facilities | Corporate | People | Finance |
|---|---|---|---|---|---|---|---|---|---|---|
| Funded Establishment- WTE | | 3640.89 | 890.59 | 467.17 | 890.41 | 772.31 | 278.03 | 131.75 | 54.68 | 155.95 |
| Vacancy Rate | 8.0% | 9.12% | 6.40% | 10.52% | 12.64% | 10.25% | 12.62% | 0.00% | 4.71% | 8.90% |
| Agency % of paybill | 7.0% | | | | | | | | | |
| Bank Usage - wte | n/a | 255.52 | 27.55 | 27.93 | 111.97 | 47.02 | 12.18 | 9.06 | 0.72 | 19.07 |
| Agency Usage -wte | n/a | 106.24 | 12.68 | 4.69 | 49.56 | 34.70 | 0.00 | 4.35 | 0.00 | 0.26 |
| April 2020 Sickness Absence | 3.7% | 6.82% | 5.21% | 7.33% | 9.02% | 6.31% | 11.34% | 3.11% | 2.71% | 3.34% |
| Short Term Sickness | 1.85% | 4.37% | 2.53% | 4.68% | 7.07% | 4.42% | 4.90% | 2.68% | 2.71% | 1.22% |
| Long Term Sickness | 1.85% | 2.45% | 2.68% | 2.64% | 1.95% | 1.89% | 6.44% | 0.43% | 0.00% | 2.12% |
| Rolling Turnover (voluntary) | 12% | 10.82% | 11.50% | 9.04% | 13.23% | 8.56% | 11.92% | 9.45% | 9.23% | 10.05% |
| Statutory & Mandatory Training | 90% | 91% | 96% | 89% | 87% | 86% | 97% | 92% | 93% | 97% |
| Appraisal | 90% | 83% | 86% | 83% | 78% | 78% | 91% | 86% | 88% | 81% |
| FFT (care of treatment) Q2 | 67% | 78% | 76% | 84% | 83% | 78% | 61% | 75% | 68% | 82% |
| FFT (place to work) Q2 | 61% | 65% | 56% | 72% | 69% | 62% | 45% | 75% | 60% | 67% |
| Starters (wte) | | 20.01 | 7.09 | 1.00 | 3.61 | 5.30 | 0.00 | 0.00 | 2.00 | 1.00 |
| Leavers (wte) | | 20.36 | 3.00 | 4.80 | 5.41 | 2.51 | 2.64 | 1.00 | 0.00 | 1.00 |
| Time to hire (Advert to formal offer made) | 31Days | | | | | | | | | |

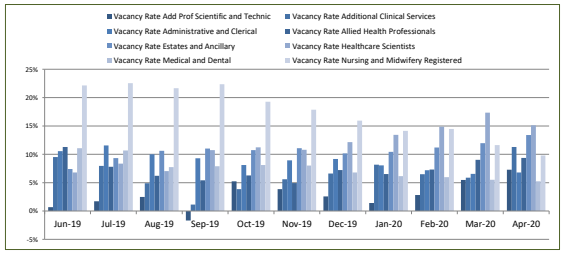
| | |
|---|---|
| Above target | |
| Improvement from last month/above or below target | |
| Underachieving target | |

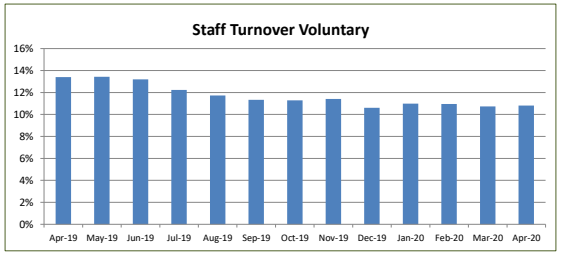
# Workforce Indicators

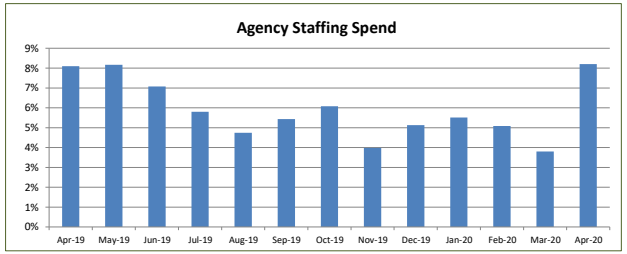


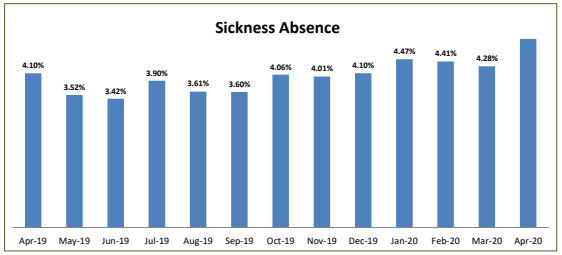



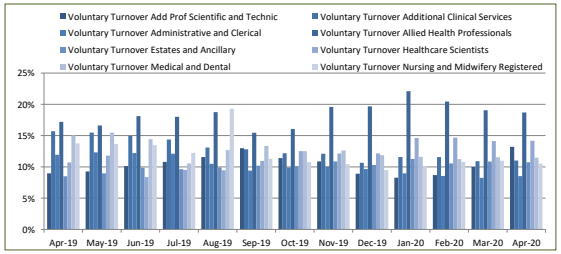



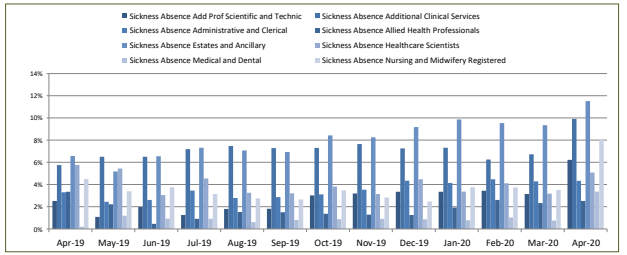



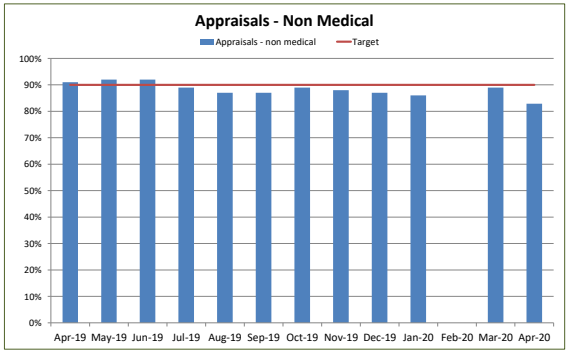



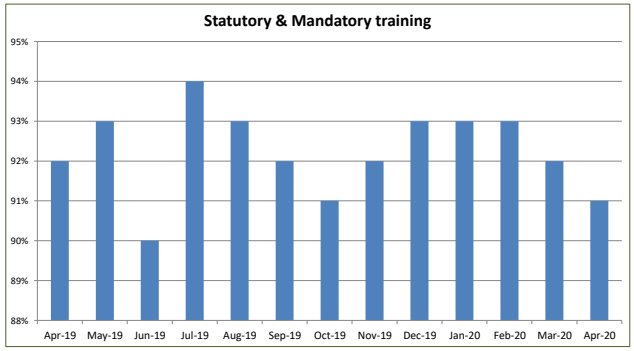



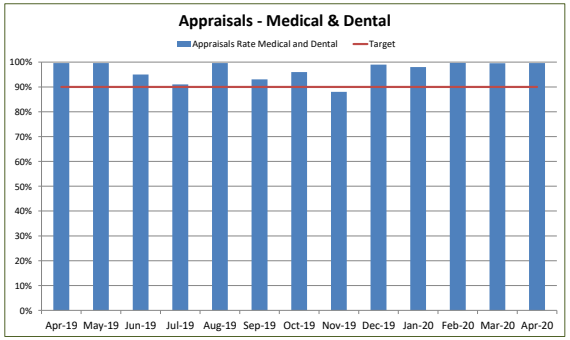



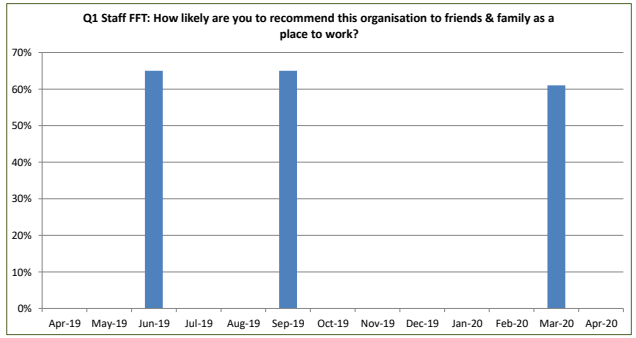



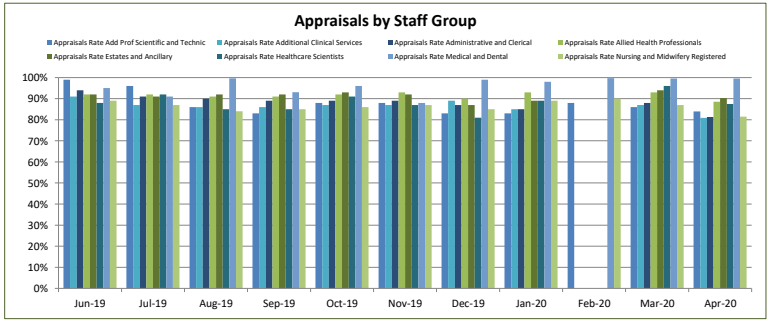
# Workforce Indicators

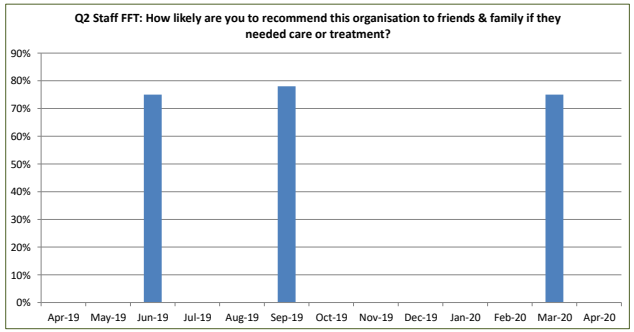


Workforce Indicators

# Annual Staff Survey 2019 & Workforce Race Equality Standard (WRES)

*These measures are included as part of the NHS Oversight Metrics.*

| *Measure* | *Average rating of:* | *Percentage* |
|---|---|---|
| **Support & Compassion** | % experiencing harassment, bullying or abuse from staff in the last 12 months* | 19.50% |
| | % not experiencing harassment, bullying or abuse at work from managers in the last 12 months | 84.40% |
| **Teamwork** | % agreeing that their team has a set of shared objectives | 73.50% |
| | % agreeing that their team often meets to discuss the team's effectiveness | 58.70% |
| **Inclusion (1)** | % staff believing the trust provides equal opportunities for career progression or promotion | 83.30% |
| | % experiencing discrimination from their manager/team leader or other colleagues in the last 12 months** | 7.80% |

*Note that this is a 'negative' experience question & does not exist within the structure of the NHS Staff Survey (all answers are scored positively); the survey asks about experience of harassment, bullying or abuse from 'managers' and 'other colleagues', but not 'staff'. Provided is the data for the responses for the 'other colleagues' question.

**Again, please note this is a 'negative' experience question & this specific data is not explicitly reported in the results – calculations are based on the raw data.

| WRES Indicator No. | WRES Report March 2018 | WRES Report March 2019 | Direction |
|---|---|---|---|
| **9**. Percentage difference between PAH Board voting Membership and its overall workforce | White = 100%<br>BME = 0% | White = 100%<br>BME = 0% | ⟺ |
| Percentage difference between PAH Executive board membership and its overall workforce | White = 88.9%<br>BME = -11.1% | White = 87.5%<br>BME = -12.5% | |

# Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

**Domestic Services:**

• Due to the Covid-19 outbreak & significant number of ward closures no cleaning audits were undertaken in April 2020. However, additional cleaning staff were employed to cover the service during April 24/7 & all areas received tiered cleaning (neutral detergent clean following by a bleach based clean). In addition the Compliance Manager has been self-isolating since mid-April.

• From beginning of May, the team are now back completing audits & so will be able to provide metric scores for the May reporting period.

**Estates:**

• New Oxygen pipeline – Henry Moore

This project is now complete & includes additional Oxygen ports at all bedheads & servicing of all existing ports.

• Birthing unit/Nightingale water management

The virulent strain of Pseudomonas that we have been dealing with since Sept 2019 has now been eradicated in all outlets & the water system is functioning well. We will continue to closely monitor the system & increased flushing regimes will remain in place until reviewed at the next water safety group meeting scheduled for July 2020.

• Planned Preventative Maintenance

PPM contracts are now in place for water management, ventilation systems & medical gas systems. This marks a signification increase in compliance with planned preventative maintenance for which the benefits can be evidenced in the comprehensive backlog maintenance capital plan for 2020/21.

• Estates consultation

The staffing consultation for the Estates team was successfully completed. The consultation implementation has been paused whilst the Trust focuses on recovery from COVID-19, but will resume in the near future.

• Premises Assurance Model (PAM)

Completion of all required documentation for the PAM submission is well underway. The increase in compliance over the last 12 months is evident from the data captured so far.

• EBME relocation

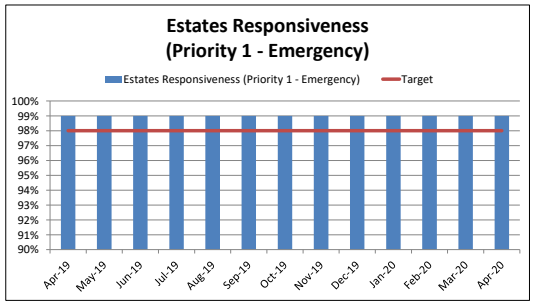
The new EBME workshop is nearing completion. Relocation of the EBME function to an onsite facility, conducive to the activities being undertaken by the EBME team with will mitigate risks relating to; gaps in decontamination process, moving & handling, staff experience, task variation.

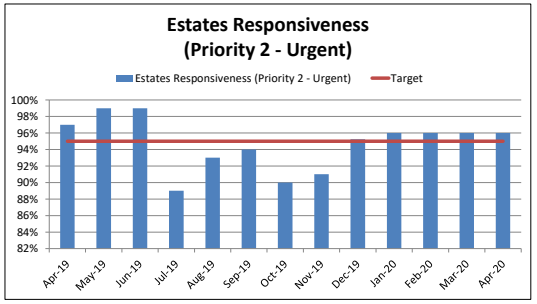
**Catering:**

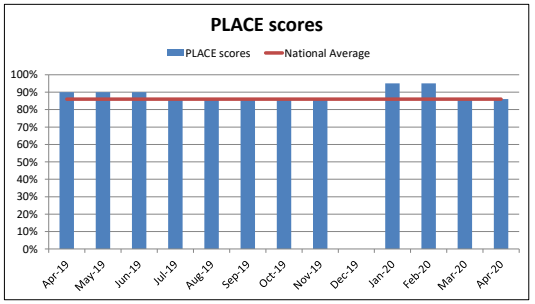
• The number of meals prepared & served to patients decreased this month due to the number of ward closures & the type of patients on the wards. The number of meals sent out to the Covid wards for the staff was 17,630. Food wastage increased due to the amount of food being sent in by local retailers in appreciation of staff.

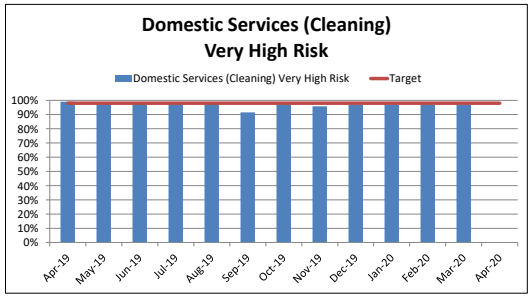
• The Restaurant became a staff only area for staff to have a place to go and sit and take time out if necessary maintaining the 2 metre social distancing rule.

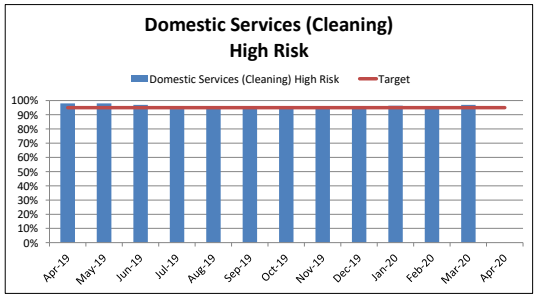
Places

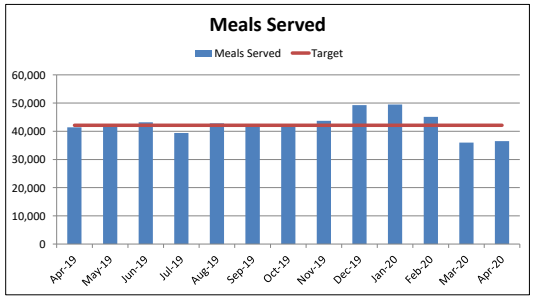

Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target

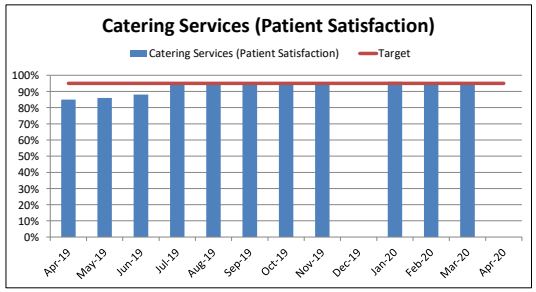

Estates Responsiveness (Priority 2 - Urgent)
Estates Responsiveness (Priority 2 - Urgent)
Target

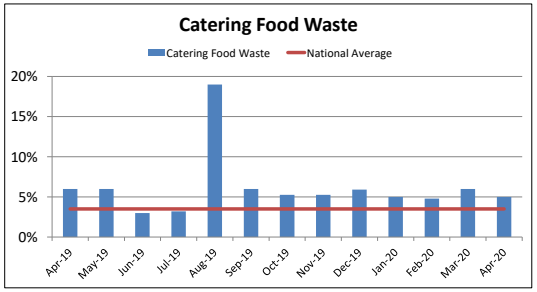

PLACE scores
PLACE scores
National Average


Domestic Services (Cleaning) Very High Risk
Domestic Services (Cleaning) Very High Risk
Target


Domestic Services (Cleaning) High Risk
Domestic Services (Cleaning) High Risk
Target


Meals Served
Meals Served
Target


Catering Services (Patient Satisfaction)
Catering Services (Patient Satisfaction)
Target


Catering Food Waste
Catering Food Waste
National Average

# Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

Against the NHSI/E annualised plan the Trust has a gross deficit of £1.6m before Covid cost recovery (£3.3m). The adapted finance regime requires the Trust to report a breakeven position for M1.

Temporary staffing expenditure was £3.3m of which £1.6m was classified as non-Covid related. As discussed at recent briefings, collective action is underway by the Executive Team to ensure this reduces to reflect the closure of beds/wards and recent stabilisation of services.

Capital expenditure was £1.0m, of which £0.5m is Covid related and subject to NHSI/E review; all Covid capital now requires pre-approval.

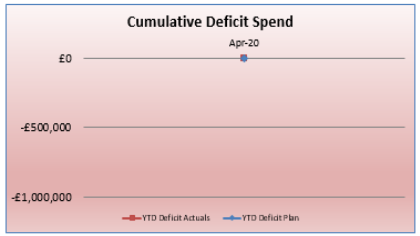
The Trust's 20/21 Capital allocation remains at £40.9m. The Regional office has issued guidance on capital prioritisation process for 2020/21. The STP are coordinating this exercise due for process for submission on 29 May.

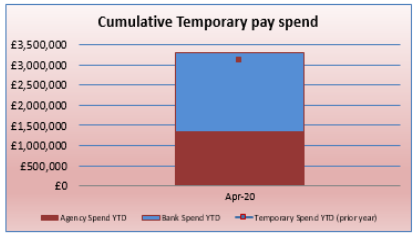
# Pounds

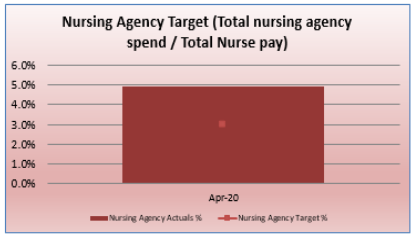
## £ Our Pounds Summary — 5.1 Overall financial position

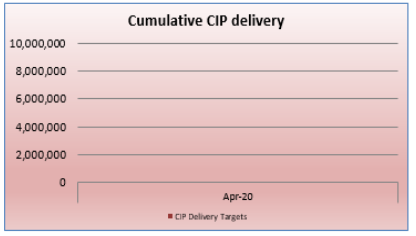
The Princess Alexandra Hospital NHS Trust

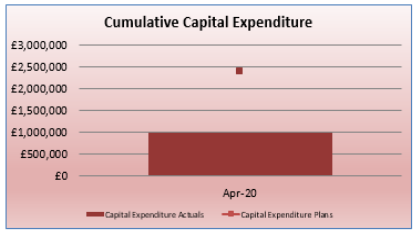
| OUR POUNDS | | |
|---|---|---|
| Metric | Annual Plan | Latest month |
| Deficit | £0 | £0 |
| Agency Spend £s | -£10,292,000 | -£1,341,159 |
| Bank Spend £s | TBC | -£1,946,588 |
| Nursing Agency Target (Total nursing agency spend / Total Nurse pay) | 3% | 5% |
| Capital Expenditure | -£40,903,000 | -£984,500 |
| BPPC Volume | 95% | 87% |
| BPPC - £s | 95% | 88% |
| Cash Balance | £1,000,000 | £26,779,000 |

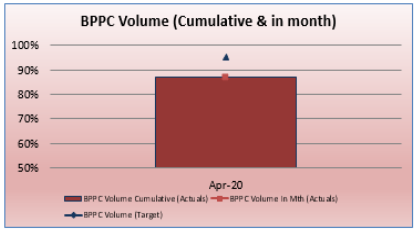


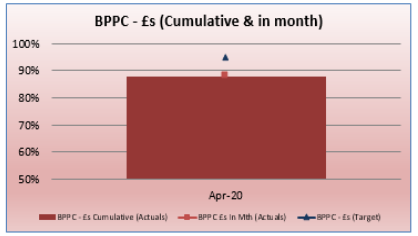



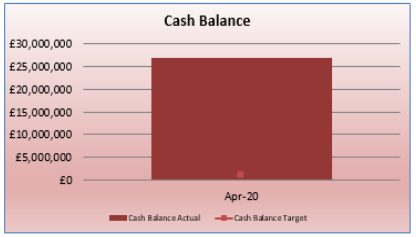




respectful | caring | responsible | committed

# CQC Rating

NHS
The Princess Alexandra Hospital
NHS Trust

CQC

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement Jul 2019 | Good Jul 2019 | Good Jul 2019 | Requires improvement Jul 2019 | Good Jul 2019 | Requires improvement Jul 2019 |
| Medical care (including older people's care) | Requires improvement Jul 2019 | Requires improvement Jul 2019 | Good Jul 2019 | Good Jul 2019 | Requires improvement Jul 2019 | Requires improvement Jul 2019 |
| Surgery | Requires improvement Jul 2019 | Good Jul 2019 | Good Jul 2019 | Good Jul 2019 | Good Jul 2019 | Good Jul 2019 |
| Critical care | Good Mar 2018 | Good Mar 2018 | Good Mar 2018 | Requires improvement Mar 2018 | Good Mar 2018 | Good Mar 2018 |
| Maternity | Requires improvement Jul 2019 | Requires improvement Jul 2019 | Good Jul 2019 | Good Jul 2019 | Requires improvement Jul 2019 | Requires improvement Jul 2019 |
| Services for children and young people | Good Jul 2019 | Good Jul 2019 | Outstanding Jul 2019 | Good Jul 2019 | Good Jul 2019 | Good Jul 2019 |
| End of life care | Good Jul 2019 | Good Jul 2019 | Good Jul 2019 | Good Jul 2019 | Good Jul 2019 | Good Jul 2019 |
| Outpatients | Good Jun 2016 | Not rated | Good Jun 2016 | Requires improvement Jun 2016 | Good Jun 2016 | Good Jun 2016 |
| **Overall*** | Requires improvement Jul 2019 | Requires improvement Jul 2019 | Good Jul 2019 | Requires improvement Jul 2019 | Requires improvement Jul 2019 | Requires improvement Jul 2019 |

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

**CQC Inpatient Survey (OS)**
20 June 2019
This survey looked at the experience of 76,668 people who were discharged from an NHS acute hospital in July 2018. Between August 2018 & January 2019, a questionnaire was sent to 1,250 recent patients at each trust. Responses were received from 422 patients at The Princess Alexandra Hospital NHS Trust.

| Patient survey | Patient response | Compared with other trusts |
|---|---|---|
| The Emergency / A&E department (answered by emergency patients only) | 8.4/10 | About the same |
| Waiting lists and planned admissions (answered by those referred to hospital) | 8.7/10 | About the same |
| Waiting to get to a bed on a ward | 6.8/10 | About the same |
| The hospital and ward | 7.4/10 | Worse |
| Doctors | 8.3/10 | About the same |
| Nurses | 7.5/10 | Worse |
| Care and treatment | 7.6/10 | About the same |
| Operations and procedures (answered by patients who had an operation or procedure) | 8.0/10 | About the same |
| Leaving hospital | 6.6/10 | About the same |
| Overall views of care and services | 2.8/10 | Worse |
| Overall experience | 7.9/10 | About the same |

respectful | caring | responsible | committed

# Commissioning for Quality and Innovation

## 2019/20 CQUIN Forecast

| | Scheme | Target | Current Trajectory | | | | | Max FY Value |
|---|---|---|---|---|---|---|---|---|
| | | | Q1 Act | Q2 | Q3 | Q4 | FY | |
| CCG1a | Antimicrobial Resistance - Lower Urinary Tract Infections in Older People | 90% | 61% | 70% | 80% | 90% | 75% | 244,128 |
| CCG1b | Antimicrobial Resistance - Antibiotic Prophylaxis in Colorectal Surgery | 90% | 0% | 0% | 65% | 90% | 39% | 244,128 |
| CCG2 | Staff Flu Vaccines | 80% | | | | 80% | 80% | 488,257 |
| CCG3a | Alcohol and Tobacco - Screening | 80% | 100% | 90% | 90% | 90% | 93% | 162,752 |
| CCG3b | Alcohol and Tobacco - Tobacco Brief Advice | 90% | 68% | 85% | 90% | 90% | 83% | 162,752 |
| CCG3c | Alcohol and Tobacco - Alcohol Brief Advice | 90% | 52% | 65% | 80% | 90% | 72% | 162,752 |
| CCG7 | Three High Impact actions to Prevent Hospital Falls | 80% | 25% | 26% | 80% | 80% | 53% | 488,257 |
| CCG11a | SDEC - Pulmonary Embolus | 75% | 66% | 75% | 75% | 75% | 73% | 162,752 |
| CCG11b | SDEC - Tachycardia with Atrial Fibrillation | 75% | 80% | 75% | 75% | 75% | 76% | 162,752 |
| CCG11c | SDEC - Community Acquired Pneumonia | 75% | 93% | 75% | 75% | 75% | 80% | 162,752 |
| | | | | | | | | 2,441,283 |

Q1 CQUIN performance totalled c52% with good performance on the SEDC and Alcohol/Tobacco screen schemes. The work to date in implementing the schemes should result in improved performance from quarter 2, with most schemes delivering the target measures from Q3.
The current trajectory reaches a forecast of c70% for the full year. Focus is being put on the Anti-microbial Resistance & Falls schemes (CCG1, CCG7) to improve performance.

The Princess Alexandra Hospital NHS Trust

**Trust Board - 04 June 2020**

5.1

| | |
|---|---|
| **Agenda item:** | 5.1 |
| **Presented by:** | Trevor Smith, Chief Financial Officer (CFO) |
| **Prepared by:** | Tracy Goodacre, Data Protection Officer / Information Governance Manager (DPO / IGM) |
| **Date prepared:** | 19.05.2020 |
| **Subject / title:** | Data Protection Security Protection/Information Governance Update |

| **Purpose:** | Approval | | Decision | | Information | X | Assurance | X |
|---|---|---|---|---|---|---|---|---|
| **Key issues:** | Data Security and Protection Standards for health and care sets out the National Data Guardian's (NDG) data security standards. Completing the Toolkit self-assessment, by providing evidence and judging whether you meet the assertions demonstrates that your organisation is working towards or meeting the NDG standards. The Trust published its toolkit 19 May meeting all 116 mandatory evidence requirements and 44 assertions i.e. full compliance. | | | | | | | |
| **Recommendation:** | The Board is asked to note the report and the submission of a fully compliant Toolkit. | | | | | | | |

| **Trust strategic objectives:** please indicate which of the five Ps is relevant to the subject of the report | Patients | People | Performance | Places | Pounds |
|---|---|---|---|---|---|
| | X | X | X | | X |

| | |
|---|---|
| **Previously considered by:** | Senior Information Risk Owner (SIRO) and Information Governance Steering Group (IGSG). |
| **Risk / links with the BAF:** | Information Commissioner's Office (ICO); Data Security Protection Toolkit (DSPT); NHS Standard Contract 2019/2020 General Conditions CG21.2; General Data Protection Regulations (GDPR); Data Protection Act 2018. |
| **Legislation, regulatory, equality, diversity and dignity implications:** | Data Security Protection Toolkit (DSPT) NHS Standard Contract 2019/2020 General Conditions – section CG21.2. |
| **Appendices:** | |

The Princess Alexandra Hospital NHS Trust

5.1

**Data Security Protection/Information Governance Toolkit 2019/20**

## 1.0 Purpose

1.1 To update the Board on the Data Security Protection Toolkit (DSPT) 2019/20 publication.

## 2.0 Background

2.1 The DSPT replaced the Information Governance Toolkit (IGT) in April 2018.

2.1.1 The DSPT is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards.

2.1.2 The Trust was required to publish a 'baseline' assessment by the 31.10.2019, and did so. In response to the Covid-19 pressures the deadline for publishing the final 2019/20 DSPT return was extended to 30.09.2020.

2.1.3 The 2020/21 standards will be implemented into the DSPT after the 30.09.2020**.**

## 3.0 Analysis

3.1 As of 05.05.2020 the Trust was able to evidence staff compliance with Data Security Awareness training of 96.01% against the mandated 95% target. This was the last mandatory assertion to evidence and the Trust therefore published its DSPT 2019/20 return as 'Standards Met' on the 19.05.2020.

## 4.0 Next steps

4.1 To review the DSPT 20/21 standard and available evidence items with assertion owners once implemented and ensure future on-going compliance.

4.2 The IGSG will continue to report routinely and by exception to Senior Management Team (SMT) when escalation is required in response to queries and progress advancement.

## 5.0 Recommendation

5.1 The Board is asked to note the report and the submission of a fully complaint toolkit for 2019/20.

**Author: Tracy Goodacre, Data Protection Officer / Information Governance Manager**

**Date: 19th May 2020**

The Princess Alexandra Hospital NHS
NHS Trust

**BOARD OF DIRECTORS**

**MEETING DATE: 04.06.20** **AGENDA ITEM NO: 5.2**

**REPORT TO THE BOARD FROM:** **New Hospital Committee (NHC)**
**REPORT FROM:** Lance McCarthy - NHC Chairman
**DATE OF COMMITTEE MEETING:** 11.05.20 (Virtual Meeting)

**5.2**

**SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION**

The following are highlighted for the Board to note or to take action:

- The first meeting of the committee took place on 11 May 2020 and the Terms of Reference were reviewed and recommended to Board for approval subject to minor amendments to the membership section. The terms of reference are attached as **Appendix 1** with amendments highlighted for ease.
- The risk register for the New Hospital programme was reviewed and members agreed that two risks should be escalated to the BAF; a draft BAF risk will be reviewed at the next meeting of the committee.
- The Programme Initiation Document was discussed and agreed subject to minor amendments.

**SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE**

The Committee discussed the following items:

- Terms of Reference and Membership
- Programme Initiation Document
- Current Status (Verbal Update)
- Future Programme/Key Deliverables
- Programme Risks and Issues

**SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN**

A work plan is being developed**.**

The Princess Alexandra Hospital NHS Trust

**2.1.1 APPENDIX 1**

**PAH NEW HOSPITAL COMMITTEE**

**TERMS OF REFERENCE**



**INTRODUCTION:**

The current facilities at Princess Alexandra Hospital are no longer fit for purpose, presenting clinical operational and financial risks to The Princess Alexandra Hospital NHS Trust (PAH). The condition of the estate adversely impacts on PAH's ability to attract appropriate staff and its ability to deliver the required CIPs to ensure financial sustainability. The estate has been identified by the CQC as "*one of the top risks for the Trust*".

Significant investment is required to:

- Maintain the performance of PAH's services or guarantee the safety of its services
- Support the implementation of the Hertfordshire and West Essex Integrated Care Strategy and PAH's aspiration to become an Integrated Care Trust
- Ensure PAH's financial sustainability.

This requirement was recognised with the inclusion of PAH in the government's Health Infrastructure Plan (HIP) as one of the first 6 new large hospitals to be allocated funding for delivery of new hospital facilities by 2025.

PAH's New Hospital Programme is critical in providing fit for purpose facilities to maintain the quality of clinical services for patients and support financially sustainable service transformation to integrated care. It is also essential in ensuring that the future needs of the local population, which is forecast to grow considerably, are met.

**PURPOSE:**

The PAH New Hospital Committee is established under delegated authority from the Trust Board to oversee the strategic direction and progress of the new build and provide a forum to monitor progress of the new hospital programme, including mitigation of risks and management of financial elements.

**DUTIES:**

- To maintain oversight of the governance arrangements for the programme, ensuring robust recommendations are made to the Trust Board on key commercial and strategic decisions;
- To ensure that the right structures, leadership and capability are in place to deliver the project successfully;
- To review the outline business case and full business case prior to making an appropriate recommendation to the Trust Board,
- To have ultimate oversight responsibility for the successful delivery of the programme within the parameters agreed by the Trust Board.
- To monitor the progress of the programme and achievement of its core aims and objectives within agreed timescales, ensuring any potential variances to plan are highlighted in a timely way.
- To ensure the project is delivered in a joined-up way across PAH departments and directorates;
- To take a strategic overview of communications activity;

- To maintain oversight of the Programme Budget and delivery of the project within the agreed Budget;
- To receive regular reports on the action being taken to remove or mitigate the principal risks, and to review and approve updates, monitor controls and examine assurance sources.

**ACCOUNTABLE TO:** Trust Board.

**REPORTING ARRANGEMENTS:** Following each meeting of the New Hospital Committee a report shall be produced for the Board of Directors by the Committee Chairman.

**CHAIRMAN:** Chief Executive Officer

**COMPOSITION OF MEMBERSHIP:**

- Director of Strategy/New Hospital Project Director
- Non-Executive Director x 2
- CFO, COO, CMO.
- Hospital construction specialist
- CCG Representative/ Accountable Officer
- NHSE/I Representative

**ATTENDANCE:** Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee meetings within each reporting year. An attendance record shall be taken at each meeting.

**INVITED TO ATTEND:** The Committee may invite internal and external attendees to attend the Committee to provide advice, support and information. The Deputy Programme Director and Senior Estates Advisor will be required to attend every meeting.

**DEPUTISING ARRANGEMENTS:** In the absence of the Chairman of the Committee, a non-executive member shall chair the meeting.

**QUORUM:** The quorum for any meeting of the Committee shall be two members, one of which must be a Non-Executive member and the Director of Strategy or another Executive member.

**DECLARATION OF INTERESTS:** All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

**LEAD EXECUTIVE:** Director of Strategy

**MEETING FREQUENCY:** Meetings shall be held monthly, but extra-ordinary meetings may be called at key points within the programme

**MEETING ORGANISATION:**

- The meeting shall be closed and not open to the public.
- The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee.
- A draft agenda shall be developed by the Head of Corporate Affairs and lead executive and agreed by the Committee Chairman at least ten clear days* before the next meeting.
- All final Committee reports must be submitted six clear days* before the meeting.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees five clear days* before the

date of the meeting and not less than three clear days* before the date of the meeting.
*'clear day' means any day which is not a Saturday or Sunday or a public or bank holiday.

**AUTHORITY:** PAH New Hospital Committee is constituted as a Committee of the Trust Board. Its constitution and terms of reference shall be as set out above, subject to amendment by the Board as necessary.

The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from inside or outside the Trust with relevant experience and expertise if it considers this necessary

**TERMS OF REFERENCE:** The terms of reference of the Committee shall be reviewed annually and approved by the Trust Board.

**DATE APPROVED:** By Committee:
By Trust Board:



| PAH New Hospital Committee Membership | |
|---|---|
| **Members** | |
| Chair and SRO | Lance McCarthy |
| Director of Strategy | Michael Meredith |
| Non-Executive Director | John Hogan |
| Non-Executive Director | John Keddie |
| CFO | Trevor Smith |
| CMO | Marcelle Michail |
| COO | Stephanie Lawton |
| Hospital Construction Specialist | Andrew Panniker |
| CCG Representative | Andrew Geldard |
| Representative from NHSE/I | Simon Wood/Nigel Littlewood |
| **Attendees** | |
| NHSE/I Land and Planning Advisor – Kevin Hopkinson<br>Deputy Programme Director – Helen Davis<br>Senior Estates Advisor – Mark Cammies | |
| **Secretariat** | |
| Corporate Affairs | |

The Princess Alexandra Hospital NHS
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**BOARD OF DIRECTORS**

**MEETING DATE: 04.06.20** **AGENDA ITEM NO: 5.2**

**REPORT TO THE BOARD FROM:** Quality & Safety Committee (QSC)
**REPORT FROM:** Helen Glenister – QSC Chair
**DATE OF COMMITTEE MEETING:** 22.05.20 (Virtual Meeting)

**5.2**

**SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION**

The following are highlighted for the Board to note or to take action:

**COVID-19:** QSC learned that patient numbers had continued to fall with current numbers of positive patients at 8. Staff swabbing continued and was going well and antigen testing would be rolled out the following week. Decisions would now need to be taken as to how to move forward over the next six months in terms of PPE in light of reducing numbers of cases. The Committee was keen to see the learning from the first phase of the virus, particularly as a second phase was likely.

**Pressure Ulcers:** The paper evidenced that the increase in pressure ulcer acquisition in Critical Care related to the time period in April when COVID patient numbers had surged from 4 to 32 in a 12 day period. A Trust-wide strategy had been developed in January 2020 with the overall aim of reducing total numbers of hospital acquired pressure ulcers by 50% within 12 months. In response to a request from the Trust Chairman it was agreed the aim would now be for zero pressure ulcers over 2020/21, with a phased approach to enable delivery of that.

**Rapid Response Peer Review – Critical Care:** The Committee learned that five of the six recommendations had already been implemented. The remaining one was being addressed by teams who were looking at different modules to support the hospital's strategy going forward and to integrate with EPR. The Committee would be kept updated on the progress of that.

**Recovery Phase/Review Lists:** QSC received an update on the Trust's recovery plans (post Covid-19) and was assured that the impact on patient safety and quality was being scrutinised. In phase 1 of the work patients had been risk stratified and prioritised in line with national guidance; this included patients on a cancer pathway. Phase 2 had now started and some elective work was starting at the Rivers hospital nearby with both patients and staff being swabbed in line with national guidance. Phase 3 of the work (August to March) would look to expand operating services further and build a capacity and demand model which would enable a response to different surges and levels of referral.

**Mortality:** QSC received an update on Mortality and asked for further assurance to be included in future reports around the learning and how that was being embedded.

**Incidents:** Members noted the positive news that 76% of incidents reported in April had been closed and 94% of procedural documents were in date.

BAF Risks: QSC reviewed BAF risk 1.1 (Variation in clinical outcomes) and agreed the risk score should remain at 16. BAF risk 1.0 (Covid-19) was reviewed and members agreed with the recommendation that the risk score be reduced from 20 to 16 to reflect the current risk situation. The BAF risks are included on the agenda for discussion by the Board.

**SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE**

In addition to the above, QSC received reports on the following agenda items:

- M1 Integrated Performance Report
- Monthly Quality, Safety & Effectiveness Report
- Report on Nursing, Midwifery and Care Staff Levels
- Infection Control Update

**SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN**

The Princess Alexandra Hospital NHS
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- The Committee continues to make good progress against the workplan although on this occasion agenda items were deferred by agreement with the Chair due to the current pressures in the hospital relating to COVID-19. The Committee focussed on key areas and areas of risk and safety.

- The workplan for 2020/21 has been revised to reflect new reporting deadlines subject to receipt of final guidance on the Maternity Incentive Scheme and CQUIN.

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**BOARD OF DIRECTORS**

**MEETING DATE: 04.06.20** **AGENDA ITEM NO: 5.2**

**REPORT TO THE BOARD FROM:** Performance and Finance Committee (PAF)
**REPORT FROM:** Pam Court - PAF Chairman
**DATE OF COMMITTEE MEETING:** 28.05.20 (Virtual Meeting)

**SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION**

The following are highlighted for the Board to note or to take action:

5.2

- **Temporary Staffing Costs:** PAF heard of the current plans in place to reduce temporary staffing on nursing with a renewed focus on a forward look (next shift/next day) and a greater challenge on absolute requirements when shifts are booked. With three wards still closed, that also provided a reserve of staff to be redeployed elsewhere. It was agreed the same focus/challenge should be rolled out in terms medical staffing and it was confirmed that work was already beginning.

- **Month 01 –** Month 01 deficit was £1.6m including £3.3m of Covid related costs. Under the adapted financial regime the Trust is required to report a breakeven position.

- **Unaudited Annual Accounts 2019/20**: The unaudited accounts were presented. Substantially all of the audit has been completed although two main areas are outstanding. The two key areas outstanding were (i) finalisation of the Going Concern wording and (ii) finalisation of the current Valuers statement that 'material uncertainty' exists on asset valuations because of Covid-19 impact. Both items do not impact on the Financial Results. The Going Concern note requires an update to reflect recent correspondence from NHSI/E to support all NHS Providers to adopt a Going concern basis. In addition, as the current financial regime outlines Block contract arrangements up until at least October 20 Auditors requested the Board assess delivery of financial plans for the forthcoming 12 months, in particular, that expected CIP deliver to levels to secure FRF funding are reasonable. The Committee discussed and considered going concern status at length. Auditors also noted that their internal consultation on Audit Opinions and Going Concern was still underway with final outcomes not expected to be received from them until mid-June. It was therefore agreed that Board be requested to give delegated authority ahead of the national submission deadline of 25.06.20 to finalise adoption and sign-off of statements.

- **IPR**: Members discussed the plans currently in place, with the support of the Independent Sector to resume elective and urgent/cancer surgery, with PPE requirements being worked through. The red and green pathways at the front door remained in place and there was on-going work around pathway realignment. A detailed IPR will be available for the next meeting.

- **Data Quality**: PAF noted the huge progress made to date and that benchmarked against its peers, the organisation was performing extremely well.

- **BAF Risk 4.2 (4 hour ED standard):** PAF supported the reduction of the risk score from 20 to 16 in light of recent improvements in ED performance.

**SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE**

In addition to the above, PAF received reports on the following agenda items:

- M1 Integrated Performance Report
- BAF risks 5.1 (finance), 1.2 (EPR) and 3.1 (Estate and Infrastructure) - all risk scores remain unchanged.
- Capital & Estates Report
- Annual Report into the Trust's Sustainable Development Management Plan and Carbon Reduction and Sustainability Strategy

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| **SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN** |
| The Committee continues to make progress against its work plan although, as previously, agenda items were deferred by agreement with the Chair due to the current pressures in the hospital relating to COVID-19. The Committee focussed on key areas and areas of risk. |

The Princess Alexandra Hospital NHS Trust

**BOARD OF DIRECTORS**

**MEETING DATE: 04/06/2020** **AGENDA ITEM NO: 5.2**

**REPORT TO THE BOARD FROM:** Audit Committee (AC)

**REPORT FROM:** George Wood – Chair of Audit Committee

**DATE OF COMMITTEE MEETING**: 28/05/2020

5.2

| **SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION** |
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| The following are highlighted for the Board to note or to take action: |
| Annual Accounts and Financial Statements 2019-20:<br>• The unaudited accounts were presented and it was noted that the External Auditors are consulting on the final wording of Audit Opinion and Going Concern (due to the impact of COVID-19) with the final adoption of the accounts requiring these documents. The Committee noted the extensive and detailed discussion of the Accounts that had taken place at Performance and Finance Committee earlier that day; in particular the going concern consideration. The Committee approved the content of Accounts and recommended them to the Board for consideration at the private Board meeting being held on 4 June 2020.<br>• It was recommended that the Board grants delegated authority to approve and sign accounts on receipt of final assurance statements from External auditors with the final submission of accounts due by 25 June 2020.<br>• The Committee noted the Section 30 Referral to the Secretary of State has been made by External Auditors relating to the Trust's failure to breakeven year on year.<br>The Annual Report and Annual Governance Statement were reviewed and recommended to Board subject to the same approvals process noted above.<br>The Head of Internal Audit Opinion was confirmed with a reasonable assurance opinion and the annual Internal Audit report was noted.<br>The committee also received the following reports:<br>1. LCFS Annual Report and NHS Protect Self Review Tool assessment.<br>2. Legal Services Annual Report<br>3. Waivers, Losses and Special Payments |
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| **SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN** |
| The Committee's progress against its Annual Work Plan is set out below: |
| The AC is making good progress against its annual work plan. |