TRUST BOARD - SUMMARY REPORT

Date of Board meeting: 22 October 2014

Name of Report: Chief Executive’s report

Heading: - (Strategy, Quality, Performance & Activity, Governance, Information) Governance

Author(s): Paul Mitchell, Trust Secretary

Approved by (name of Executive member): Dr Matthew Patrick, Chief Executive

Presented by: Dr Matthew Patrick, Chief Executive

Purpose of the report:
To inform the Board of significant issues arising from the local health economy and nationally in the NHS and Social Care. Particular attention is drawn to the update on the Monitor investigation.

Action required:
To discuss items of concern and where necessary initiate additional assurance action.

Recommendations to the Board:
To note the report.

Relationship with the Assurance Framework (Risks, Controls, and Assurance):
The report highlights issues relating to the Assurance Framework arising from the local health economy and nationally in the NHS and Social Care.

Summary of Financial and Legal Implications:
The report highlights any financial and legal Implications arising from the local health economy and nationally in the NHS and Social Care.

Equality & Diversity and Public & Patient Involvement Implications:
The report highlights equality & diversity issues arising from the local health economy and nationally in the NHS and Social Care.

Service Quality Implications:
A number of the national issues listed in the report will have an impact on the quality of services provided by the Trust.
1. National issues

In my last report I referred to the groundswell developing around mental health services nationally. Since then the Deputy Prime Minister has announced the first ever waiting time standards for mental health. There will be new waiting time standards and a five-year plan to bring treatment for mental health problems on a par with physical health, including £120 million to improve mental health services.

For the first time, from April 2015, most patients needing talking therapies will be guaranteed the treatment they need in as little as six weeks, with a maximum wait of 18 weeks. For many patients experiencing their first episode of psychosis, the NHS will start to provide treatment within two weeks of referral.

Other measures include investment in liaison psychiatry services in acute hospitals so that more people who go to A&E in a mental health crisis will get the right help at the right time. In addition there will be a £7 million investment by NHS England to create 50 new inpatient beds for children and young people and better case management so that children with specialist needs receive the right care.

In the same week, to mark World Mental Health Day, Dr Geraldine Strathdee, National Clinical Director for mental health at NHS England, spoke about the importance of improving prevention. She outlined the work NHS England was supporting to train GPs, practice nurses, and clinical commissioning group mental health leads in mental healthcare. She explained that instead of looking at mental health problems as long-term conditions, they should be viewed as a set of acute conditions that require rapid access to the best evidence-based treatments. Within London, the training of CCG mental health leads is being commissioned by the Mental Health Strategic Clinical Network which I currently chair.

2. Trust issues

Monitor update

As a Trust we have welcomed the news that health regulator Monitor has closed its investigation into the Trust. What has been difficult for many is to understand exactly what the investigation was about. Importantly it has never been focused on the quality or safety of SLaM services, which continue to be of a high quality. Rather, it was always focused on governance and assurance, that is the structures and processes that allow the Board to be confident that the reports that it receives are a true and proper reflection of what is happening at a service level. This has included committee structures, membership, terms of reference, and a number of policies and procedures for example. Monitor considered that the many steps already taken, alongside the Trust’s continuing commitment to address other issues raised, will ensure that SLaM has governance arrangements that are of a standard that match the Trust’s commitment to excellence in patient care.

I think that this has been a very positive outcome and I believe that the Trust is in a good place from which to build as a result of our work with Monitor over the past few months. Our attention will now be focused on the further actions that we need to deliver to ensure governance arrangements of the very highest quality. Attached to the report is an updated
action tracker. The SLaM Board will continue to work closely with Monitor to deliver the planned improvements.

Separately, Monitor’s analysis of our Q1 submissions has been completed. Based on this work and the closure of the investigation the Trust’s current ratings are now continuity of services risk rating – 4; governance risk rating – Green.

Monitor will now be requiring monthly finance reports from all FTs. Starting with August data, all FTs will be required to advise their monthly forecast year end surplus or deficit position, and capital expenditure on an accruals basis.

Industrial action
Planned industrial action took place across public services on Monday 13th October 2014 between 7am and 11am. The key priority for the Trust was to maintain the provision of high quality and safe services to patients and this continues to apply during any periods of industrial action. The respective unions who took strike action and Trust management agreed to put in place arrangements to minimise disruption to patient services.

Agreement was reached with local trade union officials that the following were classified as emergency services:

- All inpatient services
- Home Treatment Teams
- A&E Liaison Teams
- Clinical Support services (which are maintained on Christmas Day)

3. Information Governance (IG) Statement
The Health and Social Care Information Centre (HSCIC) released the set of IG standards for Mental Health Trusts for 2014-15. The standards that make up the HSCIC Information Governance Toolkit (version 12) were reviewed by the IG Team for benchmarking. Following the benchmarking exercise, the IG action plan was updated. The Caldicott Committee monitors progress of actions in this plan. The Information Governance Audit Programme for 2014-15, which provides assurance to demonstrate compliance with the IG Toolkit standards is underway.

The first phase of the annual information governance training needs assessments was completed. The initial focus was the central Information Governance Team.

The Trust Caldicott Guardian supported by the Caldicott Committee revised and launched an updated guidance booklet on sharing information with carers and families. The guidance developed in consultation with local family and carer groups emphasised the need to treat carers and families as partners in care whilst providing useful strategies to keep carers and families involved and informed.

The Department of Health undertook a consultation on proposals to strengthen controls and safeguards on the use of an individual’s health and care data. The proposals include allowing a number of organisations accredited by the Secretary of State to create secure safe havens that will have access under strong controls to information from peoples’ personal care records which could be used to identify an individual. The Trust contributed to the consultation in support of the proposed accredited safe havens provided that they are governed appropriately to become a vehicle to improve public awareness and confidence.
4. And Finally…

**Connecting to Patients**
Zoe Reed, Director of Organisation and Community, went to Admiralty House, Whitehall to receive a Special Recognition Certificate from Health Secretary Jeremy Hunt. The certificate was in recognition for the support and involvement of the Trust in establishing the Department of Health’s Connecting to Patients and People who Use Services Programme. Mr Hunt said that this was one of the most significant transformational activities in the Department of Health and was part of their response to the Francis Report. I would like to thank all the Clinical Academic Groups for their great work in designing such good Connecting Programmes which resulted in us receiving the certificate.

**SLaM psychologist shortlisted for NHS Leadership Award**
The NHS Leadership Recognition Awards celebrate leaders at all levels and across all professions who have improved people’s health and the public’s experience of the NHS. Senior Clinical Psychologist Rumina Taylor, who works in Gresham Unit at Bethlem Royal Hospital, has been shortlisted for NHS Innovator of the Year in the London region. This category recognises professionals who transform patient care through putting quality improvement at the heart of what they do. Rumina has been shortlisted for developing and leading a new family service, alongside nursing and medical teams. The service is for inpatients and their families and carers staying on acute wards within Croydon.

**MyHealthLocker lead awarded Rising Star Award**
David Newton, Programme Manager for eMPOWERMENT Programme, one of SLaM’s key members of staff responsible for the development of MyHealthLocker, our online patient portal, was awarded the Rising Star award at the eHI (e-health insider) awards. Many congratulations to David for such richly deserved recognition.

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Dr Matthew Patrick  
Chief Executive  
October 2014

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U / Board / Chief Exec report Oct 14
<table>
<thead>
<tr>
<th></th>
<th>SLaM Monitor Commitments - SMT Tracker</th>
<th>When</th>
<th>Lead</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>We are committing to assess the effectiveness of changes to quality governance through an audit that will be completed by December 2014.</td>
<td>Dec-14</td>
<td>GH</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>We are committing to finalising our work on CAG organisation and to making recommendations in October 2014 for implementation by the end of December 2014.</td>
<td>Oct 14/Dec 14</td>
<td>ND</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>We are committing to deliver the first version of the data quality dashboard by the end of September 2014 and the working data quality dashboard to be embedded by the end of October 2014.</td>
<td>Sept 14/Oct 14</td>
<td>GH</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>We are committing to appoint a new Chief Information officer from a very strong field by the end of September 2014.</td>
<td>Sep-14</td>
<td>MP</td>
<td></td>
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<tr>
<td>5</td>
<td>We are committing to have a revised and updated Information and Technology Strategy to be agreed by the Board in December 2014.</td>
<td>Dec-14</td>
<td>GH</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>We are committing to bring forward the Stage 2 Statutory Maintenance Improvement Plan to the October 2014 Board of Directors (having delivered the Stage 1 Plan 6 months early). Stage 2 improvements will be delivered by the end of March 2015.</td>
<td>Oct 14/Mar 15</td>
<td>ND</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>We are committing to bring forward the revised Estates Service Level Standards together with an external qualitative view of the estates service to the November 2014 Board of Directors, and to implementing all improvements by the end of January 2015.</td>
<td>Nov 14/Jan 15</td>
<td>ND</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>We are committing to bring forward the next stage Ward Renovation Programme covering the year 2015/16 also to the November 2014 Board of Directors (having committed to improve over 20 ward and clinical areas during 2014/15).</td>
<td>Nov-14</td>
<td>ND</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>We are committing to bring forward the OBCs for the four key estates strategy projects to the November 2014 Board of Directors for approval, alongside an external accreditation of our Estates Strategy, with the FBCs being brought forward to the March 2015 Board of Directors for approval.</td>
<td>Nov 14/Mar 15</td>
<td>ND</td>
<td></td>
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<td></td>
<td><strong>Estates</strong></td>
<td></td>
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<tr>
<td>10</td>
<td>the Nominations Committee is committing to work towards appointing a new Chair by early December 2014 (this process having already commenced). Monitor to appoint external assessor to be involved</td>
<td>Dec-14</td>
<td>PM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>We are committing to complete the appointment of a further two new NEDs by November 2014. Monitor to appoint external assessor to be involved.</td>
<td>Nov-14</td>
<td>PM</td>
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<tr>
<td>12</td>
<td>The Board is also committing to appoint a Senior Independent Director and a Deputy Chair in November 2014, once the Board is back up to full strength.</td>
<td>Nov-14</td>
<td>PM</td>
<td></td>
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<tr>
<td>13</td>
<td>We are committing to embedding our Board Development Programme on an ongoing basis to ensure that the Board is always functioning to the top of its skill set. This programme will include a regular focus on succession planning.</td>
<td>PM</td>
<td></td>
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<tr>
<td>Assurance</td>
<td>We are committing to create a resource within the 14/15 internal audit programme to provide additional assurance on pace and progress which will be reported to the Audit Committee as part of their regular reporting.</td>
<td>14/15</td>
<td>GH</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>We are also committing to monthly updates on the public agenda of the Board meetings on progress and pace of delivery.</td>
<td>monthly</td>
<td>MP</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>We committing to invite Deloitte, our most recent external consultants, to revisit the Trust in January/February 2015, with a view to working with the new Chair and Board to ensure that all necessary changes are in place; but also with a developmental remit to see if there is more that we can do to ensure that the quality of our governance properly matches our ambition to deliver the highest quality and safest mental health services anywhere within the NHS.</td>
<td>Jan/Feb 15</td>
<td>MP</td>
<td></td>
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<tr>
<td>16</td>
<td>We are also committing to invite Deloitte to conduct a review against the new Monitor Well-Led Governance Framework to validate changes made.</td>
<td>New Year</td>
<td>MP</td>
<td></td>
</tr>
</tbody>
</table>
### Progress on Deloitte recommendations

This document is a summary update on progress made against recommendations within the Deloitte governance review of SLaM. More detail is available in other evidence submitted to Monitor in August. Recommendations are grouped as by Deloitte into either High or Medium importance categories.

SLaM is a mental health Foundation Trust achieving much in innovation, in research and clinical practice with evidence of good quality patient care. Services are delivered in response to patient need across South London and beyond.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Recommendation</th>
<th>Response</th>
<th>RAQ</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1</td>
<td>The Nominations Committee of the Council of Governors, in consultation with the Chair, should continue to refresh the NED group therefore, they should not extend the term of office of the NED whose term comes to an end in June 2014, but rather seek new appointment.</td>
<td>Two new NEDs to be appointed by November 2014</td>
<td>Complete</td>
<td>Commitment 11</td>
</tr>
<tr>
<td>R3</td>
<td>Develop a comprehensive induction programme for the new NEDs and ensure this is communicated widely.</td>
<td>A comprehensive induction programme for new NEDs has been developed and new NEDs appointed in June 2014 have moved on to this programme.</td>
<td>In progress</td>
<td>Commitments 1 and 13</td>
</tr>
<tr>
<td>R4</td>
<td>Ensure that the current recruitment process for the third vacant NED position includes an opportunity for board members to meet prospective candidates.</td>
<td>In progress as a part of the current process of appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R5</td>
<td>Actively seek NED candidates that will address current gaps in skills and experiences on the board.</td>
<td>Complete</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R7</td>
<td>Monitor the effectiveness of planned changes to board reporting to ensure that it facilitates greater challenge and debate on quality issues.</td>
<td>In progress</td>
<td></td>
<td>Commitments 14 and 15</td>
</tr>
<tr>
<td>R9</td>
<td>Ensure that the board is more easily sighted on the pace of delivery and the consequence of consistent non-delivery or delayed progress.</td>
<td>Complete</td>
<td></td>
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</tr>
<tr>
<td>R10</td>
<td>Introduce best-practice meeting discipline by clearly summarising discussions and action to be taken at the end of each agenda item.</td>
<td>Complete</td>
<td></td>
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</tbody>
</table>

Confidential - Monitor Review Evidence Tracker
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>R12</td>
<td>Introduce a structured formal programme for the engagement of NEDs with staff and service users across the CAGs as a priority.</td>
<td>Complete</td>
</tr>
<tr>
<td>R17</td>
<td>Confirm and communicate the timetable of Quality Committee meetings, and particularly the first meeting, to ensure full attendance.</td>
<td>Complete</td>
</tr>
<tr>
<td>R18</td>
<td>Introduce the Business Development and Investment Committee in shadow form with support from relevant Executive Directors.</td>
<td>Complete</td>
</tr>
<tr>
<td>R24</td>
<td>Implement the Integrated Performance Report that supports the performance management framework and includes metrics to enable the board to monitor the achievement of Trust objectives.</td>
<td>Complete</td>
</tr>
<tr>
<td>R29</td>
<td>Ensure consistency in leadership structures across all of the CAGs.</td>
<td>In progress Commitment 2</td>
</tr>
<tr>
<td>R33</td>
<td>Establish standard terms of reference for the CAG clinical governance meetings, including frequency, agendas, attendees and reporting arrangements to Board committees.</td>
<td>In progress Commitment 2</td>
</tr>
<tr>
<td>R34</td>
<td>Develop corporate and CAG responsibilities in a formal accountability framework following a review of corporate support functions.</td>
<td>In progress Commitment 2</td>
</tr>
</tbody>
</table>
| R35            | Ensure that the changes to the performance management reviews include:  
- Short agenda focusing on quality - finance - workforce/ performance  
- Regular meetings (monthly or bi-monthly)  
- Incorporate a centrally produced dashboard with exception reporting where required  
- Focus on actions/timescales/ownership  
- High profile of the meetings across the CAG leadership teams and wider organisation to demonstrate the importance of these meetings and to set expectations accordingly  
- Involve Clinical Directors and Academic Directors to enhance engagement and accountability | Complete |
| R36            | Establish regular performance management meetings between the CAG leadership team and the Service Management teams which mirrors the format of the CAG performance management meetings. | Complete |

**Medium Importance Recommendations**

Consistent with good governance practice, we do not recommend that the Chair serves a further term given the total duration of her tenure (i.e. 15 years). Within the next three
<table>
<thead>
<tr>
<th>Commitment</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>R2</td>
<td>Months, the Nominations Committee of the Council of Governors, in consultation with key board members, should commence the process to recruit a new Chair, thereby providing sufficient time to find a candidate and allow for a handover period.</td>
<td>Complete</td>
</tr>
<tr>
<td>R6</td>
<td>Provide an opportunity for open and honest debate about the costs and benefits of KHP.</td>
<td>Complete</td>
</tr>
<tr>
<td>R8</td>
<td>Further develop the Committee reporting to the board and consider utilising a combination of minutes, Committee Chair’s reports and a verbal summary of any significant issues alongside the relevant board agenda item. Alongside this, sub-group reporting into Committees should also be strengthened ensuring that there is a clear oversight of escalation routes.</td>
<td>Complete</td>
</tr>
<tr>
<td>R11</td>
<td>Introduce estimated timings to the board agenda to support appropriate allocation of time during meetings.</td>
<td>Complete</td>
</tr>
<tr>
<td>R13</td>
<td>The board needs to formalise a Board Development Programme, which as a minimum, takes into consideration effective challenge, the differences between assurance and reassurance and the role of Board Committees.</td>
<td>Complete but part of ongoing development</td>
</tr>
<tr>
<td>R14</td>
<td>Consider the need for a NED with current relevant financial experience, who is a qualified accountant, to join the board and the AC when the opportunity arises.</td>
<td>Complete</td>
</tr>
<tr>
<td>R15</td>
<td>Increase the membership of the Quality Committee to include at least three NEDs.</td>
<td>To be completed in November 2014 once Board up to full strength</td>
</tr>
<tr>
<td>R16</td>
<td>Appoint the clinical NED as one of the members of the Quality Committee.</td>
<td>To be completed in November 2014 once Board up to full strength</td>
</tr>
<tr>
<td>R19</td>
<td>Revise the terms of reference of the AC, QC and BDIC to explicitly demonstrate the close links and requirement for joint membership and/or regular meetings between the respective Chairs.</td>
<td>Complete</td>
</tr>
<tr>
<td>R20</td>
<td>Introduce a formal assurance and escalation framework that covers all the Board committees and their sub-groups to the Board</td>
<td>Complete</td>
</tr>
</tbody>
</table>

**Confidential - Monitor Review Evidence Tracker**

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South London and Maudsley NHS FT
<table>
<thead>
<tr>
<th></th>
<th>Progress on Deloitte recommendations</th>
<th>South London and Maudsley NHS FT</th>
</tr>
</thead>
<tbody>
<tr>
<td>R21</td>
<td>Appoint a Senior Independent Director and a Deputy Chair.</td>
<td>To be completed in November 2014 once Board up to full strength</td>
</tr>
</tbody>
</table>
| R22 | Improve the NED appraisal process by introducing the following:  
- Formal feedback on their contribution from Executive and Non-Executive Directors  
- Formal feedback on their performance from Governors  
- Revised appraisal documentation that clearly links the Trust objectives to NED performance and supports the appraisal conversation | Complete |
<p>| R23 | Ensure that once appointed, the Senior Independent Director leads the performance evaluation of the Chair. | To be implemented at the time of the new Chair's first appraisal |
| R25 | Ensure the Integrated Performance Report provides benchmarking and insightful interpretation to guide board discussion. | Complete |
| R26 | Identify a series of data quality metrics which will enable the board to identify on-going trends and issues in data quality. Metrics should be reported via a scorecard and all data should have a clear source and owner. | In progress and on-going |
| R27 | Implement the recommendations in a timely manner from the recent Internal Audit Report regarding the use of information to support decision making around patient care. | Complete |
| R28 | Consider the appropriateness of the current time allocated to the Academic Directors in the context of increasing visibility of the role. | Complete |
| R30 | Establish the Head of Nursing role within the CAG leadership team with clear lines of accountability. | In progress |</p>
<table>
<thead>
<tr>
<th></th>
<th>Progress on Deloitte recommendations</th>
<th>South London and Maudsley NHS FT</th>
</tr>
</thead>
<tbody>
<tr>
<td>R31</td>
<td>Clarify the lines of reporting and accountability for the CAG leadership teams.</td>
<td>Complete</td>
</tr>
<tr>
<td>R32</td>
<td>Establish regular meetings between the CAG Service Directors and the COO to share learning across the CAGs.</td>
<td>Complete</td>
</tr>
<tr>
<td>R37</td>
<td>Develop clear performance information in an easy to use format for CAGS and services.</td>
<td>Complete</td>
</tr>
</tbody>
</table>
### TRUST BOARD OF DIRECTORS – SUMMARY REPORT

<table>
<thead>
<tr>
<th>Date of Board meeting:</th>
<th>22 October 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Report:</td>
<td>Report from the Council of Governors</td>
</tr>
<tr>
<td>Heading:</td>
<td>Governance</td>
</tr>
<tr>
<td>Author:</td>
<td>Paul Mitchell, Trust Secretary</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Dr Matthew Patrick, Chief Executive</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Chris Anderson, Council of Governors</td>
</tr>
</tbody>
</table>

**Purpose of the report:**
To update the Board on the current areas of Council of Governors’ activity.

**Action required:**
To note the report.

**Recommendations to the Board:**
To note the report.

**Relationship with the Assurance Framework (Risks, Controls and Assurance):**
The Council of Governors is an integral component of the Trust’s Constitution as a Foundation Trust.

**Summary of Financial and Legal Implications:**
Budgetary provision has been made to support the activities of the Council of Governors.

**Equality & Diversity and Public & Patient Involvement Implications:**
The Council of Governors has a responsibility to ensure that the Trust’s membership is representative of the local populations in terms of diversity and that all members, including those from the patient & public constituencies, are fully involved.

**Service Quality Implications:**
The Council of Governors’ bids programme specifically welcomes bids which “improve the patient experience”.
1. Report from the Nominations Committee

The Nominations Committee has met to review the applications made for two replacement Non-Executive Directors. The recruitment process will continue through October and an Appointments Panel will be convened in mid November. Monitor have requested that an independent assessor is involved in the recruitment process.

An initial discussion has taken place between the Board and the Nominations Committee on the process and timescale for the recruitment of the Chair. Odgers Berndtson have been appointed to assist with the search. The draft specification, advert and timescale have been agreed. Monitor have likewise requested external input to the process.

2. Changes to the Council of Governors

Alastair Edwards has resigned due to personal family commitments. He has been thanked for his contribution to the Council of Governors.

3. Elections

An election process for 2014 has commenced. There are vacancies in the public, staff, service user (local) and service user (national) constituencies. In addition a number of Governors are coming to the end of their terms.

Robert Gay has been elected unopposed as a Service User (national) governor, leaving no vacancies.

Francis Keaney, Tom Medhurst and Helena Taylor-Knox have been elected unopposed as staff governors.

We will be holding elections in the public and service user (local) constituencies. The candidates are:

Public (4 vacancies)

Handsen Chikowore
Jenny Cobley
Alan Hall
Hasani Hasani
Daphne Magidi
John Muldoon
Gillian Sharpe

Service user, local (3 vacancies)

Christine Andrews
Adam Black
Farayi Chikowore
Marnie hayward
Stuart Owen
Michael Tinarwo
4. Reports from Working Groups

Planning and Strategy group
At the most recent meeting the group discussed the strategy document sent to Monitor and the general approach to future strategy.

Ian Creagh has been nominated as the Governor observer on the Audit committee. Angela Flood will attend if Ian is unavailable.

Four public meetings will be held in November to ensure membership involvement in the development of the annual plan:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
<th>Address</th>
</tr>
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<tbody>
<tr>
<td>Thursday 6 November</td>
<td>2.00 to 4.00pm</td>
<td>We are 336</td>
<td>336 Brixton Road, London SW9 7AA</td>
</tr>
<tr>
<td>Monday 10 November</td>
<td>5.00 to 7.00pm</td>
<td>Croydon CVA</td>
<td>London Road, Croydon CR0 2TB</td>
</tr>
<tr>
<td>Monday 17 November</td>
<td>2.00 to 4.00pm</td>
<td>Blackfriars Settlement</td>
<td>1 Rushworth Street, London SE1 0RB</td>
</tr>
<tr>
<td>Thursday 27 November</td>
<td>5.00 to 7.00pm</td>
<td>Lewisham Town Hall</td>
<td>Catford Road, London SE6 4RU</td>
</tr>
</tbody>
</table>

Involvement and Social Responsibility group
This new group will appoint two members to EPIC Board and two members to SIR Board, and feed back to the Council of Governors. Mark Ganderton has agreed to act as chair.

Bids Steering group
All successful and unsuccessful bidders have been contacted. Payments are now being progressed.

5. Membership

Membership cards have now been sent out to all members so that they can access the discount scheme.

Current membership numbers (as at 10/10/14):

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>6,642</td>
</tr>
<tr>
<td>Service User</td>
<td>940</td>
</tr>
<tr>
<td>Carer</td>
<td>327</td>
</tr>
<tr>
<td>Staff</td>
<td>4,812</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,721</strong></td>
</tr>
</tbody>
</table>

Paul Mitchell
Trust Secretary
October 2014

U: / board / cog update report Oct 14
**TRUST BOARD OF DIRECTORS – SUMMARY REPORT**

**Date of Board meeting:** 21st January 2014

**Name of Report:** KHP Board Verbal Update

**Heading:** - (Strategy, Quality, Performance & Activity, Governance, Information) Governance

**Author:**

**Approved by:**  
(name of Exec Member)

**Presented by:** Professor Sir Robert Lechler

**Purpose of the report:**

| To inform the Board of Directors on the progress made on the development of SLaM/IoP Mental Health Clinical Academic Groups and the wider developments across King’s Health Partners |

**Action required:**

| The Board of Directors is asked to approve the verbal report. |

**Recommendations to the Board:**

| The verbal report is for information. |

**Relationship with the Assurance Framework (Risks, Controls and Assurance):**

| One of the purposes of the King’s Health Partners Executive is to ensure that the impact of the development of King’s Health Partners is positive with regard to each constituent organisation’s risks and controls |

**Summary of Financial and Legal Implications:**

| The current report does not contain any legal implications. As the work develops, any significant legal or financial implications will be brought to the Board of Directors for consideration. There are resource requirements to ensure that the Trust contributes to delivery within the King’s Health Partners Strategic Framework 2010-2014 |

**Equality & Diversity and Public & Patient Involvement Implications:**

| A key purpose of King’s Health Partners is to improve the health and wellbeing of local people. In developing their strategies, the CAGs are specifically required to state how they will address the health inequalities reflected in the “heat map”. This of necessity requires that service users and their carers are actively involved in their own care and the developments within services. It also requires that no service user receives less favourable services or outcomes as a result of their ethnicity, gender, disability, sexuality, faith or age. |

**Service Quality Implications:**

| A key driver of the AHSC is the improvement of the quality of the services offered to local people and beyond. This has recently been tested via the accreditation process. Of specific importance to mental health is the closer integration and parity with physical health care. |
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 22 October 2014

Name of Report: Assurance Framework Report

Heading: Governance

Author: Jenny Goody, Governance Manager

Approved by: Gus Heafield

Presented by: Gus Heafield

Purpose of the report:
To present a report on the principal risks that have been identified by the Trust’s Senior Management Team and are thought to most threaten the achievement of the Trust’s objectives in 2014/15.

Action required:
The Board of Directors is asked to review the attached report to ensure that we are satisfied that all principal risks have been identified, and note the key issues raised by the Senior Management Team.

Recommendations to the Board:
Accept the attached Assurance Framework Report, subject to any changes agreed by the Board of Directors.

Trust-wide risk(s) affected by this report and the level of assurance provided (none, low, moderate, high):
This paper forms the basis of the on-going process that ensures risk identification; mitigation and management comply with the requirements of the Trust’s Risk Management and Assurance Strategy and provides moderate assurance on this.

Service Quality Implications:
The first two sections of the Assurance Framework deal specifically with service quality risks.

Summary of Financial and Legal Implications:
The Assurance Framework underpins the statutory requirement to produce an Annual Governance Statement, which confirms that the Trust is appropriately and effectively governed and managed.

Equality & Diversity and Public & Patient Involvement Implications:
The Assurance Framework enables the Board to assess and manage the organisation’s principal risks and ensure that the Trust’s strategic aims are achieved.
# Board Assurance Framework 2014/15

## Introduction

The Trust Board of Directors reviewed the updated Trust Risk Management and Assurance Strategy in July 2014 following the reviews of governance and performance management systems in the organisation. We agreed to keep the Risk Management and Assurance Strategy under review whilst these changes were being embedded across the Trust. There have been no material changes to the systems and processes which warrant an early review of the Strategy and therefore it is proposed that a full review of the Trust Risk Management and Assurance Strategy, including the updated Risk Management committee structure will be undertaken in Quarter 4 and presented to the Board of Directors in March 2015.

This paper represents the first Assurance Framework report following the updated Assurance Framework maintenance process that was presented to the Quality Sub Committee in August and ratified by the Trust’s Senior Management Team in September.

We have worked on distilling the detailed content which Board members and colleagues often found to be cumbersome or rapidly out of date to a brief summary of the key issues which the Senior Management Team can then describe in more detail as appropriate and particularly our judgements over the risks, progress with mitigations and the relevant assurances (which as described can be referenced to other parts of the Board’s agenda). This will continue to develop as we use the document but is intended to make it easier to focus on the issues rather than the process.

## Executive Summary

The Board’s Assurance currently comprises 9 strategic risks, 4 of which are rated Red and two of which also have a Red progress status (late or not delivering as expected); the 9 strategic risks are categorised as follows:

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk Description</th>
<th>Risk Rating</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>High levels of violent and aggressive behaviour by patients on patients and by patients on staff.</td>
<td>12</td>
<td>G</td>
</tr>
<tr>
<td>2.</td>
<td>The Trust’s workforce lacks the correct skills in the correct numbers to ensure services are provided in line with best practice.</td>
<td>16</td>
<td>A</td>
</tr>
<tr>
<td>3.</td>
<td>Failure to provide the quality of service that is contracted and that service users deserve.</td>
<td>12</td>
<td>A</td>
</tr>
<tr>
<td>4.</td>
<td>Demand for services exceeds capacity and contracted levels beyond the parameters of the agreed risk share.</td>
<td>16</td>
<td>A</td>
</tr>
<tr>
<td>5.</td>
<td>Delivery of the Trust’s planned service transformation programmes could have an impact on operational performance and may lead to increases in the number of adverse events.</td>
<td>12</td>
<td>G</td>
</tr>
<tr>
<td>6.</td>
<td>Failure to deliver the financial plan for 2014/15 and contain in year additional cost pressures.</td>
<td>20</td>
<td>R</td>
</tr>
<tr>
<td>7.</td>
<td>The estate is not functionally suitable for key services and particularly ligature risks are identified and eliminated or managed.</td>
<td>12</td>
<td>A</td>
</tr>
<tr>
<td>8.</td>
<td>Performance of the ICT infrastructure and/or insufficient capacity and capability expertise which has a significant impact on experience and efficiency of staff users.</td>
<td>20</td>
<td>A</td>
</tr>
<tr>
<td>9.</td>
<td>Potential changes to the mechanisms for choice and Payment by Results may result in unpredictable movements in income flows and financial and quality pressures in the Trust from April 2015.</td>
<td>12</td>
<td>R</td>
</tr>
</tbody>
</table>
All CAGs and the Finance, Chief Operating Officer and ICT Directorates have provided comprehensive updates on the actions applicable to them. The Senior Management Team (SMT) reviewed these updates at their meeting on 29 September, where it was agreed that, in general, adequate progress is being made towards mitigating these strategic risks.

The key issues identified by the SMT are described below.

AF2 (Workforce) The Ward establishments and budgets have been subject to extensive review and investment to meet our safe staffing requirements. However there are identified challenges in recruiting appropriate staff to the ward and community environments particularly in the context of the AMH and other transformation programmes underway in the Trust. The issues of appropriate staffing continue to be flagged up in the safe staffing exception reports (see Performance Report). The planning is underway for the six monthly review of the safer staffing programme in November 2014.

AF4 (Activity): Whilst significant progress has been made to reduce private sector overspill numbers and these have been very low since the 9 September (albeit with the occasional short term peak in activity) the Trust has provided additional internal bed capacity to meet demand and this will need to be reduced in line with commissioner contract levels from month 7 onwards.

Details relating to the assurances applicable to this risk can be found in the separate Finance and Performance Reports on the agenda of this meeting.

AF5 (Transformation): The scale and scope of the Trust’s transformation programmes is such that there are significant risks to operational performance and particularly potential increases in adverse events. This was recently flagged up at the Quality Sub-Committee of the Board (QSC) and the appropriate mitigation including quality and quality impact measures for the transformation programmes will be developed and considered at the QSC.

AF6 (Financial Balance): Whilst we have hit our financial targets for Q2 of the current financial year the targets for Q3 and Q4 are increasing in line with our plan and there are some significant financial pressures in CAGs and Corporate departments driven by performance pressures or infrastructure priorities where there are not fully worked up mitigation plans. The Executive are working to ensure that there is an appropriate mitigation plan to address any emerging issues together with an assessment of the impact on quality and performance.

Details relating to the issues and assurances applicable to this risk can be found in the separate Performance and Finance Report on the agenda of this meeting.

AF7 (Estate) Progress is on track with the Estates Strategy and improved PLACE scores we have rated as amber as we are continuously seeking to raise our expectations and standards.

AF8 (ICT Infrastructure): Operational ICT has been recognised within the operational plan and Trust vision as a key enabler of delivery and on this basis we have begun a programme of investment this year in improving the capacity and capability of service and business intelligence teams. However there is much more to be done. We have appointed a
new Chief Information officer Stephen Docherty who starts with us in November 2014 and have committed to update our ICT Strategy by Christmas as a platform for continued improvement in user experience. Further investment and improvement in ICT delivery will be a key part of our business planning.

AF9 (Payment by results) Monitor have signalled a requirement to move to a Payment by Results type mechanism for adult mental health services from April 2015 although there appears to still be some potential for discretion on the implementation between commissioners and providers. We have been working closely with our local CCGs to explore the potential implications whilst internally focused on data quality to support any transition the financial context for commissioners and the Trust is such that management of risk where the implications may be difficult to anticipate will be a key issue. Further planning and engagement is ongoing.

CAGs and Directorates will continue to provide comprehensive updates to the strategic risks within the Assurance Framework, including sources of assurance and indicating whether the local risk rating is Improving (↑), Unchanged (↔) or Worsening (↓).

The AF maintenance cycle is summarised again below for reference.

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**Assurance Framework Maintenance Cycle**

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Jenny Goody
Gus Heafield
October 2014
**TRUST BOARD OF DIRECTORS – SUMMARY REPORT**

Date of Board meeting: 22\(^{nd}\) October 2014

Name of Report: EPRR Update

Headings: - (Strategy, Quality, Performance & Activity, Governance, Information) Governance

Author: Patrick Halloran

Approved by: (name of Exec Member) Paul Mitchell

Presented by: Patrick Halloran

**Purpose of the report:**
To ensure the Board is kept aware of a number of significant developments and specific issues in terms of progressing the Trusts’ Emergency Preparedness, Resilience and Response (EPRR) agenda.

**Action required:**
To consider the 3 documents presented.

**Recommendations to the Board:**
1. 2014 EPRR Assurance Process: To note the concerns leading to the Trust self-assessing as ‘Partially Compliant’ against some of the ‘questions’ and the areas of work that require attention as a result of this, and also to note that formal external review of these self-assessments is the next stage of the process.
2. Hillsborough Independent Panel: To note the EPRR related recommendations arising from this report, and also confirm that the Trust has responded to these appropriately.
3. Trust Pandemic Influenza Plan: To formally ratify this plan, noting the numerous and significant amendments from earlier versions.

**Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:**
Effective EPRR arrangements represent key elements of the Trust’s overall governance arrangements, and will enable the organisation to respond effectively to a wide range of potential risks and business interruptions, in the manner required by law, and as expected by various external bodies. Many of these risks are specifically included in the Trust’s risk registers and Assurance Framework.

**Summary of Financial and Legal Implications:**
Emergency planning and all aspects of Business Continuity management are both statutory requirements and the legal, reputational, service and financial consequences of failing in these areas could be extremely damaging to the Trust.

**Equality & Diversity and Public & Patient Involvement Implications:**
Effective planning in these areas will ensure the Trust is better able to manage its response to major incidents and other business interruptions in line with its objectives relating to Equality and Diversity.
2014 EPRR Assurance Process: Report to Trust Board October 2014

Background to 2014 EPRR Assurance Process

The Trust is required to self-assess itself against a number of specific ‘questions’, which themselves are grouped into the headings indicated below (submitted in late September). This self-assessment is scheduled to be reviewed in late October by the NHSE (London) EPRR team, along with the EPRR lead from the Trust’s Lead Commissioner, and an independent peer reviewer from another London MHT at which the Trust is also represented, and is required to explain, and if necessary, justify and defend, the self-assessments it submitted. This process will result in agreed rating for each question, and the subsequent agreeing of an action plan to address any perceived shortfalls or weaknesses in the Trust’s arrangements.

Below is a summary of the outcomes of the self-assessment process with very brief references to points of note amongst those questions assessed as Full and/or Significant compliance. The Trust also self-assessed as Amber (or partial compliance) on a number of points, which will be incorporated into the EPRR planning process over the coming year, and will obviously also be amongst the priorities for EPG and management attention. The Amber areas of most significant concern are referred to below under the appropriate headings, and presented in red text, for ease of identification.

NB. The process also included a category of zero compliance (or Red rating) which the Trust did not self-assess as being against any of the questions. For a Red self-assessment to be appropriate, an issue or concern would need to have been identified, but had no action at all taken to address it.

Governance: 4 Questions - 2 Full; 2 Substantial

Clear and appropriate allocation of responsibilities to those with competence to effectively discharge them; clear reporting and accountability routes for individuals and groups/committees; appropriate policies, plans and programmes in place to address the issues; appropriate arrangements in place for escalation and assurance reporting as necessary to appropriate ‘senior’ forums and ultimately to Board. A formal and comprehensive EPRR work plan has been agreed through which the Emergency Preparedness Group (EPG) will direct and monitor progress against the wide ranging EPRR agenda.

Assessing Risk: 3 Questions - 1 Substantial; 2 Partial

The Trust has a number of risk specific plans e.g. Heatwave, Severe Weather, Fuel Shortage, Pandemic Flu etc. which, if activated, would be ‘managed’ through the Command and Control arrangements described in the Trust EMIP. Partial: due in the main to relatively low level of validation, testing and exercising of such plans.
Trust-wide and local risk registers are maintained, and incorporate risks from local CRR's as appropriate. Trust undertakes a formal annual process of considering the EPRR work plan, its Strategic level risk registers and the Board Assurance Framework in the light of the National Risk Register and Threat Assessments to ensure no potentially significant hazards or threats are overlooked in its Risk, Safety, Emergency and BC planning. The National Risk Assessment informs the work of the Trust EPG as evidenced specifically, for example, by ongoing work on the Trust's Pandemic planning, and more generally in its work on developing robust C&C arrangements. Such work involves appropriate levels of engagement and joint working with relevant partners e.g. Local Health Resilience Partnership; London Area resilience teams, Borough Resilience forums etc. Partial: Due to relative newness of the 'external' element of these arrangements, and the consequent absence of assurances regarding their potential effectiveness, rather than concerns about their actual or likely effectiveness; and need to demonstrate appropriate engagement in the resilience work of each local Borough. Work is ongoing.

**Duty to Maintain Plans: 7 Questions - 1 Full; 5 Substantial; 1 Partial**

All risk specific emergency plans are produced in line with recognised good practice. For instance, the recently redrafted Trust Pandemic Influenza plan was consulted on with experts in both NHSE London, and in PHE, in addition to the appropriate subject matter experts and relevant managers within the Trust.

The importance of effective debriefing as part of the Trust’s overall ‘response’ to a Trust Emergency, Major Incident or significant service disruption, and the need to maximise organisational ‘learning’ from such events is fully recognised, and comprehensively covered in the Trust’s EMIP.

Although not currently considered to be a significant weakness, it is acknowledged that several areas of planning would benefit from introducing more formal systems of 'peer review' with other external organisations and agencies, as well as more formal arrangements for engagement and consultation.

The Partial rating relates to the Communications aspects of the Trust’s Current Emergency Management arrangements, where the Trust has acknowledged the need for a new Communications Strategy and Plan in relation to EPRR, which is to cover internal staff communications, external communications (including social media/website and discharging its 'warning and informing' responsibilities etc), Public Relations, 'media management' and also any 'special' VIP or celebrity arrangements. Partial: This was identified as a necessary piece of work in the 2013 Assurance Process. Progress is now being made by the Trust’s Head of Communications and reported to the Emergency Planning Group.

It is essential to ensure there is in place a formal, structured and comprehensive BC planning approach consistently applied across all the Trust’s sites and services.
Command & Control: 5 Questions - 3 Full; 2 Substantial

Further and ongoing work is required here to ensure the interfaces between the Trust’s various senior level on-call rotas are well understood and effective, that the contacting arrangement are reliable, and that appropriate levels of competence and confidence are developed and maintained amongst all participants, and that Emergency control room can be appropriately supported by trained and competent Loggists.

Duty to communicate with Public: 2 Questions - 2 Partial

These points relate to the Trust’s ongoing duty to communicate appropriately and effectively with the public with regard to EPRR matters (the warning and informing duty), and also the need for effective communication internally and externally during an emergency, including at times when some or all of the communications equipment and/or systems including emergency specific equipment/systems) have been compromised. Partial: This was identified as a necessary piece of work in the 2013 Assurance Process. Progress is now being made by the Trust’s Head of Communications and reported to the Emergency Planning Group.

Information Sharing - Mandatory Requirements: 1 Question - 1 Partial

The above partial relates in part to the Trust’s need to produce an EPRR Communications Strategy and plan. It is also acknowledged (and work is already underway) that Information Governance input will be required to ensure that EPRR needs are not undermined by restrictions/delays resulting from inappropriate application of IG related requirements.

Co-operation. 5 Questions - 2 Full; 2 Substantial; 1 Partial

The Trust actively engages in NHSE London (South) EPRR network; in the recently established EPRR London mental health forum; through attendance by AEO at the 'South' LHRP patch meetings, and in occasional relevant specific projects and/or consultation exercises etc. both with NHSE London and also partner organisations. The potential value of Mutual Aid is acknowledged and ongoing opportunities to formally investigate and plan for such possibilities will continue to be explored. Partial relates to the need to increase efforts to ensure that the Trust is appropriately aware of and involved in relevant EPRR work across all its sites and services, through appropriate engagement in the five local Borough Resilience forums.
Training and Exercising: 2 Substantial; 2 Partial

The Trust does involve itself, as appropriate, in occasional multi-disciplinary exercises of other organisations, and also seeks to maximise learning from actual incidents (including those requiring a multi-agency response).

Although The Trust is able to demonstrate a number of examples of addressing specific EPRR training needs, it also acknowledges the work still to do to introduce a more structured and formal Training Needs Analysis type approach to the wider EPRR agenda in order to identify key managers and staff and their associated EPRR related needs.

The Trust acknowledges the need to introduce a more formal exercising schedule, and also the fact that this, in the main, needs to be preceded by appropriate EPRR training.

Whilst accepting the need to demonstrate the competence of all involved in EPRR planning and response, the Trust does not require the Directors and senior managers participating in the Director on Call rota to specifically maintain a CPD portfolio relating specifically to EPRR, and neither does it believe such an approach would be either workable or appropriate.

Patrick Halloran  October 2014
LESSONS LEARNED SINCE THE HILLSBOROUGH DISASTER

This report is an update on work completed by NHS England (North) following the publication of the report by the Hillsborough Independent Panel in September 2012, and on the actions arising from this work subsequently set out for completion by LHRPs across the rest of the country.

The Board is to be reassured that the Trust has taken appropriate action to respond to the recommendations that apply to it, and also the wider ranging and more fundamental lessons from the Independent Panel’s report as they relate to full, open and honest investigations, the need for candour in investigations and reporting incidents with the potential to reflect negatively on an organisation, and the need to learn from experience (negative and positive) in EPRR terms from organisational, Health sector and London-wide perspectives.

Background

In April 1989, ninety-six people died at the Hillsborough Stadium disaster. Hundreds more were injured and thousands were traumatised in the event, which has been recognised to be the worst stadium disaster in England’s history.

The Report of the Hillsborough Independent Panel was detailed in its methodology and analysis of events, and added significantly to the understanding of the context, circumstances and aftermath of the disaster. In doing so it enabled the NHS and partner agencies to reflect and comment upon their state of preparedness for any such emergencies in future.

In December 2012, following an application by the Attorney-General, the High Court overturned the verdicts in the original inquests and ordered fresh inquests to be held. Lord Justice Goldring was appointed as Assistant Coroner for South Yorkshire (East) and West Yorkshire (West) to conduct those inquests, and these commenced on 31 March 2014.

NHS Response to the Hillsborough Independent Panel Report

In October 2012, shortly after the release of the Hillsborough Independent Panel Report, the then NHS Chief Executive, Sir David Nicholson, wrote to all NHS Trust Chairs and Chief Executives, and to the Chairs and Chief Executives of the former Primary Care Trusts and Strategic Health Authorities, advising that they should consider the report carefully and review their systems and processes for responding to major incidents.

Since this letter a number of large-scale changes have taken place to the NHS architecture, including many with particularly significant implications for the arrangements for planning for and responding to Major Incidents.

The former SHA in the North committed to undertake an analysis of the NHS systems and processes for managing incidents at large crowd events in Yorkshire and the Humber region. The North Regional Team, supported by colleagues in Area Teams and provider organisations in Yorkshire have now completed this review, and NHS England considered it important to build on this work and share it with all Regional Teams.

The review made a number of recommendations which were widely applicable to all LHRPs and as such, were shared with these forums. The National Lead for EPRR also produced a briefing note for all Area Teams Operations and Delivery Directors, and Heads of EPRR explaining the required response to the recommendations of the review.
South London and Maudsley Trust has provided assurances to NHS England (London) via Paul Mitchell, the Trust’s Accountable Emergency Officer that it did indeed, consider Sir David Nicholson’s letter of October 2012, and also that each of the recommendations of the review was considered and, where appropriate, acted upon as required. The detail of the action in each case is as described below.

**NB.** It was also noted that the return submitted to NHSE (London) was to be formally presented to the Board as part of an EPRR update at which progress on the wider EPRR agenda in general (along with specific EPRR related issues such as this ‘Hillsborough response’) and details of the annual EPRR assurance process, were to be formally brought to the attention of the Board.

The twelve recommendations of the review, which NHS England requested each of the five Regions to respond to are listed below along with, in each case (and in order to provide some context) the NHS England response and the NHS London response. Where the recommendation is applicable to SLaM, this is indicated, along with SLaM’s response in each case (reproduced alongside it).

### Recommendations Arising from the North Region Review

**Recommendation 1** Ensure the review is considered by relevant NHS England professional networks and groups, specifically, medical, operations & delivery and emergency preparedness, resilience and response.

**NHSE (London) Response:** The review and its report will be circulated across networks in London as part of the distribution of the LHRP minutes.

**SLaM:** No action required

**Recommendation 2.** NHS England area teams, in overseeing the commissioning by Clinical Commissioning Groups, should continue to work with their local ambulance services and Local Health Resilience Partnership to actively evaluate the effectiveness of the engagement of ambulance services in Safety Advisory Groups (SAGs).

**NHSE (London) Response:** London Ambulance Service engages fully in all SAGs with regard to large scale events held in London, produces event plans and communicates with relevant health partners. NHS England (London) EPRR team also attend SAG events and contribute to the multi-agency planning where appropriate.

**SLaM:** No action required

**Recommendation 3.** NHS England should make sure effective debriefing from actual or potential incidents is completed and all appropriate learning is shared and implemented across the local and the wider NHS, where relevant, enabling incident plans to be updated. This could be considered as part of the annual Emergency Preparedness, Resilience & Response (EPRR) assurance process.

**NHSE (London) Response:** NHS England (London) encourages all NHS organisations to undertake a full debrief and report process following incidents and exercises, including the highlighting of any learning to allow lessons to be incorporated into plans as early as possible. NHS England (London) produces reports for any incidents that it is involved in, and shares with LHRP partners. NHS England (London) encourages all NHS providers in London to produce reports following incidents, to share recommendations and best practice.

**SLaM Applicable Recommendation:** Providers of NHS funded care are asked to confirm that they undertake debriefing as part of the recovery to any incident or exercise, and that any recommendations are shared appropriately.
SLaM Response: Effective debriefing is recognised as an important element of the Trust’s overall ‘response’ to a Trust Emergency, Major Incident or significant service disruption, and appropriate reference to this is therefore included in the Trust’s Emergency and Major Incident Plan (EMIP).

The aim of debriefing in this context is to ensure the Trust’s response is critically and comprehensively evaluated and that all opportunities are identified for both reducing the likelihood of recurrence of the event or situation, and also mitigating the harmful or damaging consequences of the event should it recur.

The debriefing section of the EMIP makes specific reference to the need for this post incident investigation and analysis to result in sensible and proportionate recommendations which must then be considered in terms of their potential wider relevance and applicability across all the Trust’s services. Where such recommendations might also have relevance or value for other organisations, the EMIP specifically requires that they are also formally brought to the attention of NHS England (London) in order that they might be shared as appropriate across London healthcare organisations.

Recommendation 4. NHS England, via the LHRP, should actively seek assurance from NHS funded organisations with a responsibility to plan for, and respond to, major incidents, that they have tested these activation processes and they are clearly understood by staff. This should be accompanied by evidence that staff training in major incident response is.

NHSE (London) Response: NHS England (London) delivers a comprehensive annual EPRR assurance process across all NHS organisations in London based on the EPRR Core Standards, including the review of plans and training.

NHS England (London) undertakes monthly communications exercises with all NHS organisations in London, to ensure that central

SLaM Applicable Recommendation: Providers of NHS funded care are asked to confirm that they have trained and exercised appropriate staff who may be expected to respond to a major incident.

Providers of NHS funded care are asked to confirm that they undertake communications exercises at least six monthly.

SLaM Response: The Trust has identified a number of staff with key roles and responsibilities relating to responding to Trust Emergencies, Major Incidents or significant service disruptions, and training has been offered to, and taken up, by many of these individuals.

The Trust accepts that there is more to do in this regard and is looking to introduce a more structured and formal Training Needs Analysis type approach to the whole EPRR agenda in order to identify key managers and staff and their associated EPRR related needs in this regard, and to enable it to consider appropriate training and information related interventions to address these.

Although this is obviously an ongoing piece of work, some key achievements over the last year or so in this regard should be noted.

23 senior managers attended two evacuation planning workshops run in May 2013
14 attended a workshop to launch the Trust’s new Fire Safety Management System May 2014
The Trust is currently negotiating with PHE to run a day Loggist workshop which it is hoped would result in at least an additional 24 trained Loggists, to add to the 11 already trained following a similar session 2 years ago.
17 senior managers attended a Project Argus workshop (facilitated by NACTSO) in May 2014

The Trust has been keen to ensure that its most senior managers are aware of the EPRR agenda and the likely demands on an organisation during a large scale Emergency or Major Incident. Eight of the Director and senior managers who participate in the Trust Director on Call rota have attended the one day Strategic Leadership in a Crisis workshop sponsored by NHS England (London)
Emergency Communications Exercises have been, and continue to be, undertaken every six months with recommendations arising from these being followed up as appropriate. The Trust continues to perform well in the regular Communications Exercises run by NHS England (London)

**Recommendation 5.** NHS England, via the LHRP, should seek assurance from relevant NHS funded organisations and commissioners, of the ability of the local health care system to provide Medical Emergency Response Incident Team (MERIT) capability in a major incident response. This should also be considered for reporting as part of the annual EPRR assurance process.

**NHSE (London) Response:** London has a fully developed and integrated MERIT system, which is delivered by HEMS via LAS.

**SLaM:** No action required

**Recommendation 6.** NHS England should complete regular reviews of the state of readiness and suitability of specialist ambulance resources (e.g. HART) to ensure a capability is maintained effectively to respond to significant incidents beyond normal major incidents.

**NHSE (London) Response:** LAS, including HART resources, are included within the annual NHS England (London) assurance process.

**SLaM:** No action required

**Recommendation 7.** LHRPs to consider and action as appropriate this review and NHS England Co-Chairs to report the outcome of these considerations with their relevant Local Resilience Forum.

**NHSE (London) Response:** Review to be an agenda item at the LHRP and Patch LHRPs.

**SLaM Applicable Recommendation:** AEOs from NHS funded organisations are asked to provide a signed return as evidence that these recommendations have been reviewed by their Board.

**SLaM Response** The Trust’s AEO Paul Mitchell signed and returned the paper as required.

**Recommendation 8.** LHRPs should ensure their ambulance services remain fully engaged in SAGs, and via the LHRP, that all NHS funded organisations with a role in responding to a major incident at large crowd events are aware of the type of event and the potential impacts on health services to the local population for the duration of the event, or should a major incident occur.

**NHSE (London) Response:** London Ambulance Service engages fully in all SAGs with regard to large scale events held in London, produces event plans and communicates with relevant health partners.

**NHSE England (London) EPRR team also attend SAG events and contribute to the multi-agency planning where appropriate.**

**SLaM Applicable Recommendation:** NHS funded organisations are asked to confirm that they are represented at key Safety Advisory Groups for large scale events occurring within their geographical area?

**SLaM Response:** The Trust is not formally a member of any such local SAG. However, the working arrangements and relationships between the Trust and its five ‘main’ local Boroughs (and associated engagement with their respective LRF’s) inspire confidence that, as and when formal involvement with one or more SAG’s with regard to any specific safety related risk was thought to be required or beneficial, this would occur in response to the relevant Borough making this fact known.
Recommendation 9. LHRP member organisations should take the opportunity to review their emergency preparedness and resilience arrangements in their local area in line with Sir David Nicholson’s letter of October 2012, and the LHRP should be able to demonstrate that the lessons from the Hillsborough Independent Panel Report have been considered and any recommendations implemented accordingly by local partner organisations. NHSE (London) Response: All NHS organisations in London undertake an annual EPRR review as part of the assurance process. The London LHRP will task the Patch LHRPs to obtain signed statements from NHS funded providers, to confirm that these lessons have been considered.

SLaM Applicable Recommendation. AEOs are asked to confirm by signing and returning a copy of this letter once it has been reviewed by the organisations Trust Board.

SLaM Response: As per Recommendation no. 7

Recommendation 10. LHRPs should ensure that the learning from any exercises, and any incident that produces a number of casualties, is identified, shared amongst relevant NHS providers, and reflected in major incident planning. NHSE (London) Response: NHS England (London) encourages all NHS organisations to undertake a full debrief and report process following incidents and exercises, including the highlighting of any learning, and that this is shared across all NHS partners via the EPRR newsletter. NHS England (London) produces reports for any incidents that it is involved in, and shares with LHRP partners.

SLaM Applicable Recommendation: Providers of NHS funded care are asked to confirm that they undertake debriefing as part of the recovery to any incident or exercise, and that any recommendations are shared appropriately. SLaM Response: As per Recommendation no. 3

Recommendation 11. LHRPs may wish to use their remit to assure that all NHS funded providers with a requirement to plan for and respond to major incidents, have joint communications/media plans in place as part of their major incident plans. HSE (London) Response: All plans are reviewed as part of the annual EPRR assurance process, including the presence of comms/media arrangements.

SLaM Applicable Recommendation. NHS funded organisations are asked to confirm that they have media/communications plans in place, and that they are linked to their major incident response.

SLaM Response: The Trust has both media and communications plans, which are also integral elements of its Emergency and Major Incident Plan (EMIP). Work is currently in hand on reviewing and updating both of these, partly in recognition of the very fast moving nature of both the media and communications ‘environment’ and the need for the Trust to ensure it keeps up to date with all relevant developments in these areas, and attempts to response appropriately to, and benefit from, for instance the rapid developments in social media.

Recommendation 12. Airwave radio systems should be exercised and tested under full scale exercise conditions on a regular basis to identify any capacity or interoperability problems with the network. NHSE (London) Response: Airwave arrangements are currently under review by the blue light services. SLaM: No action required
PANDEMIC INFLUENZA PLAN

This Plan provides background information, advice and planning guidance to enable the South London and Maudsley NHS Foundation Trust (the Trust) to maintain agreed levels of essential services during an Influenza Pandemic, and to plan for recovery following such a situation.

The Plan applies to all staff employed and seconded within the Trust, to all its patients, service users, carers, visitors and any organisations contracted to work on sites operated or owned by the Trust, as well as to all Trust staff working on premises not owned by the Trust.

This Plan, in common with all the Trust’s emergency and business continuity plans will be updated as new guidance is made available and following recommendations from internal or external exercises or ‘relevant’ incidents. The Plan will also take account of developments in the configuration and structures of the NHS in terms of the effects on local trusts, providers, commissioners and other bodies (and their changing responsibilities re emergency preparedness) to ensure it remains relevant and up to date.

<table>
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<th>Summary of changes</th>
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<td>v.1</td>
<td>Circulated for comment</td>
<td>February 2012: Trust Board</td>
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<tr>
<td>v.2</td>
<td>Incorporating all implications of the move away from the WHO Pandemic Phases and the introduction of the UK’s new Alert Levels and associated DATER approach; updating to take account of the significant NHS reorganisation (including the impact on EPRR arrangements of April 2013).</td>
<td>October 2014 Trust Board PENDING</td>
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Author: Patrick Halloran; Emergency Planning Liaison Officer
Executive Lead: Martin Baggaley
Ratified by: Trust Board
Date: October 2014
Review Date: October 2015
FOREWORD

The Trust has a duty to protect and promote the health of the community, including during times of emergency, (for example, during an Influenza Pandemic) with various elements of this duty made explicit in the requirements of the Civil Contingencies Act 2004.

This Plan outlines the contingency arrangements to be implemented within South London and Maudsley Mental Health Foundation Trust (the Trust) in response to the threat, and/or the formal declaration of an Influenza Pandemic. Any formal declaration of an Influenza Pandemic will trigger the activation of the Trust’s Emergency and Major Incident Plan (EMIP). These two Plans should therefore be considered together.

A pandemic will differ from most Trust emergencies and major incidents in that there is likely to be at least 2-4 weeks warning of its ‘arrival’ and it may then continue for up to two years coming in three or four waves with variable amounts of time in between each wave.

The Plan acknowledges that the Trust will have to work differently in order to optimise the use of the restricted resources available to it, and to maximise capability for caring for its client group and staff. It is likely that staff will need to be flexible and to work in unfamiliar environments, possibly for extended periods, and the Trust will rely on your co-operation and support if such arrangements become necessary, in order to effectively manage during such a crisis. Such work may include:

- caring for individuals who would normally be looked after by primary or general secondary care;
- working in different areas and on different tasks to your usual routines;
- broader consideration of physical symptoms influencing admission, placement, treatment and discharge decisions.

The Plan provides background information on the probable nature and impact of an influenza pandemic, and details the arrangements to be put in place in response to a pandemic. It also provides information and guidance relating to important Business Continuity concerns likely to arise during a pandemic, and offers advice and guidance on relevant Infection Control matters.

Every member of staff will play a vital role in ensuring a professional and effective Trust response to a pandemic, and you must therefore be familiar with, and understand, the content of this Plan in terms of your own specific responsibilities, those of any staff you manage, and the roles of other organisations you may be asked to work with.

The Plan is intended to be flexible in order to allow the Trust's response to adapt as a pandemic evolves, and as knowledge relating to the new virus, its impact and the effectiveness of available countermeasures emerges. Improving preparedness is a continuous activity and this Plan will be reviewed and updated on an ongoing basis, so as to take account of relevant new knowledge, advice and guidance. We will also need to ensure that appropriate testing of the Plan, together with appropriate exercising and training is undertaken in readiness for a pandemic.

In the event of a pandemic, this Plan would be activated and implemented by the Trust’s Pandemic Outbreak Control Team in similar fashion to the arrangements for the Trust Incident Response Team described in the Trust Emergency and Major Incident Plan. The Pandemic Outbreak Control Team will liaise closely with appropriate Trust senior managers and those in partner organisations throughout the duration of the pandemic.

Comprehensive and effective planning for an Influenza Pandemic is a requirement of good governance, and as such, is considered to be a priority within the Trust. I therefore ask that you read and familiarise yourself with this Plan and with your own responsibilities, and those of your staff in this regard.

Matthew Patrick: Chief Executive
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1. PURPOSE, STRUCTURE & MANAGEMENT OF THE PLAN

1.1 INTRODUCTION TO THE PLAN

Mental Health services are critical public services that should be maintained, as far as is reasonably practicable, during a pandemic. Mental Health services are provided across a spectrum of user groups, including children and adolescents, adults of working age and older people. In addition, they include services for people who have learning disabilities, misuse substances or who require forensic mental health services.

During a pandemic, the Trust’s service users may need additional assistance and guidance in order to access primary and secondary care services for their physical health needs. The Department of Health’s ‘Pandemic Influenza Guidance on preparing mental health services in England’ sets out the potential impact of a pandemic on mental health services. The Civil Contingencies Act 2004 also requires the Trust to plan for a pandemic, and outlines the roles and responsibilities of Category 1 responders during an emergency, with some of the specific requirements in this regard made explicit in the Health and Social Care Act 2012.

The management of any major incident is invariably difficult, but particular challenges are inherent in the management of an influenza pandemic. Preparation, planning, training and testing of plans are essential to maximising the effectiveness of any response. This Plan does not remove the need to prepare contingency plans for specific possible incidents or scenarios, in line with the Trust’s existing Business Continuity Management processes, nor should it in any way supersede or contradict the Trust’s Emergency and Major Incident Plan (EMIP). Indeed, all Directors and Trust managers should consider this Plan in conjunction with the Trust’s EMIP and the various Business Continuity plans for each service.

1.2 PURPOSE OF THE PLAN

This plan provides a framework for coordinating the Trust’s response to an influenza pandemic, and includes information relating to the decision making arrangements to be implemented and other possible actions that may prove necessary in order for the Trust to function effectively during a pandemic.

In line with national guidance the plan is intended to be:

- Flexibly constructed so as to be able to deal with a wide range of possibilities;
- Built on effective service and business continuity arrangements;
- Responsive to local challenges and needs; and
- Supported by strong local, regional and national leadership

Once activated, this plan contains precautionary, yet proportionate, procedures that allow the Trust to:

- Comply with agreed Pandemic Influenza reporting requirements;
- Contain and minimise the spread of the virus if any part of the Trust is affected;
- Ensure that essential services are maintained at pre-agreed levels;
- Prevent and reduce the likelihood of transmissions of influenza;
- Provide treatment and care for those who become ill in the Trust’s care;
- Cope with large numbers of ill patients and staff;
• Consider different ways of working in order to support clients, their families and carers;
• Ensure vulnerable service users are identified and are able to access primary and secondary care;
• Reduce morbidity and mortality from influenza illness among staff;
• Promote partnership working and integrated local response within Croydon, Lambeth, Lewisham and Southwark;
• Make appropriate arrangements, relevant to the outbreak, for the protection and safety of patients and staff;
• Slow or limit the spread of infection by supporting self-care in the home, and by ‘taking care to the service user’ (rather than service users to care) wherever possible;
• Assist service users to access primary care assessment and prompt treatment with antiviral and other medicines if indicated and appropriate;
• Ensure the continued delivery of essential services for people with influenza and its complications and for ‘non-influenza suffering’ service users;
• Provide vaccination to identified groups of staff and service users (if and when suitable vaccines become available) as advised and appropriate;
• Ensure maximum utilisation of other public health measures such as robust infection control;
• Co-ordinate appropriate communications with existing and potential service users;
• Provide timely, authoritative and up-to-date information for staff and all other stakeholders
• Receive or provide ‘Mutual Aid’ as appropriate; and
• Return to ‘normal’ working after each local outbreak and after each ‘wave’ of the pandemic, as rapidly and efficiently as possible.

1.2.1 Audience
The main audience for this plan is Trust staff, especially Directors and senior managers who will be making a critical contribution to co-ordinating an effective Trust response to a pandemic. The Plan may also be useful for local partner organisations and local responding organisations (as defined by the CCA) to assist them in understanding the nature and scope of the Trust’s proposed response.

1.3 STRUCTURE OF THE PLAN

Section 1 describes the purpose of, and background or context to, the creation of this Plan, and the arrangements through which the Plan itself will be managed.

Section 2 provides some basic information relating to the threats posed by Influenza pandemics, and the possible impact of such an outbreak, as well as offering some information on the Influenza strains currently being monitored.

Section 3 on International and National planning response phases reflects the UK’s introduction of a flexible, precautionary and proportionate approach, (i.e. DATER), which is able to respond as required, on a regional basis if appropriate, according to the level and severity of the disruption being faced.
Section 4 describes the arrangements by which NHS-wide Pandemic planning is managed, whilst Section 5 goes on to describe in detail the responsibilities for Pandemic planning within the Trust, and also the detail of its engagement with London-wide planning.

Section 6 describes the actions to be taken by the Trust during a Pandemic, concentrating in general terms on the principles of service prioritisation, and the management arrangements for managing a response across the Trusts CAG’s and many sites.

Section 7 raises a number of Pandemic related issues for managers to consider in terms of both planning and response, whilst Sections 8 and 9 specifically address in some detail the issues of Communications, and Staff Management and Welfare.

Section 10 considers issues around Recovery following a pandemic, and Section 11 lists a range of potential Business Continuity related concerns that local planning must consider. This section (11) is included purely for the sake of completeness, and for convenience, as most of this content is also included within the Trust's Business Continuity Programme, its Business Continuity Policy and associated Guidance papers and other documentation.

Section 12 is a summary of Infection Control Guidance, included in order to inform planning. In the event of Pandemic, additional and significantly more comprehensive and detailed guidance would be drafted and made widely available, along with the various training initiatives that would have to accompany such guidance.

1.4 MANAGEMENT OF THE PLAN

1.4.1 Legislative Compliance

The Department of Health has issued guidance to all health organisations with instructions to plan for an Influenza Pandemic, and NHS trusts are also required to undertake comprehensive Business Continuity Planning as one of the specific duties of the Civil Contingencies Act (2004).

This Plan has been written to comply with the Department of Health document “Pandemic Influenza: A national framework for responding to an influenza pandemic 2007”, the Civil Contingencies Act (2004), and the Department of Health’s NHS Emergency Planning Guidance 2005, as well as a wide range of other guidance from the DH, Cabinet Office, and other interested parties.

A list of references and sources of further information and Guidance is included as Appendix 1.

1.4.2 Relevant Trust Policies

The Plan details the specific actions required of the Trust in order to contribute to an integrated and effective London-wide response to an influenza pandemic. The roles of various organisations and the intended lines of communication between these and the Trust are also described.

The following Trust Policies, Plans and Procedures have been referred to in this document, and those with responsibilities relating to the Trust’s response to an influenza pandemic should ensure that they are familiar with the relevant content of these documents:

- Infection Control Policy
- Hand Hygiene - Clinical Guideline
- Standard Infection Control practice - Clinical Guideline
- Physical Healthcare Policy
- Standing Operating Procedures for influenza vaccination
- Trust Emergency and Major Incident Plan
• Trust Health and Safety Policy
• Trust Business Continuity Policy
• Trust Business Continuity Plan

The Plan should also be read in conjunction with the Influenza Pandemic Committee plans for each local Borough.

1.4.3 Training & Exercising
A range of exercises will be designed to rehearse and test specific elements of the Plan and to ensure that its content is both appropriate and relevant, and these may well be undertaken in conjunction with elements of the Trust’s EMIP and business continuity plans.

Exercises should involve both plan validation and the rehearsal of key staff roles. They should seek to confirm that plans and systems can be operationalised, and would also be expected to identify any problems or weaknesses in the plans, along with any erroneous assumptions on which the plans might be based.

The need for training on specific Infection Control and Pandemic Influenza procedures will be identified along with the various ‘target groups’ for each such intervention, and a planned approach for the design, sourcing and delivery of such training will be overseen by the Trust’s Emergency Preparedness Group (EPG), or following a pandemic being declared, by the Trust’s POCT.

It should be noted that, in line with a prioritised approach to the risks faced, much of the training and exercising referred to above would be of a relatively infrequent and general (rather than purely ‘pandemic specific’) nature, and would probably usually be combined with other BC, Emergency, Infection Control or Safety related initiatives. In the event of the threat of an Influenza Pandemic being considered more likely, and/or its ‘arrival’ being more imminent, the Trust would (through its Emergency Preparedness Group) ensure the range and intensity of training was increased as appropriate, and that the numbers of staff groups receiving it was extended accordingly.

1.4.4 Plan Distribution
Following approval by the Trust Board, the Plan will be circulated to all Directors and their EPG representatives as well as being placed on the Trust’s intranet for reference by all staff. Copies of the plan should also be available on request from the EPG representatives of each Directorate or CAG.

Copies should also be made available to the Trust’s partner organisations.

2. BACKGROUND INFORMATION RE: PANDEMIC INFLUENZA

2.1 INFLUENZA TYPES

Influenza is an acute infectious viral illness that spreads rapidly from person to person when in close contact. It is characterised by the sudden onset of fever, chills, headache, muscle pain and usually a cough – with or without a sore throat - or other respiratory symptoms. The acute symptoms generally last for about a week, although a full recovery may take longer.

There are three broad types of Influenza viruses –

• Influenza A: a group of viruses that cause most winter epidemics (and all known pandemics to date) and that can affect a wide range of animal species as well as humans.
- **Influenza B**: viruses that only infect humans (generally children) and circulate most winters and tend to cause less severe illnesses and smaller outbreaks than influenza A viruses.
- **Influenza C**: a group of viruses, that are amongst the many causes of the common cold.

### 2.1.1 Influenza Incubation Period

The incubation period (from the time of exposure to first symptoms) is short for influenza ranging between one and four days, with historical evidence suggesting that one person infects on average two others. People infected with influenza are most infectious soon after they develop symptoms although they can continue to shed the virus for up to five days after the onset of symptoms (up to seven days in children). Influenza also spreads particularly rapidly in closed communities such as schools, residential homes or hospitals, bringing extra challenges to NHS providers.

An influenza pandemic occurs when a novel influenza virus appears, against which the human population has little or no immunity, and it is inevitable that another influenza pandemic will occur at some time. Unfortunately, however, it is impossible to forecast its exact timing or the precise nature of its impact. Once a fully contagious virus emerges, global spread is considered inevitable, and since most people are likely to have no immunity to the pandemic virus, infection and illness rates could be much higher than during normal epidemics of seasonal influenza.

When a pandemic occurs, the new virus may infect large swathes of the population over a relatively short period of time. It may be associated with extensive mild to moderate illness in the population or significant severe illness and mortality in certain age or patient groups within the population and may significantly disrupt the normal functioning of society if staff absenteeism impairs the delivery of essential services.

In many respects, pandemic influenza can be treated in the same way as seasonal influenza; with good hygiene measures reducing the spread of infection and usual self-care measures (staying at home, keeping warm, drinking plenty of fluids and the use of over the counter medicines) sufficient to meet the needs of most patients. Like seasonal influenza the same treatments for those with more severe illness are likely to be used in a pandemic and the same pressures on the health and social care system will quickly emerge.

For instance, a pandemic would be expected to lead to more widespread use of antivirals, ACP’s and the NPFS. It is also likely that access to a vaccine would be significantly delayed, with it quite possibly taking 6 months to both develop such a vaccine and produce sufficient quantities to enable a national campaign to be launched.

It is also important to note that the threat of a pandemic is not restricted to the Winter months and could actually occur at any time of the year.

Influenza, regardless of type, is one of the most difficult infectious diseases to control because the virus spreads so easily from person to person via the respiratory route when an infected person talks, coughs or sneezes. It also spreads through hand-to-face contact if hands are contaminated.

### 2.2 Pandemic Influenza History and Uncertainties

Past influenza pandemics have varied in scale, severity and consequence, although in general their impact has been much greater than that of even the most severe winter epidemic. Three well documented influenza pandemics occurred in the 20th century. The worst of them was the ‘Spanish Flu’ occurring in 1918/19; it caused serious illness, an estimated 20–40 million deaths worldwide (with peak mortality rates in people aged 20–45) and major disruption. The pandemics in 1957 and 1968 (often referred to as Asian and Hong Kong flu respectively) were
less severe than the ‘Spanish Flu’ but caused significant illness levels and an estimated 1–4 million deaths between them.

Lessons from H1N1 Swine Flu pandemic
More recently, there was the 2009/10 ‘Swine Flu’ pandemic due to a relatively mild virus that had a recorded level in the community below that of the 1999/2000 seasonal influenza outbreak and throughout which day-to-day life continued largely unaffected.

However, the fact that the pandemic has ‘been and gone’ offers no grounds for complacency and any presumption that the relatively mild H1N1 influenza pandemic is representative of future pandemics is dangerous and inappropriate.

This pandemic provided an important test of pandemic preparedness plans and the following important lessons were identified:

- **Uncertainty:** there will be little or no information at the outset of a new pandemic about the severity of the illness, requiring accurate and detailed surveillance data, including numbers affected, hospital and critical care admissions, to be gathered as an early priority.
- **Speed:** in local areas, the number of cases and demand for services can be expected to develop with great pace, requiring an agile yet coordinated response.
- **Local hotspots:** the demands of the pandemic are unlikely to be uniform, but different areas will be under pressure at different times (and some not at all), requiring flexibility of approach, as well as planning for easy access to antiviral medicines.
- **Profile:** the media and public and professional appetite for information is likely to be intense at times, requiring frequent, consistent and coordinated communications.
- **Duration:** a pandemic wave can be expected to continue for many weeks, requiring robust arrangements to support individuals involved in the response. In time, further waves may also occur.
- **Cross-sector:** whilst the health sector will be under particular pressure, the response will span different sectors and organisations, requiring close working and mutual support.
- **Wider applicability:** the response to the H1N1 (2009) influenza pandemic built on, and enhanced, the response to more routine pressures such as those arising from severe weather.

These lessons have informed and continue to inform UK planning and preparedness with regard to possible future Influenza pandemics.

### 2.2.1 Uncertainties around Pandemic Influenza

As seen in the above examples of past pandemics there is massive variation between the effects and severity of the illness. The interval period between pandemics is also variable, ranging from 11-39 years during the last century. Currently (July 2014) there are no markers identified that could be used to herald the start of a new pandemic. The previous ‘swine flu’ pandemic showed there will also be little or no information at the onset of a new pandemic about the severity and effects of the infection leading to high levels of uncertainty until detailed surveillance is carried out. Further, more detailed information about influenza and pandemic influenza can be obtained online from the following sources:

http://www.dh.gov.uk/en/Publichealth/Flu/PandemicFlu/index.htm
http://www.who.int/topics/influenza/en/
2.3 CURRENTLY MONITORED INFLUENZA STRAINS

2.3.1 A/H1N1 ‘Swine Flu’
H1N1 ‘swine flu’ was a novel influenza virus that triggered the first declared flu pandemic of the 21st century in 2009. The swine flu was a relatively mild virus with most of those affected responding well to antivirals, over the counter medicines, bed rest and fluids. However, some cases were more serious and required acute hospital care. During the pandemic phase there were 85 recorded deaths as a result of the swine flu virus in London. The majority of swine flu cases were in younger age groups than those usually affected by seasonal flu with pregnant women and morbidly obese people identified as high-risk groups. There were also a number of cases and deaths of people with no previously identified underlying condition. There were two waves of the pandemic in the UK during 2009 and early 2010, after which H1/N1 became one of the circulating seasonal influenza viruses. The 2010/11 winter saw more severe pressures on the acute healthcare sector than were experienced during the pandemic waves.

2.3.2 A/H5N1 Avian Influenza
Avian influenza (‘bird flu’) is an infectious disease of birds caused by an influenza A virus that spreads rapidly and is highly contagious to domestic poultry. The H5N1 virus is able to infect other species of bird and pigs and can infect humans; such infections have only happened to a small proportion of those who have had direct exposure to infected birds. Currently there is limited evidence of person-to-person transmission and, even where that has occurred; it has not been sustained. However, human-adapted avian viruses like H5N1 were the most likely origin of the three twentieth century human influenza pandemics.

H5N1 has caused concern in recent years due to the increased opportunities for the virus either to adapt through a growing reservoir of infection in birds and transmission to more people. If the virus adapts it could exchange genes with a human influenza virus to produce a completely novel virus capable of spreading easily between people and causing a pandemic. H5N1 has pandemic potential all avian and human cases are reported and monitored closely.

A number of other novel viruses, such as H7N9 in China, are also causing some concern and, as a result, are being closely monitored on an on-going basis (with further details on such viruses and associated monitoring on the WHO website).

2.4 NATURE AND SCALE OF INFLUENZA PANDEMICS

The outbreaks or epidemics of seasonal influenza which occur most in winters, affect some 5-10% of the population. The vast majority of sufferers will have an unpleasant but self-limiting illness or even no symptoms, with less than 0.5% consulting their GP. Those most at risk of serious illness or deaths (the elderly and those with chronic underlying diseases) are offered annual vaccination. Death from influenza is often due to complications such as secondary bacterial infections, e.g. pneumonia, or exacerbation of an underlying disease, as well as to the direct effects of the influenza virus itself.

The most common complications of seasonal influenza are bronchitis and secondary bacterial pneumonia. These illnesses may require treatment in hospital and can be life threatening especially in the elderly, asthmatics and those in poor health. The influenza virus does not necessarily cause high mortality, but for elderly people with pre-existing illnesses, it may speed up their death. During a pandemic, influenza can cause serious illness in young healthy individuals including cyanosis where no clinical intervention may assist the patient’s poor prognosis.

2.4.1 Potential Impact Of A Pandemic
In general terms, in a pandemic the following can be expected:
The pandemic virus may spread rapidly, leaving little or no time to prepare. Vaccines, antiviral agents and antibiotics to treat secondary infections may be initially unavailable, and then only in short supply, and may then be unequally distributed. Medical facilities may be overwhelmed. Widespread illness may result in sudden and significant shortages of personnel to provide essential services.

The actual impact of a pandemic will be determined by the following factors:

- The number of cases, the 'severity' and duration of symptoms, and the number of deaths - all of which will only become apparent once sufficient data are available;
- The number of patients presenting at primary care services or at hospital;
- The number of patients requiring specialist treatment, e.g. extra corporeal membrane oxygenation (ECMO) or intensive care;
- The capacity of UK infrastructure (e.g. public services, utilities, transport and fuel networks etc.) and businesses to cope with high levels of staff absence and/or increased demand;
- The level of concern experienced by the population, and the extent to which they 'buy in' to good respiratory and hand hygiene campaigns, and encouragement to take up antivirals and vaccinations to reduce the spread of the illness.

Any age-specific differential attack rate will affect the overall impact of the pandemic. If working-age adults are predominantly affected, this will have a more serious impact on the provision of services and overall business continuity, whilst illness in very young children and elderly people is likely to present a greater burden on health and social care services.

In the absence of early or effective intervention, there could be widespread social and economic disruption including:

- Threats to the continuity of essential services (including fuel);
- Lower production levels of essential goods (including pharmaceuticals); and
- Widespread transport disruption causing shortages and distribution difficulties of essential goods.

It is possible to mitigate the effects of all the above through comprehensive business continuity management and much of the Trust's business continuity planning is likely to be 'called upon' during a pandemic. This is another example of a situation where the Trust's decision to manage its Emergency and Major Incident response using the same Command and Control arrangements as used for managing its business continuity capability, would be expected to prove beneficial.

2.5 UK PANDEMIC PREPAREDNESS

The many uncertainties regarding the most likely impact of a pandemic make it impossible to predict with confidence what will happen, how serious the consequences will be, and therefore to be confident how best to plan for it. Notwithstanding this, however, the UK has put in place the following arrangements:

- UK wide stockpiles and distribution arrangements of antiviral medicines and antibiotics sufficient for a widespread severe pandemic;
- Health service preparation for up to 30% of symptomatic patients requiring assessment and treatment in usual primary care pathways through surge planning;
• Health service preparation for between 1 and 4% of symptomatic patients requiring hospital care through surge planning;
• Multi-agency ‘excess death’ planning to cope locally with up to 200,000 ‘additional deaths’ across the UK over a 15 week period (this is a ‘worst case’ precautionary measure, and with a less widespread and/or a lower ‘impact’ pandemic, the number of deaths would be significantly lower)

3. INTERNATIONAL AND NATIONAL PANDEMIC RESPONSE PHASES

3.1 WORLD HEALTH ORGANISATION PHASES

In 2013, the World Health Organisation (WHO) introduced a four phase alert system to replace its previous 6 phase system. The four phases are Inter-pandemic, Alert, Pandemic and Transition

These phases reflect WHO’s risk assessment of the global situation regarding each influenza virus with pandemic potential that is infecting humans. These assessments are made initially when such viruses are identified, and are updated based on evolving virological, epidemiological and clinical data. Thus, the phases provide a high-level, global view of the evolving picture.

As pandemic viruses emerge, countries and regions face different risks at different times. For that reason, countries are being strongly advised to (and the UK has) develop their own national risk assessments based on local circumstances, taking into consideration the information provided by the global assessments produced by WHO. Risk management decisions by individual countries are therefore expected to be informed by global risk assessments, but primarily based on local risk assessments.

The four new phases are:

**Inter-Pandemic:** This is the period between influenza pandemics.

**Alert:** This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the inter-pandemic phase may occur.

**Pandemic:** This is the period of global spread of human influenza caused by a new subtype. NB. Movement between the inter-pandemic, alert and pandemic phases may occur quickly or gradually as indicated by the global risk assessment, principally based on virological, epidemiological and clinical data.

**Transition:** As the assessed global risk reduces, de-escalation of global actions may occur, and reduction in response activities or movement towards recovery actions by countries may be appropriate, in line with the results of their own risk assessments.

*NB. The above four global phases and their application in risk management, are distinct from both the determination of a Public Health Emergency of International Concern (PHEIC) under the IHR (2005) and the declaration of a pandemic. These are based upon specific assessments and can be used for communication of the need for collective global action, or by regulatory bodies and/or for legal or contractual agreements, should these be based on a determination of a PHEIC or on a pandemic declaration.*
**Determination of a PHEIC:** The responsibility for determining a PHEIC lies with the WHO Director-General under Article 12 of the IHR (2005). The determination leads to the communication of temporary recommendations.

**Declaration of a pandemic:** During the period of spread of human influenza caused by a new subtype, the WHO Director-General may make a declaration of a pandemic, if this is considered to be appropriate to the situation.

It should be noted that while the determination of a PHEIC and/or declaration of a pandemic may trigger certain regulatory actions by WHO and Member States, actions at national level should be based on national/local risk assessments and be commensurate with local risk.

**NB:** The WHO plan is based on the overall international situation, and is used internationally for alerting purposes. It should be noted that following the 2009/10 Swine Flu pandemic the revised UK pandemic influenza strategy moved away from close alignment with these phases and now aims instead for a significantly more flexible and proportionate response, driven more by the needs of the UK itself, rather than a perceived need to align with the above WHO Phases. (See section 3.2 below)

The Department of Health will inform health and social care organisations of any change to World Health Organisation phases or UK Pandemic Phases via NHS England, and via the Chief Medical Officer’s public health communication arrangements. The local Influenza Pandemic Committees will then cascade the relevant information to alert organisations and enable them to put in place the necessary coordination arrangements.

In terms of response, the Department of Health is the Lead Government Department, supported by Public Health England. Once a Pandemic is confirmed, cross-government coordination and liaison relating to the national response will be provided through the Civil Contingencies Committee. The Department of Health will communicate this information on an ongoing basis, together with an assessment of the changing risk to the UK, to all relevant organisations, including the NHS. This will include guidance and advice for the public and planners across all sectors.

Below is a diagrammatic representation of the relationships between the various groups involved in managing and delivering the UK response to the threat of an Influenza Pandemic.
Diagram of the Relationships Between UK Response Groups
3.2 UK PANDEMIC PHASES (DATER)

In addition to 'moving away' from the WHO Phases, the UK has also stopped using the UK Alert Levels (that many would have become familiar with during the 2009/2010 pandemic, and instead now bases its pandemic planning on a five phase model, referred to by the acronym DATER:

- Detect;
- Assess;
- Treat;
- Escalate; and
- Recover.

The phases are deliberately not 'numbered' since they are not linear; it is possible that the UK could move back and forth or 'jump' phases. For instance, in a severe situation, it may be necessary to activate Detect and Assess at the same time, and then possibly Treat and Escalate in short order, if not concurrently. The DATER phases are intended to be used in a flexible, precautionary and proportionate manner in response to the level and severity of the influenza pandemic. Importantly, it is also envisaged that a 'regional' approach will be adopted as appropriate, if, as in the most recent pandemic, particular regions had more virus activity than others.

3.2.1 Detect

This phase would commence either on the basis of reliable intelligence, or if an influenza-related “Public Health Emergency of International Concern” (a PHEIC) is declared by the WHO. The focus during this phase would be:

- Intelligence gathering from countries already affected
- Enhanced surveillance within the UK
- The development of diagnostics specific to the new virus
- Information and communication flow to the public and professionals.

NB. The indicator for moving to the next phase would be the identification of the new influenza virus in patients in the UK.

3.2.2 Assess

The focus during this phase would be:

- The collection of detailed clinical and epidemiological information from early cases, on which to base initial estimates of impact and severity in the UK,
- Reducing the spread of the virus within the local community by:
  - actively finding cases
  - self-isolation of cases and suspected cases
  - treatment of cases/suspected cases and use of antiviral prophylaxis for close/vulnerable contacts, based on a risk assessment of the possible impact of the disease.

NB. The indicator for moving from this phase would be evidence of sustained community transmission of the virus, i.e. cases not linked to any known or previously identified cases.

These two phases together (i.e. Detect and Assess) form the initial response. The duration of these two phases might be relatively short and the phases may be 'combined' depending on the speed with which the virus spreads, or the severity with which individuals and communities are affected. It will not be possible to halt the spread of a new pandemic influenza virus, and it must
therefore, be understood that it would be a waste of public health resources and capacity to attempt to do so.

3.2.3 Treat
The focus during this phase would be:

- Treatment of cases
- Enhancement of the health response to deal with increasing numbers of cases
- Consider enhancing public health measures as appropriate, to limit transmission of the virus, such as localised school closures based on public health risk assessment.
- Activate appropriate arrangements to ensure that necessary detailed surveillance activity continues in relation to reporting of community cases, hospitalised cases and deaths.

NB. The indicator to move to the next phase would be when demands for services start to exceed the available capacity. This decision is likely to be made at a regional or local level since the UK is unlikely to be affected evenly in terms of intensity of either distribution or severity.

3.2.4 Escalate
The focus in this phase would be:

- Escalation of surge management arrangements in health and other sectors
- Prioritisation and triage of service delivery
- Introduction of appropriate resilience measures.

This phase might well not be reached or activated in a mild to moderate pandemic, such as that experienced in 2009/2010.

3.2.5 Recover
The focus in this phase would be:

- Normalisation of services
- Restoration of business as usual services
- Evaluation
- Planning and preparation for a resurgence of activity
- Targeted vaccination as this becomes available.

The indicator for this phase would be when influenza activity levels are either, significantly reduced compared to the ‘peak’, or when the activity is considered to be within acceptable parameters. An overview of how services’ capacities are able to meet demand will also inform this decision.

3.3 UK’S FLEXIBLE, PRECAUTIONARY AND PROPORTIONATE RESPONSE TO PANDEMIC INFLUENZA

The UK’s DATER approach describes a series of actions intended to be proportionate with regard to the nature and scale of the illness and the associated pressures faced by ‘local’ healthcare services. This flexible, precautionary and proportionate response to pandemic influenza describes four broad impact based event types (Unknown, Low Impact, Moderate Impact and High Impact) as seen in the table below. These will not be declared formally on a UK-wide basis, as the intention of this approach is to encourage ‘local level’ assessment, followed by whatever ‘local level’ response is deemed to be appropriate.
<table>
<thead>
<tr>
<th>Event Type</th>
<th>Nature and Scale of Illness</th>
<th>Healthcare Delivery Impacts</th>
</tr>
</thead>
</table>
| **Initial Phase**        | • Reports of sporadic influenza cases in the local community  
AND/OR  
• Limited influenza local outbreaks in schools, care homes, prisons and other ‘closed communities’ etc.  
AND/OR  
• Increased ratio of influenza cases in critical care | • None: business continuing as usual                                                                 |
| **(Impact Unknown)**     |                                                                                             |                                                                                             |
| **Low Impact Event**     | • Similar numbers to moderate or severe seasonal influenza outbreaks  
AND  
• In the vast majority of cases - mild to moderate clinical features | • Primary and hospital services coping with increased pressures associated with respiratory illness, with maximum effort  
WITH  
• No significant deferral of usual activities  
AND/OR  
• Intensive care units (ICUs) nearing, or at, maximum pressure |
| **Moderate Impact Event**| • Higher number of cases than large seasonal epidemic  
WITH  
• Young healthy people and those in at-risk groups severely affected  
AND/OR  
• More severe illness | • Health services no longer able to continue all activity  
WITH  
• Local and regional decisions being taken to cease some healthcare activity  
AND/OR  
• ICUs under severe pressure |
| **High Impact Event**    | • Widespread disease in the UK  
WITH  
• Most age-groups affected  
AND/OR  
• Severe, debilitating illness with or without severe or frequent complications | • GPs, community pharmacies, district nurses and social carers, independent sector, residential homes and voluntary organisations fully-stretched trying to support essential care in the community  
WITH  
• Consequential significant pressure on secondary care  
AND/OR  
• Hospitals only able to provide emergency services  
AND/OR  
• Demand outstripping Critical Care services capacity - even at maximum expansion |
| **There will be no formal declaration of the above as they will be assessed at a local level** |                                                                                             |                                                                                             |
4. NHS PLANNING FOR PANDEMIC INFLUENZA

4.1 ROLES AND RESPONSIBILITIES OF VARIOUS AGENCIES

Central and Local Government, NHS organisations, public and private bodies and a wide range of other agencies continue to work on developing, maintaining and integrating their emergency and business continuity planning arrangements so as to minimise the health and social impact of an influenza pandemic. It is important that the plans of all these organisations consider, in a coordinated manner, the many and significant business continuity challenges likely be faced during such a pandemic. They must also ensure that their plans do not contradict one another, or make erroneous assumptions regarding the likely actions or ability to assist, of other organisations.

4.1.1 The Department of Health

The Department of Health (DH) is responsible for the national directing and monitoring of the influenza pandemic response, including overseeing, developing and maintaining UK preparedness for the health and social care response to such a situation. It will:

- Initiate and direct the Government’s health response
- Procure a suitable vaccine as soon as this is possible
- Secure and distribute supplies of appropriate medical countermeasures
- Maintain robust links with the WHO and the European Centre for Disease Prevention and Control (ECDC)
- Lead work with the devolved administrations to secure consistent public health and health service responses
- Provide information and input into other Government Departments and other services to assist them in their response arrangements
- Provide information for the media and public
- Give strategic and tactical health policy direction by creating a central focal point for clinical advice and expertise
- Provide leadership for all health professionals in the NHS

4.1.2 NHS England (London)

NHS England (London) is responsible for:

- Monitoring and auditing the Influenza Pandemic plans of NHS organisations within London during the Inter-Pandemic Period
- The general oversight and co-ordination of the Health response
- Ensuring the most effective deployment of available health resources
- Providing health advice and information to Regional Civil Contingencies Committee (RCCC)
- Acting as a reporting link to the DH
- Collating and forwarding monitoring information
- Providing a communication link and supporting media handling and the provision of public information
- Commissioning and ensuring the delivery of primary care based response to pandemic influenza – particularly antiviral collection points and pandemic specific vaccination
- Clarifying which routine NHS targets are to be dropped or modified i.e. what business will not be continued “as usual” in the event of a Pandemic disrupting normal work

4.1.3 Directors of Public Health (located within Local Authorities)

These Borough based posts must be assured that local services and plans are in place, and are expected to:
21

South London and Maudsley FT Pandemic Influenza Plan v2 (DRAFT). September 2014 January 2012

- Ensure a 24 hour capability to support, as required, local CCG’s, NHS England (London) and the Department of Health
- Co-ordinate public health resources, as necessary, to ensure an appropriate and consistent response to public health emergencies
- Ensure appropriate Business Continuity plans and arrangements are in place for social care and community services
- Support the ‘public health’ interface with other regional Government Departments and Regional Resilience mechanisms

4.1.4 Public Health England

Public Health England (PHE) is now responsible for numerous elements of the role previously fulfilled by the Health Protection Agency (HPA), and has a key role in advising on and supporting the UK’s national response, particularly through international and national surveillance and intelligence gathering and, in England, through informing public health policy development, planning and response at all levels. PHE will provide, amongst others things, the following specialist health protection related services:

- Reference virological and microbiological services
- Co-ordination of the investigations and management of early cases and contacts
- Data for national decisions such as choice of vaccine
- Expertise, advice and operational support to the NHS through local and regional teams
- Co-ordination of the collection and publication of UK wide influenza surveillance data

4.1.5 Clinical Commissioning Groups

Clinical Commissioning Groups will make arrangements to sustain patients in the community, to mobilise and direct healthcare resources to local hospitals and other relevant facilities at short notice and support these hospitals and facilities should their services be significantly reduced or compromised for any length of time. They will:

- Develop, monitor, co-ordinate and support NHS and public health service response arrangements at local level
- Develop protocols for sustaining patients in the community
- Provide relevant advice and information
- Collate and report information to NHS England (London)
- Make contingency arrangements for the distribution of antiviral medicines and vaccination

More information on the likely role of CCG’s during a Pandemic can be found at http://www.england.nhs.uk/ourwork/eprr

4.1.6 NHS Trusts

All NHS Trusts are required to develop internal contingency plans for responding to the many and potentially significant additional demands and business continuity challenges likely to be associated with maintaining the delivery of essential healthcare throughout an influenza pandemic. Plans must pay particular attention to the possible requirements for, for instance, significant surge capacity, increased demand for specialist or additional forms of care, patient transport, support of patients in community settings, redeployment of staff at short notice, staff protection and strict infection control.

4.2 TRUST ENGAGEMENT IN LONDON INFLUENZA PANDEMIC PLANNING

It is essential that the Trust is fully involved in the pandemic related planning of its partner health and other local organisations, so as to ensure that no inappropriate assumptions are
made in their planning, and that expectations amongst the various players within the local health economy, of the likely response and actions of others, are both realistic and appropriate. This point applies as much to the wider Emergency Preparedness agenda as to just influenza pandemic planning.

With this wider scale involvement in mind, the Trust is represented at the Emergency Preparedness forums of its five local Boroughs - Croydon, Lambeth, Lewisham, Southwark and Bromley. The Trust also engages, as appropriate, in any pandemic specific planning of these Boroughs, and would obviously become more actively engaged in the work of these should the threat of another pandemic become imminent.

The Trust would also ensure appropriate formal ‘involvement’ with the Pandemic response management forums of its partner Boroughs once a pandemic was actually declared in these Boroughs, with this being maintained for the duration of the pandemic. It should be noted that depending on the severity of the pandemic, the concerns being addressed and the significance of their consequences, such involvement could mean regular or occasional attendance, or just formal representation at relevant Borough meetings, and also this ‘level’ of involvement would be expected to change as appropriate throughout the duration of the pandemic.

4.2.1 Pandemic Phases: Triggers and Actions

<table>
<thead>
<tr>
<th>DETECT PHASE – PANDEMIC IMPACT UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRIGGERS</strong></td>
</tr>
<tr>
<td>Nature and Scale of Illness</td>
</tr>
<tr>
<td>Reports of sporadic influenza cases in the local community</td>
</tr>
<tr>
<td>Limited influenza local outbreaks in schools, care homes, prisons etc.</td>
</tr>
<tr>
<td>Increased ratio of influenza cases in critical care area</td>
</tr>
</tbody>
</table>

**KEY NATIONAL HEALTHCARE RESPONSE ACTIONS**

- Public Health England response supported by primary care.
- Detection and diagnoses of early cases through testing and contact tracing.
- No activation of the ‘National Pandemic Flu Service (NPFS) or Antiviral Collection Points (ACPs), but local areas to start initial preparations to use NPFS and ACPs.
- Influenza information line may be activated.
- Continuation of Normal Healthcare Services.

**SLaM Specific Actions**

<table>
<thead>
<tr>
<th>Actions</th>
<th>Responsible for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Initiate urgent and comprehensive review of current pandemic response plans, business/service continuity arrangements and any emerging relevant information and guidance. Report on status of plans and significant concerns to Trust Emergency Preparedness Group (EPG) and frequency of EPG meetings increased.</td>
</tr>
<tr>
<td>2</td>
<td>Review current response strategies in respect of any updated ‘good practice’ and experience. All services to pay particular attention to identifying ‘vulnerable’ service users and considering (in conjunction with other organisations if appropriate) strategies for ensuring their safety and good health during a pandemic</td>
</tr>
</tbody>
</table>
3 Accelerate and complete development; reviewing updating of any outstanding BC plans, consolidate and test all BC plans especially at Operational level. All BC plan owners as instructed by Directors and with guidance from EPG

4 Ensure effective engagement (almost certainly at 'increased levels') in local multi-agency pandemic preparedness work (likely to be initiated through the Borough based IPC's) EPG; Trust Executive; Trust 'Borough' Em Prep Leads

5 Review response plans and other arrangements of main suppliers and service providers including commissioned services. EPG (possibly via specific sub-group)

6 Increase staff awareness of signs, symptoms and epidemiology of pandemic influenza, and any relevant infection control measures, or campaigns. (e.g. catch it, bin it, kill it) using posters, intranet and newsletters. Communications Leads; Trust Infection Control Team

7 Seek advice and guidance re likely DH 'position'; advice guidance from Director(s) Public Health (DPH); and/or agree Trust stance re use of Personal Protective Equipment (PPE) Trust DIPC; Trust Infection Control Team Director of Nursing Director(s) Public Health

8 Continue Business as normal All staff

On-going monitoring of the nature and scale of illness in the local area and its actual and potential effect on healthcare delivery

ASSESS & TREAT: Possible Triggers and Actions

WHilst LOCALLy PREsenting AS A LOW IMPACT EVENT

<table>
<thead>
<tr>
<th>TRIGGERS</th>
<th>Healthcare Delivery Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature and Scale of Illness</td>
<td>Primary and Secondary services mostly coping (although some stress) with increased pressures associated with respiratory illness</td>
</tr>
<tr>
<td>• Similar numbers to moderate or severe seasonal influenza outbreaks AND</td>
<td>• No significant deferral of usual activities across providers, e.g. planned visits, elective work AND/OR</td>
</tr>
<tr>
<td>• In the vast majority of cases - mild to moderate clinical features</td>
<td>• Intensive care units (ICUs) nearing or at maximum pressure</td>
</tr>
</tbody>
</table>

KEY NATIONAL HEALTHCARE RESPONSE ACTIONS

- Influenza information line activated
- ACPs established as necessary (in ‘hotspots’ only)
- Use of existing legislation to allow the supply of antiviral medicines at premises that are not a registered pharmacy

SLaM Specific Actions

<table>
<thead>
<tr>
<th>Actions</th>
<th>Responsible for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Ensure Trust representation and engagement at all relevant pandemic related groups and committees, with appropriate formal arrangements being agreed for reporting back to Trust as a whole.</td>
<td>EPG; Trust 'Borough' Em Prep Leads</td>
</tr>
<tr>
<td>2 Establish (and consider exercising) Situation Report processes, to include number of infected service users and staff, and enhance surveillance and/or data collection to</td>
<td>EPG</td>
</tr>
</tbody>
</table>
reflect legitimate 3rd party data requests

3 On-going review of sickness levels across the Trust. Activate Business Continuity plans as appropriate, ensuring any planned actions and service changes effectively communicated to staff and service users.

4 Increase awareness and 'compliance levels' with infection control procedures, and distribute additional or 'pandemic specific' PPE (with appropriate instruction/training) as required

5 Liaise with partner organisations regarding potential additional service requirements e.g. ACP’s, vaccination centres or changes to admission/discharge arrangements with Acute Trusts

6 Implement any Pandemic Influenza training as required

7 Review staff skills (including volunteers and recently retired staff lists) and training requirements relating to possible BC and contingency measures

8 Continue business as usual.

On-going monitoring of the nature and scale of illness in the local area and its effect on healthcare delivery

ASSESS and TREAT Possible Triggers and Actions

WHILST LOCALLY PRESENTING AS A MODERATE IMPACT EVENT

<table>
<thead>
<tr>
<th>TRIGGERS</th>
<th>Healthcare Delivery Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher number of cases than large seasonal epidemic&lt;br&gt;<strong>WITH</strong>&lt;br&gt;Young healthy people and those in at-risk groups severely affected&lt;br&gt;<strong>AND/OR</strong>&lt;br&gt;More severe illness</td>
<td>Health services no longer able to continue all 'usual' activity&lt;br&gt;<strong>WITH</strong>&lt;br&gt;Local and regional decisions to cease some health care activity&lt;br&gt;<strong>AND/OR</strong>&lt;br&gt;ICUs under severe pressure</td>
</tr>
</tbody>
</table>

KEY NATIONAL HEALTHCARE RESPONSE ACTIONS

- Influenza information line active
- Local areas to establish ACPs as required
- Activation of contingency plans for supporting care at home and respite care

SLaM Specific Actions

This is the stage at which the Trust would most likely formally activate the POCT; and the EPG formally ‘hand over’ to the POCT the responsibility for directing and coordinating the Trust’s response to the influenza pandemic

<table>
<thead>
<tr>
<th>Actions</th>
<th>Responsible for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-going and close liaison with NHS England (London), relevant partner organisations and formal establishment if appropriate, of Trust POCT (see below for further information)</td>
<td>POCT; Trust AEO; Trust Executive Lead for Pandemic Planning and Response; Trust ‘Borough’ Em Prep Leads</td>
</tr>
</tbody>
</table>
2 On-going work with partners re the need for additional services, e.g. ACP’s or vaccination centres etc. and supporting service users access to such pandemic specific measures. POCT

3 Complete pre-pandemic or seasonal flu vaccination of staff if available (and advised) POCT; Human Resources (ref. OH contract)

4 On-going review of sickness levels across the Trust, and internal Trust reporting arrangements POCT; Human Resources

5 Activate appropriate BC and contingency plans as necessary, as ‘trigger points’ are reached, and as required to maintain the Trust’s critical services (communicating any changes to service delivery to service users and staff) POCT; Trust Communications function; All Directors

6 Review current situation re pressures on acute and primary care services (including changes to acute hospital admission criteria) and paying particular attention to the potential implications for ‘vulnerable’ service users. Formally consider options for increasing physical healthcare support to Trust inpatients and/or community based service users in order to reduce demand on inpatient services of local acute trust partners. POCT; Service Directors; Medical & Nursing Directors

7 Review use of infection control procedures and PPE use across services, paying particular attention to associated information/training needs and seeking assurances regarding usage and stock levels. POCT; Director of Nursing; Trust Infection Control Team Supplies function; Training function

Review Trust pandemic Influenza and BC plans in light of available information. POCT; All Directors

On-going monitoring of the nature and scale of illness in the local area and its effect on healthcare delivery

**TREAT AND ESCALATE: Possible Triggers and Actions**

### WHILST LOCALLY PRESENTING AS A HIGH IMPACT EVENT

#### TRIGGERS

<table>
<thead>
<tr>
<th>Nature and Scale of Illness</th>
<th>Healthcare Delivery Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Widespread disease in the UK</td>
<td>• GPs, community pharmacies, district nurses and social carers, independent sector, residential homes and voluntary organisations- all fully stretched trying to support essential care in the community</td>
</tr>
<tr>
<td>• Most age-groups affected AND/OR</td>
<td>• Consequential pressure on secondary care AND/OR</td>
</tr>
<tr>
<td>• Severe, debilitating illness with or without severe or frequent complications</td>
<td>• Hospitals only able to provide emergency services AND/OR</td>
</tr>
<tr>
<td></td>
<td>• Demand outstripping Critical Care service capacity - even at maximum expansion</td>
</tr>
</tbody>
</table>

#### KEY NATIONAL HEALTHCARE RESPONSE ACTIONS

- Emphasis on supplies and staffing, and continued delivery of NHS’s critical services
- Possible amendments to legislation to facilitate changes in working practice. (e.g. death certification, drivers’ hours, sickness self-certification requirements, aspects of the Mental Health Act, benefits payments etc.)

#### SLaM Specific Actions (all to be taken if, as and when the Trust deems them necessary)

<table>
<thead>
<tr>
<th>Actions</th>
<th>Responsible for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Continue (or commence) all actions as for ‘Moderate Event’</td>
<td>As above</td>
</tr>
</tbody>
</table>
2. Activate EMIP C&C and Communications arrangements

3. Regularly report situation to Borough Resilience Forums, and other relevant organisations and forums

4. Establish/maintain daily reporting and briefing bulletin including number of cases and mortality rate

5. Review data collection and surveillance requirements during peak period

6. Review staff absence rates and ability to resource essential services. Ensure continued daily reporting, collating and analysis of Trust-wide sickness levels.

7. Ensure all necessary BC and contingency plans are in operation in order to facilitate continued delivery of Trust’s critical services.

8. Ensure deputies are appointed to all key roles in case of illness / absence

9. Review staff welfare arrangements to enable well staff to return to work as quickly as possible, and to where they will have greatest positive effect

10. Implement agreed arrangements (as indicated by thorough risk assessment) of options for increasing physical healthcare support to Trust inpatients and/or community based service users in order to reduce demand on inpatient services of local acute trust partners.

11. Review implications of changes in duties, responsibilities or locations for staff (whether pre or post illness)

12. Communicate latest medical and self-care information to staff and public

13. Determine level of care to be provided in the community for service users in relation to staffing and resource availability

14. Ensure regular communication updates are consistent those of NHS London, Partner Boroughs, local partner trusts and other relevant bodies

15. Assess availability of medicines and essential resources

16. On-going monitoring of the nature and scale of illness in the local area and its effect on healthcare delivery

**NB:** The aim of this plan is that the Trust would be able to implement any or all of it according to the needs of its own services and service users, and in response to the level (numbers and acuity) of illness prevalent amongst the local population, and the extent of general ‘disruption’ being faced. For example: it is recognised that the impact of the pandemic on the Trust and its services, could, at any point in time throughout its duration, be classed as Low, Medium or High, and also that this could change (‘up’ and ‘down’) and possibly numerous times, during the pandemic.

5. **SLaM PANDEMIC INFLUENZA PLANNING**

5.1 **PLANNING RESPONSIBILITIES DURING THE ‘INTER PANDEMIC’ PHASE**

5.1.1 **Chief Executive**
The Chief Executive has overall responsibility for ensuring that an effective and appropriate pandemic influenza planning process is in place which covers the full range of Trust services and which supports the pandemic planning of the wider community. The Chief Executive is represented on the Trust’s Emergency Preparedness Group (EPG) by the Trust Board Secretary, who also chairs this Group in his role as the Trust’s Emergency Accountable Officer (AEO).
In the event of a pandemic, the EPG’s pandemic related planning and response responsibilities would transfer to the Trust Pandemic Outbreak Control Team (POCT) which, for the duration of the pandemic, would be chaired by the Trust’s Medical Director.

5.1.2 Lead Executive Director
The Trust’s Medical Director who is also the named Director of Infection Prevention and Control (DIPC), has the Lead responsibility for overseeing the Trust’s preparations for maintaining agreed service levels during a pandemic. The Medical Director reports to the Chief Executive and the Board on these matters.

In the event of a pandemic, The Medical Director will assume the role of Chair of the Trust’s Pandemic Outbreak Control Team (POCT)

5.1.3 Trust Emergency Preparedness Group
In the current ‘Inter Pandemic’ Phase, the responsibility for the Trust’s ongoing pandemic planning rests with the Trust’s Emergency Preparedness Group as one part of its responsibilities for progressing the Trust’s EPRR agenda. This Group will ensure that appropriate planning takes place and in the event of the risk of a pandemic increasing, and as it becomes more imminent, will increase the emphasis on the pandemic related planning aspects of its work. If it becomes necessary, then at an appropriate time, the EPG will hand over its pandemic related responsibilities to the Pandemic Outbreak Control Team (POCT), which will be specifically established to direct and coordinate the Trusts response.

In the event of a pandemic - and the associated activation of the POCT -, the EPG would assume a much reduced role, with all pandemic related planning and response responsibilities having transferred to the POCT which would then operate for the duration of the pandemic.

It should be noted that the EPG will not formally disband at this stage as there could well be any number of non-pandemic related EPRR issues that would need to continue to receive attention during the pandemic period. It is however, inevitable, that a pandemic would very significantly change the perceived priorities of the Trust and the EPG would need to transfer its attentions and resources from a planning role to considering just the most urgent and pressing of the non-pandemic related EPRR issues that might continue to arise.

5.2 COMMAND AND CONTROL
In the event of a pandemic, each organisation is expected to activate and implement its own pandemic influenza plan and contribute in whatever manner previously agreed, to the various joint plans and responses of partner organisations.

Although this Plan is specific to SLaM, it also takes account of the need to establish Command and Control arrangements capable of supporting the response to the ‘national emergency’ that would almost certainly be declared in the event of a ‘serious’ pandemic. The Trust’s Pandemic Influenza planning is in line with the requirements of the Civil Contingencies Act (2004) and is designed to provide a structure that will effectively underpin local resilience related activities and initiatives across both the London-wide health economy and the wider community.

The Trust’s Command and Control arrangements will be driven by the UK’s 5 phase DATER model (see section 3.2). At the point at which service pressures or anxiety levels are beginning to increase, or at which significant amounts of pandemic specific work is being identified for Trust managers, it might be decided the time is right to activate the POCT.

Given that a pandemic could last for 12 or 18 months or more, the formal convening of this Team will not mean that all the ongoing pandemic related work that the EPG had been doing will stop; rather that the responsibility for continuing this work, or possibly even prioritising other
work ‘above’ it, will transfer to the POCT. Neither will the convening of the POCT affect the need to activate the EMIP in the normal way in order to respond to any Trust Emergencies, Major Incidents, or other significant service disruptions (not pandemic related) that might occur at any point during the pandemic.

5.2.1 Response to Trust Emergency or Major Incident during a Pandemic

In the event of a Major Incident or Trust Emergency or Significant Disruption (unrelated to the pandemic) being declared during the pandemic, the POCT will either assume responsibility for managing the response to any such incident alongside its pandemic related responsibilities or alternatively, if more appropriate, oversee the establishment and operation of a separate Trust Incident Response Team (TIRT) in line with the arrangements described in the Trust EMIP. This TIRT would then be responsible for dealing with the specific Emergency or Major Incident - and associated issues - on behalf of the Chief Executive - just as the POCT has been established to do the same on his behalf, with regard to the pandemic.

The decision as to whether to establish a separate TIRT to respond to an incident, or to incorporate these responsibilities into the existing POCT will be taken, without delay, by the Chair of the POCT in conjunction with the Director on Call (and of course, also in conjunction with any other appropriate and relevant Director or senior management colleagues who might be available).

5.3 PANDEMIC OUTBREAK CONTROL TEAM (POCT) (see also action cards)

- POCT Chair: Trust Medical Director (or his designated deputy)
- Trust Accountable Emergency Officer (or designated deputy)
- Trust Executive Director of Nursing (and/or designated deputy(s) who are likely to include those able to advise on Infection Control, Physical Healthcare, and other relevant matters)
- Trust Chief Operating Officer (or designated deputy)
- Director(s) representing ‘front line’ clinical services from the ‘most affected’, or all, CAGs
- HR Director (or designated deputy)
- Communications Lead Officer
- Emergency Planning Liaison Officer (who is also the Trust BC Adviser)

Given the possible longer term duration of a pandemic, the POCT may well find its ‘core business’ to be long term planning, information management, ongoing internal and external communications, and the strategic coordination of business continuity and contingency plans, rather than the more ‘reactive’ and urgent response more usually associated with an ‘emergency response team’.

The POCT will ensure robust Command and Control (and Communications) arrangements are in place Trust wide through which to oversee the direction and coordination of the Trusts pandemic response efforts.

It is anticipated that the membership and precise ‘purpose’ of the POCT will vary during the course of the Pandemic, along with the emphasis on particular issues during this time, and Action Cards have been developed to assist in directing its efforts and in guiding its decision making. However, it can safely be assumed that the role of the POCT is likely to include ensuring that:

- Staff complete the appropriate pandemic related training including infection control, basic medical training, providing self-care advice to service users etc.
- Enhanced HR management systems are introduced as agreed, to comprehensively monitor sickness/absence
That arrangements are established to support staff during the pandemic and increase their inclination and motivation to work, and the practical likelihood of being able to

Infection control information and personal protective equipment is issued to staff, commissioned services and subcontractors where necessary (along with the relevant information and training regarding its purpose and its effective and safe use)

Ensure any amendments or changes to Mental Health Legislation are clearly communicated to staff and revisions to normal procedures made as necessary

A comprehensive communications strategy is in place to provide key messages to staff, service users, suppliers and other interested parties.

Arrangements are maintained which ensure the Trust is appropriately represented and engaged in the pandemic response management forums of its partner Boroughs throughout the duration of the pandemic.

Subcontracted, commissioned or supplied services have effective business continuity plans and agreed (possibly amended) models of working so as to offer the maximum support possible during the pandemic.

All services pay particular attention to any of their service users who are considered to be particularly ‘vulnerable’, whether this is directly or indirectly as a result of pandemic related factors, and however the term ‘vulnerable’ might be defined.

Appropriate local surveillance systems and record keeping are agreed with NHSE (London), Public Health England, and any other legitimate agency(s) and adhered to.

Changes are introduced to admission and discharge policies as necessary, and in agreement with local organisations and Acute Trusts, and that these are effectively communicated.

Provision is made for assessment of, and antiviral provision to, as required, all residential service users and those becoming ill at day care facilities.

Guidance is provided for staff to assist community based ‘vulnerable service users’ in accessing primary and secondary care during a pandemic.

Arrangements are in place (and understood) for dealing with additional deaths, including any changes to death certification and registration procedures for influenza related deaths (in line with local Coroner arrangements).

When available, the pandemic vaccine is given to staff and identified service users, as per the Trust’s agreed prioritisation of these individuals/groups, and in line with DH or other legitimate guidance.

Thus, the role of the POCT is essentially Tactical (Silver) i.e. the on-going assessment of the current situation and informed decision-making in terms of resource allocation, information and communications management. See Trust EMIP for further explanation of concept of Gold, Silver Bronze management levels and emergency response.

5.4 LOCATION OF POCT AND ADMINISTRATIVE SUPPORT

The POCT will base itself initially in the Trust ECR, and this facility will be considered by the whole Trust to be the ‘focal point’ for all pandemic related communications, requests for information, situation reports etc. throughout the duration of the pandemic

Throughout the pandemic, the ECR will require a permanent administration ‘presence’ (at least during office hours and possibly also occasionally over weekends and/or at night during times of particular pressure) A rota of administration staff will be drawn up from suitable and available staff based at, or likely to have reasonable access to the Maudsley Emergency Control Room (ECR).
This rota will enable a named individual to be Emergency Control Room Manager at all times that the ECR is 'open'. This role (See Action Card for Pandemic ECR Manager) will co-ordinate and support POCT meetings, note taking, decision logging, record keeping and archiving, information management, management of additional administrative support where this is necessary, and providing all manner of general administrative and logistical support for the POCT. Sufficient resources must be allocated to maintain both daily and permanent records, and to maintain relevant files, including copies of minutes or reports from Borough level groups.

It is recognised that resource allocation must at all times be proportionate, and it might be that in the event of a long duration pandemic, the ECR manager and the permanent 'presence' might well, on occasions, be appropriately reduced. This might be for instance, reduced to a named individual responsible for regularly checking a particular email inbox (for instance, the designated pandemic address) for new emails, or some other less 'intense' but nevertheless appropriate, and proportionate approach.

In such circumstances, it must always be clear that the resource availability could be rapidly 'ramped up' to manage the ECR and support the POCT at any time, should this become necessary.

5.4.1 Maintaining Records
During a pandemic, records must be kept of all actions taken in relation to the response to the incident just as they should be for any other Trust Emergency or Major Incident. This can be aided by the use of trained ‘Loggists’ who will record all the decisions made by the POCT in the dedicated Log Book. All CAG’s and Directorates should have a number of trained Loggists amongst their staff, and these would all be expected to assist in supporting the work of the POCT throughout the pandemic.

5.4.2 Storage of Incident Documentation
All documents associated with decisions, actions and information management during the whole of the pandemic period should be sent the Pandemic ECR Manager for collating and filing. This is likely to be via a dedicated email address publicised at the time.

6. TRUST ACTIONS DURING A PANDEMIC

6.1 LIKELY TRUST ACTIONS
The Low, Moderate and High Impact Triggers and Actions table above offer only a summarised version of the sorts of actions the Trust is likely to take when faced with these ‘Events’.

Some additional detail and guidance is provided below which might be useful in terms of service continuity planning.

The fine detail and explanations of what is meant by these ‘summaries’ of possible actions should be found in local service Business Continuity Plans, which all managers should fully understand, should have exercised and should be capable of implementing, long in advance of any actual pandemic.

The following actions will form the backdrop to the Trust’s Pandemic response:

- Convene the Trust Pandemic Outbreak Control Team (POCT)
- Activate the Trust’s Command and Control (and Communications) arrangements
- Receive and act upon national advice regarding the ordering of essential supplies
- Evaluate the on-going effects of the pandemic on any particularly vulnerable individuals or groups amongst the Trust’s client groups
- Administer medications, prophylaxis, vaccines and counter measures as required and appropriate
- Provide support, advice and leadership to the local community on mental health aspects of the pandemic
- Proactively communicate information to all Trust staff and ensure relevant guidance and advice is made available
- Continue to provide essential services to pre-agreed levels
- Communicate effectively with NHS England (London) throughout the pandemic
- Work with partner trusts, NHS England (London), Public Health England, the Local Authorities, voluntary sector and the wider community to support response through all phases of the pandemic.

6.2 SURGE MANAGEMENT

Whilst the Trust has business continuity plans to deal with emergencies as required by the Civil Contingencies Act (2004), a pandemic requires additional planning due to the anticipated duration and potentially repeated nature of pandemic waves, and the consequent longer term impact on the whole of the Trust’s services, staff, resources and service users.

To assist with planning in such circumstances, the Trust’s provision of mental health services can be categorised (in very general terms) into three levels:

**Level 1: Generic Mental Health Support**
General mental health support and promotion easily accessible to the local community, and also support to people with an emerging mental health problem in primary care settings

**Level 2: Community based specialist Mental Health Support**
Specialist services for those with serious mental health problems, including emergency referrals and crisis resolution

**Level 3: Inpatient Mental Health Services**
Inpatient stays for those who cannot be adequately supported by home treatment teams or other outreach services, and for those with complex needs or learning disabilities. Forensic units house the most at risk service users, and those for whom a normal prison environment would be inappropriate.

During a pandemic, each CAG will assess on a daily basis, the availability of staff and the consequent ability to provide services. Whilst the detail will be much more complicated (and will be explained in detail in local Business Continuity Plans) in very general terms, Level 1 Services may be reduced or withdrawn for short or longer term spells in order to support the provision of the more ‘critical’ Level 2 and 3 Services.
At the peak of the pandemic, the Trust is likely to prioritise staffing at Level 3 in-patient facilities across all CAG’s and sites.

6.3 MANAGEMENT DURING A PANDEMIC

Deputies for all significant roles must be clearly identified in local plans, as well as those who will be asked to take on additional responsibilities such as signing orders, authorising leave, making clinical and managerial decisions etc. All such individuals must be aware of the detail of what will be expected of them, and they should receive appropriate information and training so as to ensure they are competent and confident to safely and effectively undertake these roles and responsibilities.
The ‘stepped’ level of delegation of various responsibilities must be agreed, together with the ‘lowest level’ beyond which further delegation should not be allowed (thus implying that the responsibility would instead have to be passed sideways across the organisation to an acceptable level of seniority in another function or service)

All Directors need to look after their own services and agree levels of responsibility that make the maximum possible use of existing management structures.

Particular attention will need to be paid to the ‘stand-alone’ sites: for instance, should one individual manage such sites and report ‘up’ the management chain on behalf of all Trust services contained therein, or will the efforts of several individuals need to be coordinated to gain an overall picture of the activity taking place and the challenges faced on a particular site?

Each Director must ensure that each service, function or department within their sphere of responsibility has appropriate business continuity and contingency plans that will enable it to continue to deliver pre-agreed levels of service throughout the duration of a pandemic.

6.3.1 CAG and Directorate Pandemic ‘Teams’
Each of the Trust’s CAGs and Directorates will establish and staff/support a specific Pandemic Team which will co-ordinate staff and resources during a pandemic and will also act as the focal point for communications and for the coordination of pandemic related efforts for all sites, buildings, services and individuals ‘beneath’ it in the Command and Control arrangements, and with the Pandemic Outbreak Control Team (POCT) ‘above’ it in these arrangements. (See the Trust EMIP for a detailed explanation of these arrangements and their interface with Trust Main Hubs)

Depending on the size and complexity of the CAG or Directorate, and the severity of pandemic related pressures at any time, this function might require a number of dedicated individuals working ‘in it’ or might be a ‘role’ with a range of agreed responsibilities allocated to, and formally ‘handed over’ between, designated individuals.

Clear communication between all these respective Teams will be critical in facilitating informed decision making at all levels and relating to all services, and in managing the challenges relating to service reductions and withdrawal.

Each CAG or Directorate Pandemic Team will have (where applicable) arrangements in place to:

- monitor staff absence and availability
- record the number of service users infected with influenza
- ensure service users receiving daily medication are assessed and allocated antiviral medicine as appropriate
- assist service users (and carers where appropriate) to access primary care services including flu assessment and antiviral medication
- prioritise service provision and service users
- redeploy staff to priority and essential services as appropriate
- maintain key managerial and administrative functions and associated essential records
- provide alternatives to restricted services (such as telephone based contact)
- distribute appropriate personal protective equipment as required
- inform service users of changes to facilities and the care being provided e.g. day hospitals, respite care etc.
- advise local organisations on changes to admission and referral protocols
Requests for, and agreements relating to, staff redeployment between CAGs or Trust sites, will be ratified by the POCT who are responsible for reviewing the pressures and priorities for the whole Trust, and who need to maintain an accurate overall picture of these factors and the actions being taken to respond.

6.4 GENERAL PRINCIPLES RE: THE PRIORITISATION OF SERVICES

6.4.1 Essential Services

Whilst the detail of which services could be reduced or halted and for what time period, in order to enable more critical services to continue at agreed levels, are to be found in the business continuity plans of each CAG and Directorate, the following are guidelines as to what these detailed plans are likely to contain.

Services likely to be identified as needing to continue (whether at full or slightly reduced levels) during a pandemic in order to provide continuity for service users might include:

- Duty Systems (including ASW rota)
- Emergency Assessments (including A&E, Section 136 referrals, Emergency Clinics)
- Outreach Teams, Home Treatment Team
- Substance misuse facilities, including needle exchange
- Crisis/Emergency services
- Core CPA process
- Support for Carers and respite care
- Children’s Services
- Underpinning management, administration and record keeping processes

Where ‘face to face’ visits are deemed non-essential, services may reduce the risk of infection to both staff and service users (and again, make optimum use of available staff resource) through the use of telephone contact. Converting to telephone based systems may also increase the number of service users staff are able to contact on a regular basis. Consider also that staff may be able to carry out some of their telephone contact duties from home if attendance at work is compromised by personal care obligations or again, to reduce the risk of becoming infected.

6.4.2 Non-Essential Services

The following activities should be thoroughly reviewed to ensure that they are necessary and that in the changed priorities of a pandemic response, committing resources to them delivers acceptable ‘benefits’ as against their ‘costs’. They are examples of activities that might be stopped completely, or reduced, during a pandemic:

- Training & Development
- Meetings
- Redevelopment of services/Commissioning
- Occupational Therapy
- General support (housing, financial, job advice, etc.)
- Primary care/gateway work

It is generally anticipated that the Department of Health/ NHS England (London) may suspend performance management and reporting arrangements during a pandemic. However, there will still need to be appropriate record keeping and maintenance of service user records to ensure that services are able to function effectively, and that adequate records are available to enable the resumption of services in a timely manner, as well as comprehensive ‘catch up’ of services where necessary following the pandemic.
6.4.3 Day Attendance
Where possible, day hospitals/units and facilities should remain open to non-infected service users if availability of staff and facilities permit. Planning to close such facilities ‘automatically’ would increase the burden on community based staff who may then have to visit individual service users instead. Staff should identify an area for isolation where service users could be moved to if they develop influenza symptoms during their attendance. Staff should also be prepared to assist service users to access antiviral medicine using the agreed and appropriate arrangements.

6.4.4 Vulnerable Service Users
The Trust provides a wide range of services to the community, from Assertive Outreach Teams to Specialist Addiction Units, with many of the users of these and other Trust services likely to be categorised as ‘vulnerable’ in a wide variety of ways. Services must develop a good understanding of the ways in which their service users might become ‘vulnerable’ when faced by various scenarios, and make the necessary arrangements for them to be supported at such times.

7. PANDEMIC PLANNING AND RESPONSE: ISSUES TO CONSIDER

The following pages consider a range of issues that are likely to require particular attention in the event of a pandemic. These issues are accompanied by some background information relating to them, along with any agreed principles for responding to, or managing, these matters. The issues are therefore not necessarily covered in a prescriptive manner, but rather presented more as a ‘checklist’ of generic headings and issues, and associated concerns or challenges. This is to assist those responsible for pandemic flu planning in incorporating all these matters into their local Business Continuity discussions and planning processes. These issues should therefore be covered in appropriate detail in relevant Business Continuity plans but are also included here to generate discussion during the early stages of pandemic ‘planning’ once such a threat has become ‘imminent’, and as an additional source of information for those who may not be particularly familiar with, or involved in, the Trust's Business Continuity planning processes.

It should be noted that with increasingly sophisticated and comprehensive Business Continuity plans being produced across the Trust, more and more of this content will be fully covered in these plans, and this section will gradually become even more of ‘pandemic issues checklist’ or aide memoire.

7.1 INFLUENZA PANDEMIC VACCINE

A vaccine will not be available in the early stages of a Pandemic, and therefore cannot be stockpiled in advance. The appropriate vaccine must be produced specifically for the virus concerned, meaning that development of this vaccine cannot even start until the precise virus is known. Everything will be done to produce a vaccine as quickly as possible, but this will probably take at least six months.

Once available, the vaccine is likely to be in short supply and worldwide demand will be high. Vaccine will only be administered in the first instance to high priority groups according to nationally agreed priorities, starting with essential healthcare and other critical infrastructure workers and groups considered to be particularly ‘high risk’.

Beyond that, the final decisions on prioritization will be based on early information about the most severely affected age groups. When vaccine supplies become more widely available only then might vaccination be considered for the general population.
At the first sign of a realistic threat of pandemic, the Trust must devise, test and implement (in conjunction with partner organisations, and all relevant departments and functions) a system for the safe and secure receipt, storage, onward distribution, administration, and associated record keeping relating to anti-virals and vaccines.

7.1.1 Staff Immunisation
Once it has been determined which individuals or groups of staff are to be immunised, special Occupational Health Clinics will be organised and staff informed when and where they should attend.

Trust managers, in conjunction with Occupational Health staff, must draw up lists, in priority order, of those staff who should be immunised. Healthcare workers responsible for direct patient care should be immunised first, followed by those staff essential to the running of the Trust. Such prioritisation must be based on the contribution of each role to delivering essential Trust services including sufficient catering, portering, domestic, estates, administrative and support staff to allow the continued delivery of pre-agreed service levels.

Nurses with immunisation experience may be required to help immunise other members of staff, essential services staff and high-risk patients. If adequate supplies of vaccine become available their help may be sought in more widespread immunisation sessions.

7.1.2 Patient Immunisation
Immunisation will be available for inpatients in identified priority risk groups. The work of immunising patients in line with these agreed priorities will be coordinated by the Responsible Medical Officer (RMO) in conjunction with the senior members of the Trust’s Nursing Directorate Management Team.

7.1.3 Antivirals
It is anticipated that antiviral agents, which are active in reducing the duration of symptoms and their severity, when used to treat seasonal influenza, will have a similar effect on pandemic influenza. The existing UK stockpile allows for the treatment of all symptomatic patients through the early stages of a pandemic, and arrangements to make it rapidly available in the event of a pandemic are a critical part of the health response.

Treatment is a 5-day course of tablets which should be started for patients who have been symptomatic for less than 48 hours, and preferably within 12 hours and not later than 24 hours from reporting symptoms indicative of influenza.

7.2 SLOWING THE PROGRESS OF INFECTION

For uncomplicated influenza, the success of local management arrangements will depend on the majority of those who are ill managing their own illness at home. Basic information on self-management will be made available and will be widely circulated during a pandemic. The distribution of this information will be overseen by the Communications function, as advised by the POCT and with the content being ‘signed off’ by the POCT.

The critical messages are likely to include to:
- Drink plenty of fluids
- Take pain relievers like aspirin (not for children), paracetamol or ibuprofen
- Rest until feeling better

Those concerned about their illness or for whom symptoms are worsening, will be advised to ring a 24/7 manned telephone line for advice rather than attend their GP surgery or local Hospital Emergency Department. Numbers for a recorded information line for the concerned
and “worried well” will signpost to further sources of information e.g. leaflets. Details will be incorporated into the Trust’s plans at the time of the pandemic.

Although it is unlikely that the spread of influenza can be halted, some slowing of the spread can be achieved by the nationwide implementation of measures such as:

- Careful attention to personal hygiene including respiratory hygiene and hand washing
- Travel advice to restrict international travel to and from affected areas
- Health screening in United Kingdom ports
- Voluntary home isolation of cases
- Voluntary quarantine of contacts of known cases
- Local restrictions on the movement of people, e.g. in a local community or town
- Restriction of public gatherings, especially mass gatherings may be recommended
- School closures in affected areas (whilst acknowledging the impact this will have on maintaining the workforce across a range of service sectors)
- The use of facemasks by infected people (to reduce droplet spread), and by those in contact with infected people, or by the general public when visiting inpatients

Clear guidance will be issued by the Department of Health based on the advice of the UK National Influenza Pandemic Committee and/or guidance from the World Health Organisation

7.3 Infected Patients and Staff

- The Infection Control Team must be notified of all patients suspected of having influenza
- In order to effectively coordinate the outbreak response, the Infection Control Team needs to know the exact number of people who are ill, their names, date of birth, date and time of the onset of symptoms, and their ward or department
- Infected staff must stay at home for the duration of their infectivity; i.e. at least five days from the onset of symptoms
- The Occupational Health Department must be notified of all staff suspected of having influenza
- There is no evidence that antibiotics have a place in the management of uncomplicated influenza. Treatment of secondary bacterial pneumonia will be guided by PHE and the Infection Control nurses and doctors who will advise which antibiotics are to be used dependent on prevalent organisms and their sensitivities.

7.4 IN-PATIENT FACILITIES

Whilst most in-patient facilities will continue to treat service users during a pandemic, it must be recognised that service users may become infected with influenza and therefore require enhanced physical care. Admission and discharge arrangements may need to be altered to reflect the availability of staff and resources. For the purposes of planning, it is assumed that all service users in in-patient facilities are at risk of infection and, if they become ill, will remain in the facility unless access to secondary care is available (and this may, of course, be significantly reduced).

Where possible, flu suffering service users should be kept in their own rooms and normal environments to avoid further distress. Managers should consider designating particular wards as being for flu sufferers, and transfer service users accordingly. It is however, recognised, that mental health wards are designated according to occupants mental, rather than physical, health needs and are resourced and staffed accordingly. It is anticipated that any flu virus will spread rapidly within a ‘closed’ environment such as most mental health wards, thus the requirement to transfer patients if specific wards are so designated, and the additional pressure and confusion this may cause might make this a less attractive option.
Agreement will need to be reached with each relevant acute trust regarding the enhanced clinical support each may be able to offer the Trust to support it in delivering care to these physically unwell service users.

**7.4.1 River House Forensic Unit**

The Trust provides a number of forensic in-patient services, and additional clinical support for these patients may well be required as it is unlikely that any of these patients could be admitted to secondary care facilities for minor illnesses or influenza care.

Staff working in these services require specific training relating to various aspects of security and safety and associated procedures, and any staff being redeployed into this service would have to be similarly trained and competent, with managers needing to be assured that such staff were sufficiently confident and ‘comfortable’ working in this environment. During a pandemic it is essential that safe staffing numbers and skill/mix levels are maintained in these services, and ensuring that this is so could well become one of the most pressing challenges of a pandemic.

**7.5 STAFF TRAINING**

As a general rule, mental health staff do not have the necessary clinical training and competence to look after service users who have physical health needs. During a pandemic, staff may be requested to assess service users for influenza signs and symptoms, ensure that they take antiviral medication and assist them to look after themselves during their illness by managing symptoms.

Service users may also feel that their mental health problems are exacerbated by the pandemic especially if there is significant disruption to their normal support systems. Once the threat of a pandemic is considered to be sufficiently ‘imminent’, staff will be requested to participate in training to learn about pandemic influenza signs, symptoms, treatment and their specific role during a pandemic. Communication and training for working with service users, including help with self-care during a pandemic will also be rolled out in the initial stages of a pandemic.

The Infection Control Nurses will, through face-to-face meetings, provide both general and ‘targeted’ training, as appropriate, to all staff covering the infection control implications of pandemic influenza, and the controls and mitigating measures to be employed.

**7.6 IMPLICATIONS OF PANDEMIC FOR MENTAL HEALTH ACTS 1983 AND 2007**

Severe staff shortages are likely to affect the availability and priorities of, amongst others, Approved Social Workers, and Section 12 Doctors and Psychiatrists. This may reduce capacity with regard to conducting Mental Health Act Hearings etc.

A pandemic has the potential to delay timescales in establishing various MHA related Appeals and hearings. Access to staff with specific qualifications and/or authority relating to various safeguards, for instance, relating to psychosurgery, ECT, SOAD’s, and others previously falling under the auspices of the Mental Health Act Commission, and now within the remit of the Care and Quality Commission (CQC) contacting those acting with Power of Attorney for inpatients etc., may all be compromised.

All services potentially facing such problems need to consider how such issues will be addressed so as to ensure that patients retain such protection or that any reductions in, or absence of, such protection is for as short a period as possible, and that they can be demonstrated to have been unavoidable.
There are currently no powers in the Mental Health Act 1983 to derogate the statutory timescales and other requirements that apply to decisions to detain patients. It is possible that in the event of a pandemic, the Government may introduce emergency legislation (under powers contained within the Civil Contingencies Act 2004). Depending on when this happens (if it does) the content of such legislation will be considered by the POCT and either incorporated into this Plan or communicated by other means at the time, to those for whom it is relevant.

7.7 DEATH CERTIFICATION

During a pandemic, changes to the current death certification legislation may be implemented for individuals dying from influenza or complications of influenza. However, deaths of service users may still need to be referred to the Coroner for investigation. There may be a delay in organising funerals and, during the peak of a pandemic funerals may not be allowed in order to reduce the risk of infection.

7.8 RECORD KEEPING

The immediate demands of the flu pandemic might easily fully occupy staff to the point where inadequate records are kept, and people try to remember what they did “after the event”. As with all Major Incidents, this is not acceptable. The Trust is required to keep appropriate logs/records of all individual actions, decisions, communications and instructions issued. It is helpful to review previous actions and information during an ongoing incident and also after the event, in order to provide evidence for any subsequent review.

All information and records relevant to the actions and decision making during the pandemic must be retained, in similar fashion to the arrangements for other Trust emergencies and Major Incidents.

All such records must be gathered by the Pandemic Outbreak Control Team on an ongoing basis, and at the point at which the pandemic is declared to be over. This is essential in order to enable appropriate reports to be compiled.

7.9 VISITORS

In order to limit the risk of infection, all visitors should follow strict infection control procedures. Although it may be useful to limit visitors to non-acute wards during a pandemic, individuals who are familiar to the service user may be keen and able to provide additional support and reassurance during a pandemic, and also assist Trust staff to educate the service user about their illness and ability to self-care.

7.10 PSYCHOLOGICAL SUPPORT/DEBRIEFING

A pandemic outbreak will be a difficult time for the whole community, creating extra pressures for service users, their carers and families and staff. Bereavement, loss and caring for people are very stressful and will take their toll on individuals.

Some staff will be affected by loss and grief in the event of a pandemic, and the Trust’s specialist psychology staff will be available to address these issues within the limits of their organisational roles. All staff with line management responsibilities will be responsible for ensuring their staff are able to access appropriate debrief sessions during a pandemic, and also for monitoring individuals who may require extra support following a pandemic.

However, as staff and resources will be limited during a pandemic, Mental Health Trusts in London have agreed that they will not be able to provide any additional bereavement and counselling services during the pandemic. Non-service users with non-acute mental health conditions...
needs should be referred to primary care or voluntary services in the first instance until community mental health services are re-established.

Service users who experience bereavement during the pandemic should have their CPA reassessed as normal, including their ability to ‘self care’ during a pandemic.

8 COMMUNICATIONS

8.1 PRE-PANDEMIC

- Agree routine communications for seasonal influenza for professionals and the public in line with national policy
- Adapt and prepare ‘near-ready’ pandemic communication materials for professionals, media and the public, as these are developed nationally.
- Ensure the technology and administrative systems are available that will enable all organisations/professionals and others involved in planning and delivering the pandemic response to communicate with each other

8.2 DURING THE PANDEMIC

A timely, reliable, accurate flow of information through a communication system providing comprehensive coverage is an essential part of the response to a pandemic.

This is likely to include a flow of communication maintained via the Trust Intranet, providing a source of local information and available as a supplement to the authoritative national sources of pandemic related information on the Department of Health and other credible agency websites.

The POCT will maintain an oversight of all the communications flowing through the various Trust Communications channels, both internal and external, and ensure that such messages are clear, accurate, relevant, consistent and delivered through appropriate media to the intended audience in a timely manner.

The Trust lead officer for all the above will be the Head of Communications or named deputy who will work closely with the Trust Lead Director with responsibility for managing the pandemic response, and the Chair of the POCT. All communications will be discussed and agreed as appropriate in conjunction with the NHS England (London) communications leads, local Trusts, Local Authorities, and other relevant organisations.

8.3 DEPARTMENT OF HEALTH COMMUNICATIONS

In cases where service users may be unable or unwilling to access DH national public health messages, the Trust will need to develop and ‘deliver’ focused communication material for service users to support these messages.

Trust staff may need to educate service users in self-care during a pandemic and provide a source of information on how to access healthcare if normal services are interrupted. Clear advice on the use of antiviral medication is required as service users may be unable to fulfil the criteria for allocation on the standard algorithms likely to be used by the National Flu Line.

The POCT will be responsible for overseeing the effectiveness of pandemic related communications (internally and externally) with the main objectives being:
• For staff to have the knowledge and materials to advise service users about managing symptoms and maintaining their mental health in advance of a pandemic
• For staff to be able to identify the symptoms of flu
• For staff and service users to be aware of hygiene practices which can reduce the spread of infection and practice these
• For staff to be able to knowledgeably advise clients about symptom management, access to medicines and the availability of services as the pandemic progresses
• For service users to know who to contact, and how to access medication and support in the event of a flu pandemic
• For staff to get clear messages from the Executive Management team at each phase of the pandemic about a range of issues including temporary policy changes, revisions of policies, changes in levels of authorisation, any agreed time limited ‘relaxing’ of specific standards, protocols etc., access to petrol, agreed essential and non-essential services, taking sick leave and/or carers leave, signing off and signing on, arrangements for critical supplies, etc.
• To communicate Sit Reps to NHS England (London)
• To liaise appropriately with relevant partner and external agencies

9 STAFF MANAGEMENT AND WELFARE

In the event of an influenza pandemic the Trust will seek to operate within its existing employment principles, but will also be ready to adopt emergency staffing protocols to deal with depleted staffing levels and internal or externally generated pressures on services. Any such departures from existing employment principles must be as ‘limited’ as possible and be for the shortest time possible, commensurate with continued delivery of essential services. All decisions relating to departures from the existing employment principles and procedures will be based on risk assessment and, in general terms, on the principle of the ‘greatest good for the greatest number’.

The Trust expects staff to attend work in the normal way but acknowledges that its staff will share the same worries and concerns as all members of the general public for their own wellbeing and that of their children and other family members.

Set out below are emergency HR protocols that may need to be implemented during a pandemic and which have been designed to assist managers with decision making on a range of possible staffing issues. Whilst it is useful to describe these in general terms, it is not possible to be too prescriptive with regard to exactly where and when, and in precisely what circumstances, it might be appropriate for these measures to be taken. The detail of what each of these protocols means for various services in various scenarios needs to be considered by managers and, where appropriate, decisions made in advance, regarding their implementation. As the threat of a pandemic becomes both more likely and imminent, the detail of these and similar arrangements will be discussed throughout the Trust.

As part of business continuity planning across the Trust, managers will have identified minimum service and staffing levels (headcount and skill mix) required to ensure business continuity, and also established the ‘criticality’ of each of their services and discrete service elements. As only essential services are likely to be functioning at the height of each pandemic wave, consideration must be given to ‘backfilling’ in order that staff may be able to undertake to support these critical services. This information should be stored securely at service and departmental level, and be accessible for use in the event of a pandemic flu outbreak (as well as for other potential business continuity scenarios).
9.1 GENERAL STAFF WELFARE PLANNING

People will be the most valuable resource and the most vulnerable during a pandemic. In order to effectively manage this essential resource, the POCT will need to pay particular attention to a range of initiatives and changes to ‘normal’ working practice that may encourage or assist staff to come to work. Such initiatives will need to cover all aspects of staff management from recording absences, authorising various types of leave, advising on redeployment and assisting staff in returning to work after suffering pandemic flu or its effects.

As part of the planning process, the POCT will need to oversee the development of plans to:

- ensure that contact details and skills, experience, qualifications (and other potentially useful ‘characteristics’) of the available workforce are captured so that they can be easily contacted in the event of a pandemic, identifying possible risks in service delivery relating to the pandemic, and finding solutions where possible.
- identify where a specific part of the workforce, or specific teams (e.g. those with a high proportion of members with young children and other personal caring responsibilities) are particularly vulnerable to high absence levels relating to various ‘carer leave’ pressures, and attempt to develop plans to support them with childcare or alternative work options.
- develop a training and education programme that builds capacity into the existing workforce through teaching new skills and updating existing ones (both clinical and non-clinical). This will allow some staff to take on additional duties, so that those with ‘higher’ level clinical skills or experience (and consequently relatively more ‘scarce’) can focus on those patients who may be at particular risk or on treating those suffering from the complications of influenza.
- pool staff as a ‘critical mass’, which would enable staff without a set stream of work to be directed towards the most necessary tasks within their capability.
- ensure that consideration has been given to employing and allocating agency or locum staff, to support the coordination of locum resource across the locality and, where this is possible, ensuring that appropriate arrangements are in place with such staff providers (i.e. that stipulate terms and conditions) prior to a pandemic.
- facilitate arrangements for joint working and ‘buddying up’ of community teams or specialist services.
- build on or develop links with voluntary organisations, community partnerships and local businesses to maximise opportunities to support the community at large as well as the health service response.
- review normal and acceptable minimum staffing levels of core functions and services and address any potential changes to working practices that may be needed when changing between these ‘levels’.
- develop internal systems for monitoring and reporting real-time absence rates.
- inform staff in an appropriate way of the risks associated with pandemic influenza and what action they can take to protect themselves and others, and instructing them not to attend work when they are symptomatic, but to attend work when they are well.
- review locations of staff at home and at work and implement a travel assistance policy in the event that normal transport services are unavailable or significantly disrupted.
- working with local organisations, map out those health and social care professionals who provide services to the same patient and where care might therefore be ‘consolidated’.
- develop arrangements for staff to access counselling and support services.
- review local human resources policies and procedures to maximise flexibility for staff to be able to work as well as accommodating carer obligations, annual leave and special leave (carer’s leave, bereavement leave, etc.).
- provide education and training relating to the pandemic, including to voluntary and recently retired staff.
9.2 PANDEMIC RELATED HR PROTOCOLS

9.2.1 Communication.
The Trust will provide as much information as possible to assist staff in protecting their own health and safety, and that of others who may be affected by their actions. Staff will be briefed as appropriate about the key facts relating to the pandemic, including how it spreads, risks of infection and infection control methods together with the role of antivirals and vaccines. Under the guidance of the POCT all line managers should be regularly briefed in order that they in turn are able to keep all their staff informed of the ‘progress’ of the pandemic and the Trust’s response to it.

9.2.2 Staff Sickness/ Absence Management
Staff who report ill with influenza during a pandemic might well be expected to be absent for up to ten days. Initial absence should be reported to the place of work or line managers in the usual way. Staff who are off sick for non pandemic related reasons should also continue to report their absence in the normal manner.

Arrangements must be in place to ensure that the CAG or Directorate Pandemic Team is promptly made aware of each and every instance of pandemic related absence amongst its staff.

Staff who are absent for non-medical reasons may be contacted by managers to see if the Trust can assist with enabling them to continue working by providing assistance with for instance, transport, temporary changes in working arrangements, or other support.

Staff who experience flu like symptoms must not attend work and must remain at home for the duration of their infectivity, i.e. at least five days from the onset of symptoms. They should be advised to contact the National Pandemic Flu Line for advice. During an outbreak, access to GP services may be restricted and the Trust may accept self-certification from staff members for longer periods of time than under the Statutory Sickness rules. Any such relaxing of the normal requirements will be as agreed with the Trust’s HR function.

9.2.3 Staff Reporting Absence
Normal absence reporting procedures will apply. Staff must report as early as possible prior to the commencement of their period of duty if they are unable to come to work, whether due to their own illness or the need to care for others. Reliable arrangements for receiving and accurately recording such calls (not answer machines) must be in place which, between them, provide ‘coverage’ for the whole Trust.

NB. It is important to stress to all staff that during a pandemic they must be particularly careful to provide factual information about their illness and recognise the true symptoms of influenza. The term ‘Flu’ is used widely on Self Certification forms for an absence from work over one to three days. It is likely that the illness suffered was not influenza. If staff wrongly self-diagnose and then return to work in an area of high infectivity, they will be at higher risk of contracting pandemic influenza.

Arrangements must clarify where staff absences should be reported to and collated, along with who will be responsible for collating sickness absence information – both locally and Trust wide.

9.2.4 Staff Presenting for Duty who are Sick
A good indicator of the presence of influenza during the incubation period and prior to becoming ill is a raised temperature. Where it appears that staff are ill or are becoming ill, the possibility of taking that individual’s temperature should be considered. Any person with a raised temperature should be asked to go home.
9.2.5 Staff returning from sick leave
Return to work interviews must be held for all staff who have been absent due to sickness in line with the normal policy so as to ensure the reasons for absence are accurately recorded and to confirm fitness to return. Where flu like symptoms have been the cause of absence this must be recorded on the personal file and it should be established that all symptoms have disappeared prior to return. It is recommended that return to work interviews are also held for staff who have been absent for other reasons; to check their own position and update them on the situation, changes or contingency measures required in their area of work to deal with the effects of the outbreak. This is particularly important where the person may be required to take on additional hours/ changed duties upon return.

9.2.6 Record keeping
Each ward, department or service will need to keep up to date records of staff illnesses and absences, with every effort being made to distinguish between those who are actually suffering from flu and those who the pandemic is causing to be absent for more ‘indirect’ reasons.

9.2.7 Acting-up.
Managers will be responsible for deciding on temporary acting up arrangements where this is necessary to cover gaps in essential service delivery or loss of key priority skills. Staff will not be asked or expected to undertake tasks outside their level of competence.

9.2.8 Annual Leave.
The Trust may need to limit the taking of annual leave in order to sustain services. This may include cancelling leave that has been pre-booked, but which is not yet in the process of being taken. If absolutely necessary, and on direction from the POCT, large scale cancellation of annual leave booked by staff may be required. Staff already on leave will be allowed to continue with their leave. Where reasonably practicable and in the interest of the Trust, additional leave will be allowed to be ‘carried over’ into subsequent ‘leave years’ in some circumstances where such action will assist the Trust in maintaining minimum ‘numbers’ or critical levels of key skills during the pandemic. Managers should note any cases where it is claimed that the individual and/or their family has suffered any adverse financial impact as a result of being requested, by the employer, to cancel any pre-booked leave arrangements. Any cases where such a loss can be demonstrated will be fully met by the Trust.

During the early stages of a pandemic, individual services should review annual leave requests with a view to postponing leave during the likely peak of the pandemic. Staff may wish to cancel pre-booked annual leave in any event due to restrictions on travel and closure of holiday facilities. During the peak of the pandemic, staff requests for annual leave may be refused due to limited staff availability.

9.2.9 Other Leave Issues:
- **Compassionate Leave.** Requests for leave/time off to attend funerals may well become more commonplace during a pandemic and should be treated sympathetically, with the time granted wherever possible.
- **Carers leave.** It is likely that in the event of pandemic, schools, nurseries and various other care facilities will be unavailable for various periods of time. Requests to line managers for emergency leave to seek alternative care arrangements should be considered sympathetically and individually.
- **Leave Requests**
  Requests for various kinds of leave (annual, carer, compassionate) should be managed locally or, where the case is contentious, or the cumulative effects of large numbers of such requests are making decision making difficult, they should be discussed with the
relevant CAG, Directorate and/or Borough Pandemic Team, so as to facilitate awareness of the ‘wider’ situation. Any disputes over leave entitlement should be referred to the HR function for early resolution, or deferred for full investigation after the pandemic wave.

9.2.10 Non-attendance at Work.
The Trust acknowledges that a pandemic may well cause high levels of anxiety, and it is acknowledged that some staff will not wish to attend work during a pandemic due to fear of infection and putting themselves and their families at risk. However, if a member of staff does not present for work, does not report sickness or otherwise make contact to explain the reasons for absenteeism and cannot be contacted, they may be deemed to be on unauthorised unpaid leave. In some cases of absence from work or other failure to attend or report, use of the Trust’s disciplinary procedures may be appropriate (albeit these may be delayed beyond the usual timescales due to pandemic related pressures)

9.2.11 Refusal to work
Staff who refuse to work with infected service users or in ‘infected’ areas due to perceived increased personal risk (i.e. not those known to be facing potentially greater risk due to pregnancy or through themselves being immune-suppressed) will have the risks explained to them and be informed that appropriate PPE will be provided where necessary. Following this, and any other reassurance the manager may be able to offer, they will again be asked to work as originally requested (with this considered to constitute a reasonable management instruction). If they continue to refuse, they may be subject to the Trust’s disciplinary procedures (albeit these may be delayed beyond the usual timescales due to pandemic related pressures)

9.2.12 Employment Checks
It may not be possible to undertake Disclosure and Barring Service (DBS) checks (previously known as CRB checks) and any other necessary checks during a pandemic, or these checks may take much longer than the normal timescales. Each manager is responsible for ensuring that anyone being placed in roles that should be subject to a DBS check is not assigned to duties that would mean working directly and in an unsupervised capacity with vulnerable groups or individuals. Given that many of these issues are likely to be somewhat ‘grey’ areas, with the actual risks presented possibly being dependent on a wide range of variables, any such decisions must always be risk based and capable of being shown, after the event, to have been reasonable based on the information available, and the particular circumstances faced, at the time.

9.2.13 Pregnant women and immuno-compromised workers
These staff are at high risk of complications of pandemic influenza and must be considered for alternative work assignment away from areas of risk for the duration of the pandemic or until vaccinated.

9.2.14 Extended hours
Part time staff may be asked to increase their hours of work during a pandemic and will be paid for any additional hours of work they are required to complete over and above their normal contracted hours, in line with their contracts of employment and Agenda for Change provisions.

9.2.15 Internal Trust ‘mutual aid’
The principle with regard to managing local (CAG and Directorate) pressures is for each manager and their Director to initially identify options for cross cover, redeployment and service reductions within their own sphere of responsibility, and only resort to seeking support and assistance from other CAG’s and Directorates, when all such ‘local’ options have been exhausted. When such support or assistance from other CAG’s or Directorates becomes necessary such requests and the associated discussions, arguments and decisions will be overseen and ratified by the POCT.
9.2.16 Flexible Working.
The minimum safe staffing levels for each ward or service are contained within that area's business continuity plan, and these may change as a result of various factors including the levels of infection within that service or area.

During a pandemic, staff may be requested to work in different services, teams or facilities around the Trust in order to keep the organisation’s essential services running. The traditional geographical/functional boundaries within which staff normally operate may well be suspended, either in whole or in part, and staff may be requested to attend different work locations to carry out their usual, or various other, duties. Staff will not, however, be expected to work in such roles without appropriate training and qualifications. i.e. staff will not be asked, and will not be expected, to undertake tasks beyond their level of competence. Redeployment and pandemic related pressures will not be accepted as a reason or excuse for significantly compromising infection control, health and safety or other risk management controls.

It is the responsibility of each manager ‘receiving’ redeployed staff to ensure that they are appropriately qualified, experienced, trained, orientated and otherwise competent to undertake the role, before commencing duties. Further guidance on redeploying staff in emergency conditions can be found in the Trust’s Emergency and Major incident Plan.

It is expected that staff will reasonably cooperate with any requests relating to flexible working and/or redeployment.

9.2.17 Occupational Health and Staff Counselling Services.
During a pandemic staff may be affected by loss and grief. Line managers will be responsible for monitoring and supporting individuals who may require extra consideration or assistance, for instance following death or serious illness of a relative, close friend or colleague. The Occupational Health Service and Staff Counselling Service may be available to provide advice and support as required, although it is likely that the service provision may be reduced, and demand for advice and support will be high during a flu pandemic.

9.2.18 Training and Study Days
The Trust may need to restrict staff absence for training and study purposes to ensure that essential services are adequately staffed.

For the duration of a pandemic outbreak the Trust will seek to ensure that staff will generally not be required to work more than an average of 48 hours in any one week. Staff with essential skills or expertise may exceptionally be requested to work extended hours beyond this and will be expected not to unreasonably refuse. Managers will be responsible for ensuring that an average of 48 hours per week is not exceeded when measured over a 17 week period.

It is, however, accepted that circumstances might dictate that some staff are asked to, or end up, working what would normally be considered unacceptably excessive hours over a period of perhaps many weeks. As with other risk related matters, all such cases must be capable of being shown after the event, to have been reasonable based on the information available, and the particular circumstances, faced at the time.

9.2.20 HR Policies and Procedures.
All current HR policies and Procedures will remain in force unless specifically advised otherwise. Staff will have the right to invoke the Trust's Grievance procedure if they feel that emergency measures put in place to safeguard the services provided by the Trust have an unreasonable detrimental effect on them. It should however, be noted that the timescales
relating to responding to any such grievance may well be delayed by pandemic related pressures.

9.2.21 Staff Welfare Team During the Recovery Process
During the Recovery process (and also in between pandemic ‘waves’) the HR team will focus on enabling staff to take appropriate leave, enabling staff to return to work and reviewing vacancies and prioritising recruitment. The Team will also play an important part in preparing for possible future ‘waves’ and in recording the lessons learnt during the pandemic.

10. RECOVERY PHASE

As the impact of the pandemic wave subsides and it is considered that there is no threat of further waves occurring, the UK will move into the Recovery Phase. Although the objective is to return to inter-pandemic levels of functioning as soon as possible, the pace of recovery will depend on the residual impact of the pandemic, on-going demands, backlogs, staff and organisational fatigue, and continuing blockages or disruptions within the supply chain in many organisations. Therefore, only a gradual return to normality can reasonably be anticipated, and expectations shaped accordingly. Plans at all levels should recognise the need to prioritise the restoration of services, and to phase the return to normality in a managed and sustainable way.

Health and social services are likely to experience persistent secondary effects for some time, with increased demand for continuing care from:

- service users whose existing illnesses have been exacerbated by influenza
- those who may continue to suffer potential medium or long-term health complications (e.g. the encephalitis lethargica that may have been linked to the 1918 pandemic)
- a backlog of work resulting from the postponement of treatment for less urgent conditions.

The reintroduction of performance targets and normal care standards also needs to recognise the possible loss of skilled staff and their experience. Most others will have been working under acute pressure for prolonged periods and are likely to require periods of rest and continuing support. Facilities and essential supplies may also be depleted, resupply difficulties might persist and critical physical assets are likely to be in need of backlog maintenance, refurbishment or replacement. Impact assessments relating to all these issues will therefore be required.

The Trust may consider redefining services at a strategic level to reflect the reduction in staffing and resources. Recruitment to healthcare posts will be difficult at this time and the number of overseas applicants will also be affected. As the two pandemics prior to 2009/10 pandemic were only ten years apart, it is important that the Trusts Pandemic Flu plan is kept up to date and that lessons learnt are implemented effectively.

10.1 DEBRIEFING AND RECOVERY

A single wave pandemic profile with a sharp peak provides the most prudent basis for planning. Second and subsequent waves have occurred in some previous pandemics some weeks or months after the first.

Although the immediate priority after the first wave will be to develop and implement recovery plans and gradually restore services depleted or curtailed during the pandemic, plans must allow for some element of ‘regrouping’ in anticipation of a future wave.
Heightened surveillance and monitoring will be required for some time beyond the first wave. All Trust plans will require review and revision in the light of lessons learnt. In particular, the likelihood of ongoing constraints on supplies and services and continuing pressure on health and social care services must be taken into account.

Second and subsequent waves may be more or less severe than the first, but response is likely to be better informed as a result of epidemiological and mathematical modelling following the first wave. The Department of Health will issue guidance to inform health plans following review of the first wave, and the changing availability of countermeasures.

It will be necessary for all CAG’s and Directorates to prioritise the restoration of their services and to phase the return to normality in a managed and sensible way. The pace of recovery will depend on the residual impact of the pandemic, ongoing demands, backlogs, staff and organisational fatigue together with potential continuing infrastructure and supply difficulties.

A formal debrief should be held after each wave of the pandemic and after the pandemic itself. Such a debrief should:

- be held within 4 weeks of the end of the ‘wave’;
- include key individuals within the Trust who were involved in the response to the incident;
- address organisational issues, not personal or psychological issues;
- look for both strengths and weaknesses and ideas for future learning;
- provide an opportunity to thank staff and provide positive feedback;

In addition to this formal debrief the POCT should ensure that the Trust as a whole establishes and oversees processes that comprehensively:

- Consider the experiences of staff
- Identify any difficulties encountered
- Review and revise this Plan and the response framework in light of experiences and lessons learned
- Listen to the experiences, thoughts and suggestions from appropriate staff and identify any recommendations they may have to improve the Plan
- Evaluate the effectiveness of CAG and Directorate Business Continuity and Contingency plans
- Consider education and training issues
- Prepare for future pandemic waves
- Produce a formal report for the Trust Board detailing the response, successes and failures, lessons learned and agreed actions to be taken to improve the response to future pandemic waves

10.2 RECOVERY PHASE: TRIGGERS AND ACTIONS

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<th>RECOVERY ACTIONS</th>
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<td><strong>SLaM Specific Actions</strong></td>
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<td>Debrief reports to be submitted to:</td>
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Once it has been confirmed that the number of cases of new influenza infections is reducing on a weekly basis, it will be important to manage the return to ‘normality’. This will need to take account of both the availability and skill-mix of staff across the whole Trust, available resources, the effects of the pandemic on infrastructure and supply chains, and the ‘health impact’ of the pandemic on the local population.
### 11 TRUST BUSINESS CONTINUITY MANAGEMENT

In the event of an influenza pandemic, it will almost certainly be necessary to invoke some or all of the Trust’s business continuity arrangements. These identify the Trust’s key services and the critical activities on which each of these depend as well as the resources needed to sustain these activities. The Trust’s local and tactical Business Continuity plans will assist the POCT in making decisions about allocation of available resources during a pandemic.

The complete versions of any and all such plans should be readily available on request from Directors and the managers of the service(s) in question.

The diversity of sites from which the Trust provides services, ranging from large and complex acute hospitals, through purpose built clinics and health centres, to converted domestic houses, makes it inappropriate to be too prescriptive regarding specific actions and responses for each site. It is therefore the responsibility of local operational management teams, in conjunction with their Directors, to define, agree, communicate and be ready and able implement, their own specific service continuity plans in line with the Trust’s agreed Business Continuity Programme, which will be applied when appropriate within the framework of this overall Plan.

Sections 7,8 and 9 made reference to a number of issues that are likely to require consideration by managers during the pandemic, and explained in general terms what needed to be done or what needed to happen with regard to each. This Section, on Business Continuity Management, is included in order to assist managers in identifying the even wider range of issues that they may need to consider when making plans for the continuation of their service at pre-agreed levels throughout the duration of a pandemic. It also offers further information on the sort of

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<td>Executive Lead for Pandemic Response in conjunction with Trust CEO</td>
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issues and possible consequences that need to be addressed in local level service continuity planning.

Business Continuity Planning is a responsibility of every Director and manager in the Trust, and each should be well aware of the structure for undertaking this within their particular area of responsibility and should be contributing fully to the creation, maintenance and exercising of these plans.

Managers should note that there is also significant overlap between the content of this Business Continuity Management Section and the Section of the Plan relating to Guidance on Infection Control matters. This is both deliberate and appropriate, and is intended to ensure that managers are again reminded about the wide range, and frequent inter-dependency of, their Business Continuity responsibilities and those relating to various Infection Control issues.

The intention is that, as BCM planning throughout the Trust becomes more sophisticated and comprehensive, this section of future drafts of the Trust Pandemic Flu plan will gradually become little more than a checklist of points and concerns specifically relating to a flu pandemic.

Over time, confidence will increase and evidence will demonstrate that BCM plans at all levels of the Trust are addressing all these matters in appropriate depth and in a coordinated manner across all the Trust's activities and with the involvement of relevant Partner organizations. This will be capable of being confirmed by checking the various business continuity plans against the pandemic related ‘checklist’ included in this Plan. It should be noted here that each CAG and Directorate, and all services within them, should be clear re the BCM plans specific to their own activities, and this Plan should be read in conjunction with the relevant local BCM plans.

The following headings and supporting information should be considered by managers when producing their local Business Continuity plans, and particularly when considering pandemic specific aspects of such contingency planning. Each issue identified as being relevant to the ‘subject’ service, department or function should be allocated a separate heading or section within the ‘local’ plan, which should then incorporate the detailed supporting processes and information relevant to the working of that service, department or function.

The Trust’s Business Continuity planning processes should already cover much of the content required for pandemic planning purpose. However, to provide some context for this Plan, for information purposes, and for the sake of completeness, the following pages offer a range of information and pointers to be considered during the Business Continuity Management process with regard to pandemic flu, or for managers to use to review existing BC plans against, when a pandemic becomes likely and imminent.

11.1 MUTUAL AID

Whilst it is generally acknowledged that during a pandemic, there may well be limited opportunities for mutual aid between neighbouring organizations, it is also likely some areas will be more severely affected than, and at different times to, others which makes such action potentially more likely.

It is possible that the Trust may experience up to 90% infection rate in in-patient units over a short period, or that, due to its catchment area consisting of many densely populated areas, it may have a higher rate of infection amongst service users.

Mutual aid requests from other trusts will be co-ordinated through each Borough’s IPC (Response) Group and/or communicated directly to the NHSE (London) Influenza Management Team (or similarly titled forum) for action. In the event of national shortages of essentials...
including food and fuel, it is essential that the Trust has a clear strategy for communicating with, and requesting assistance from and co-ordinating distribution of, staff and resources with each of the Boroughs to avoid confusion. Requests for mutual aid should be discussed by the POCT and reviewed against the current requirements of the Trust, levels of infection across the Trust and treatment of patients, business continuity concerns and the potential for future pandemic waves but, notwithstanding these considerations, with the understanding that it will do its reasonable best to respond positively to any such request.

11.2 ETHICS

The Department of Health's publication “Responding to pandemic influenza: The ethical framework for policy and planning” is designed for use by planners and strategic policy makers at national, regional and local level, both before and during a pandemic. It is also designed to assist clinicians and others (who will also be guided by their own professional codes) in developing policies on clinical issues for use during a pandemic.

In developing policies and procedures the Trust will endeavor to use the principles outlined in the guidance:

- Respect
- Minimising the harm that a pandemic could cause
- Fairness
- Working together
- Reciprocity
- Keeping things in proportion
- Flexibility
- Good decision-making

11.3 CRITICAL OR ESSENTIAL SERVICES

The Trust's Business Continuity process has identified its 'key services' and, consequently its 'critical activities' along with the Continuity Requirements for each of these.

During the most extreme pandemic related pressures, it is possible that the existing service categorisations will be simplified even further, and reduced to 'easier to manage' basics such as:

- Priority 1: Essential Services: priority for business continuity - must be delivered
- Priority 2: Important Services: but not essential - consider partial or temporary suspension in order to redirect resources to Priority 1 services
- Priority 3: 'Donor Services': first to suspend, with resources to be allocated to Priority 1 and/or Priority 2 Services

The above is an extremely over simplified representation of what will actually be quite sophisticated prioritisation both between and within services and elements of service. A service may not, of itself, be considered particularly crucial but it (or elements of it) might be vital to the continued delivery of a service that everyone would consider to be essential i.e. many services are likely to contain a combination of ‘critical activities’ (in BC terms) and non-critical activities. It is also often the case that such dependencies might not be at all obvious and might only be identified as a result of a comprehensive business continuity planning.

It is also important to remember that a service may initially not be classed as Essential, and this might be appropriate in the short term, but it may, over the medium or longer term, need to be
classed as Essential, so any such planning will need to be very dynamic, and subject to frequent review once implemented.

11.4 PANDEMIC RELATED ISSUES FOR MANAGERS TO CONSIDER IN THEIR BUSINESS CONTINUITY PLANS

Whilst Business Continuity planning will probably have identified many (or all) of the issues to be considered during a pandemic, it is possible that other scenarios or potential disruptions might have dominated or biased such planning. The following is a checklist of various issues, more specific to the type of challenges likely to be faced during a pandemic, which if managers discover their BC plans do not adequately address, they should use to improve these plans as a pandemic becomes more likely and imminent. It is intended to be helpful and offer various ‘pointers’; many of the specific points will not apply to various services, and it is also not expected to be exhaustive or comprehensive.

11.4.1 Clinical Services Managers

- All routine work should be reviewed, to identify where possible, those tasks which may safely be deferred to allow resources to be channeled into the support of critical activities.
- Work which cannot be deferred may still have to be prioritised to facilitate the support of key services and their associated critical activities.
- Consider reducing and/or cancelling of outpatient clinics and home visits where this can be done safely.
- Community staff may become aware of situations where care has failed, or is about to fail, due to pandemic related pressures.

11.4.2 Wards and Residential Units (specifically who, or what role, will do what?)

- Whose responsibility will it be to report cases of patients and staff with Influenza to the nurse in charge and the Infection Control Team
- Who will make the decision to close the ward to new admissions?
- Who will decide to cease inter-ward transfers and discharges?
- Note that staff should not be required to work and ‘move between’ infected and non-infected areas
- Closure of a ward to new admissions may be recommended by the Infection Control Team
- Restrict numbers of staff entering the ward to those who genuinely need to be there
- Encourage patients to recover in their own rooms
- Encourage patients to bath or shower daily
- Ensure dirty linen is placed in red linen bags
- Ensure bedrooms, en-suites and toilets are cleaned daily
- Hand hygiene is paramount - all staff must wash their hands thoroughly after every contact with patients, their linen and the collection of samples
- All Infection Control advice and instructions to be strictly adhered to
- All non disposable crockery and cutlery must be washed in a dishwasher where possible
- Ensure that sick patients have vital signs recorded twice daily using the early warning scores observation charts and that scores of 4 or above are escalated to the medical team
- Ensure that extra fluids and nourishing drinks are available to prevent dehydration and that these are recorded on the trust fluid balance chart
- Implement the Trusts influenza care plan for those who are unwell with influenza
- Ensure that there is an adequate supply of sample pots, disposable gloves and aprons, bed linen, towels, soap and red linen bags
11.4.3 Barrier Nursing
- Consider options for isolating infected patients (barrier nursing) inside rooms or cohorting of cases in groups of rooms, or wards.
- Consider if cohorting of patients and associated transport and other issues might increase risk of infection spread to other areas.
- Consider if patients may be better cared for in their own rooms by staff with whom they are familiar.

11.4.4 IV Fluids
Consider what additional equipment will needed, where it will be stored, who will require what level of training, etc.

11.4.5 Seclusion
Review seclusion care plans in view of reduced staffing levels or ‘lower’ or inadequate skill mix

11.4.6 Information for Relatives
- Keep relatives of sick patients informed and advise that children and elderly relatives should not visit so as to reduce the risk of infection
- Advise all relatives regarding restrictions to visiting times for flu suffering patients
- Advise relatives if/when patients are transferred to hospital
- Ensure staff contact details are up to date

11.4.7 Closure of Wards
- Decision process for closure of wards to admissions/transfers – who decides?
- How will this be communicated and to whom?
- Will it be possible to use the bed spaces for patients suffering from flu?

11.4.8 Cancelling Appointments/Visits and Closing Clinics
- The decision process for closure and cancellation of all appointments should be clarified. Consider also redeployment of staff.
- The giving of depot injections must be seen as a critical function.
- Standard letters for clients/patients advising them of the cancellation of appointments, visits, and or closure of clinics should be prepared in advance.
- Advice sheets should be prepared in advance for issuing to clients/patients on how to cope.
- Copies of all standard letters and advice sheets should be inserted as Appendices to this or local plans, together with details of where they are located electronically for use

11.4.9 Equipment/Stores/Consumables
- Establish core equipment requirements and availability in a pandemic.
- Ensure sufficient supplies of PPE and arrangements for stock management, ordering, distribution, training in use, security of storage, and increased levels of waste disposal
- Arrangements for keeping rechargeable equipment charged at all times and regularly serviced
- Ensure there is an adequate supply of sample pots, tissues, disposable containers, aprons, masks, gloves, alcohol hand gel, shrouds, ‘no touch’ waste bins, body bags, labels etc.
- Establish stock levels of core consumables
- Ensure Trust procurement function agrees and communicates arrangements for effective access to catalogues, local ordering from national stockpiles, delivery schedules and on-site movement, etc.
- Use single use equipment wherever possible
11.4.10 Personal Protective Equipment (PPE)

- What PPE is available? Gloves, aprons, masks, theatre gowns
- Where is it stored?
- Who will authorize access and issuing
- When is it to be worn?
- Is any information, training or education relating to its use required?
- Are staff aware of how to dispose of used items?

11.4.11 Managing Deaths

- Who will inform the next of kin?
- Is there a supply of shrouds and where?
- Where are labels kept for attaching to the outside of the shroud?
- How will cadavers be transported to the mortuary?
- Who will record where bodies have been relocated to?
- How will the area the death occurred in be ‘secured’ until a thorough clean has been undertaken?

11.4.12 Laundry Facilities

- Will these cope with additional flat linen?
- Should disposable linen be purchased?
- Where will it be stored?
- How often will linen be changed if the patient is not ill?
- How often if the patient is ill?

11.4.13 Dirty Laundry

- How/where will this be stored if it can’t be collected?
- Are there enough red linen bags available?
- If washing machines are available locally, will there be enough soap powder for increased use?
  
  *NB All soiled linen must be sealed in plastic bags before leaving the infected area.*
- Linen should be placed in appropriate receptacles immediately after use and bagged at the point of use.
- Linen bags must be tied and sealed before removal from the influenza patient care room/area
- Gloves and aprons must be worn for handling all contaminated linen
- Hand hygiene protocols must be performed after removing gloves

11.4.14 Clinical Waste Management

- Where will this be stored if it can’t be collected as regularly as usual?
- If outside, will it be free from the attention of rats and other vermin?
- All *contaminated* waste must be disposed of in line with the agreed clinical waste process, with all cleaning staff (including contracted cleaning staff) being formally instructed accordingly.

11.4.15 Cleaning

- Who will remind staff not to use vacuum cleaners in infected areas?
- Who will undertake cleaning duties in the absence of domestic staff?
- Assuming less such work will be done in such circumstances, are cleaning tasks prioritized?
- What training and PPE will they be provided with?
The Trust Cleaning contractor (taking account of advice from the Trust’s Infection Control Team) will provide appropriate PPE to all staff undertaking cleaning on wards, with the correct use of such PPE being actively monitored by the Contractors Supervisors and Managers.

11.4.16 Air Conditioning
- Seek advice on whether switching off air conditioning systems would be helpful in the specific circumstances of each such system.

11.4.17 Reception and Waiting Areas
- All toys, books, newspapers and magazines must be removed.
- All soft furnishings should be removed and only easy to clean furniture used.
- By whom and when?

11.4.18 Reducing/Failing Food Supplies
- How will this be managed?
- Consider reduced choices and restricted service as short term solution.

11.4.19 Catering
- Plans for internally provided services need to be considered.
- If options for ‘self catering’ are to be considered, where will goods be purchased, if any are to be stored/stockpiled and how will they be kept secure and stock managed?

11.4.20 Shared Premises
- This section must detail any joint working relationships developed in shared premises to ensure continuation of service delivery.

11.4.21 Working From Home
- Will this be acceptable?
- What sort of message does it give to Trust staff who have no choice regarding where they work?

11.4.22 Carers
- How can they be used?
- Who will provide training in the use of PPE?
- Where will any training received be recorded?

11.4.23 Volunteers
- Local managers will need to consider the appropriateness of the use of volunteers?
- If so, how they can be used?
- What will they not be allowed to do?
- Who will supervise them?
- Who will train volunteers in the use of PPE?
- Where will any training received be recorded?

12 INFECTION CONTROL GUIDANCE

12.1 BASIC INFECTION CONTROL

Much of the following information is taken from the DH publication ‘Pandemic flu – A summary of guidance for infection control in healthcare settings’ which constitutes one element of the Trust’s Infection Control Training Material published in October 2007.
Key General Points

- Standard infection control principles and droplet precautions must be used for patients with or suspected of having pandemic influenza.
- Good staff and patient hand hygiene is vital for the protection of both parties.
- Good respiratory hygiene is essential.
- The use of PPE should be proportional to the risk of contact with respiratory secretions and other body fluids, and will therefore be determined by the type of work / procedure being undertaken.

Infection control precautions for pandemic influenza

Standard infection control principles and droplet precautions must be used for patients with, or suspected of having, pandemic influenza. Standard infection control principles are a set of broad statements of good practice to minimise exposure to and transmission of a wide variety of micro-organisms. Standard principles should be applied by all healthcare practitioners to the care of all patients all of the time.

Hand hygiene

Hand hygiene is the single most important practice in reducing the transmission of infection in healthcare settings and is an essential element of standard infection control principles. Hand hygiene includes hand washing with soap and water and thorough drying, and also the use of alcohol-based products that do not require the use of water. If hands are visibly soiled or contaminated (for example, contaminated with respiratory secretions), they should be washed with soap and water and dried. When using an alcohol handrub, hands should be free of visible dirt and organic material.

Hands should be decontaminated, even if gloves have been worn, before and after all contact with an infected patient or their bed area (including inanimate objects), removal of protective clothing and cleaning of equipment. All staff, patients and visitors should clean their hands when entering and leaving areas where care is delivered. At all times, hand hygiene must be performed in accordance with the Trust Hand Hygiene Clinical Guidelines.

Droplet precautions for pandemic influenza

In addition to standard infection control principles, droplet precautions should be used for a patient known, or suspected to be, infected with influenza, which is transmitted by droplets capable of being generated by the patient during coughing, sneezing or talking, and during some procedures.

12.2 COUGHING AND SNEEZING: PATIENTS, STAFF AND VISITORS

Management of a coughing and sneezing patient

Patients, staff and visitors should be encouraged to minimise potential influenza transmission through good hygiene measures:

- Cover nose and mouth with disposable, single-use tissues when sneezing, coughing, wiping and blowing noses.
- Dispose of used tissues in nearest waste bin.
- Wash hands after coughing, sneezing, using tissues or contact with respiratory secretions and contaminated objects.
- Keep hands away from the eyes, mouth and nose.
- Some patients (for example older people, children) may need assistance with containment of respiratory secretions; those who are immobile will need a container (for
example a plastic bag) readily at hand for immediate disposal of tissues and a supply of hand wipes and tissues.

- Where possible, in common waiting areas or during transport, coughing and sneezing patients should wear surgical masks to minimise the spread of respiratory secretions and reduce environmental contamination.

**Segregation and cohorting**
- Cohorting of patients in segregated areas of the hospital should be considered as the pandemic worsens in order to help contain influenza infection within specific buildings or parts of buildings e.g. side rooms, thus reducing the risk to other patients.
- If possible, a designated self-contained area/group of rooms should be used for the treatment and care of patients with pandemic influenza, and should:
  - include a ‘reception’ area separate from the rest of the building and, if feasible, have a separate entrance/exit from the rest of the building
  - not be used as a thoroughfare by other patients, visitors or staff, including patient transfers, staff going for meal breaks, and staff and visitors entering and exiting the building
  - be separated from other non-segregated areas by closed doors.
- To control entry, signs should be displayed warning of the segregated pandemic influenza area.

**Visitors**
- During a pandemic, only ‘essential’ visitors should be allowed into inpatient wards.
- Visitors displaying symptoms of upper respiratory infection, or influenza symptoms should not enter clinical areas and should be encouraged to return home.
- It is particularly important that every effort is made to ensure that people with influenza symptoms do not enter wards or units where there are immunocompromised patients.
- All visitors entering a cohorted area must be instructed on hand hygiene practice and the wearing of protective clothing as appropriate.

**Infected Patients**

The Infection Control Team must be informed of all patients suspected of having Pandemic flu. The Infection Control Team need to know the exact number of people who are ill, their names, their dates of birth, date and time of onset of symptoms, and relevant site and ward, in order to be able to coordinate the outbreak response.

The Trust's Pandemic Flu management plan for inpatients or community patients, as appropriate, will be implemented for all patients suffering from flu during the pandemic.

### 12.3 PERSONAL PROTECTIVE EQUIPMENT (PPE)

PPE must be worn to protect staff from contamination with body fluids and thus reduce the risk of transmission of pandemic influenza between patients and staff from one patient to another.

The minimum PPE to be worn by all staff entering the room of a patient suffering from influenza is:
- Routine surgical mask
- Disposable plastic apron
- Latex free disposable gloves

**Surgical Masks**

A surgical mask must be worn by staff who are within close contact i.e. within three feet of an infected patient. This will provide a physical barrier and minimise contamination of facial
mucosa by large particle droplets, one of the principle routes of transmission. Surgical masks should:

- Cover both the nose and the mouth and not be allowed to dangle around the neck after usage
- Not be touched once put on
- Be changed when they become moist
- Be worn once and then discarded in an appropriate receptacle as clinical waste

**Hand hygiene must be performed after disposal is complete.**

If patients with pandemic influenza are cohorted in one area and multiple patients must be visited over a short time or in rapid sequence, it may be practical to wear a single surgical mask. The mask must be put on prior to entry to the area and kept on for the duration of the activity or until the surgical mask requires replacement. NB. Other PPE (gloves and disposable aprons) must be removed between patients and hand hygiene performed. All contaminated PPE must be removed before leaving a patient care area. Surgical masks or respirators must be removed last, followed by thorough hand hygiene.

**Gloves**

Sterile or non-sterile latex/nitrile gloves must be worn for the following:

- Invasive procedures
- Contact with sterile sites
- Contact with non-intact skin
- Contact with mucous membranes
- During activities that carry a risk of exposure to blood, body fluids, secretions (including respiratory secretions) and excretions
- When handling sharp or contaminated instruments/waste
- When a member of staff has cuts/abrasions that cannot be covered with a waterproof dressing

Gloves must be removed immediately after use, disposed of as clinical waste and hand hygiene performed.

**Aprons**

Disposable plastic aprons must be worn whenever there is a risk of personal clothing or uniform coming into contact with a patient’s blood, body fluids, secretions (including respiratory secretions) and excretions or during procedures that involve close contact with the patient (e.g. examining the patient, assisting with activities of daily living). Plastic aprons must be worn as a single use item for one procedure or episode of patient care and then discarded and disposed of as clinical waste. Aprons must be changed between patients.

**Gowns**

Gowns are not required for routine care of patients with influenza. However, gowns must be worn if:

- Extensive soiling of personal clothing or uniform with respiratory secretions is expected
- There is a risk of extensive splashing of blood, body fluids, secretions and excretions onto the skin of the healthcare worker
- Procedures such as intubation and activities that involve holding the patient close

When worn, gowns must:

- Fully cover the areas that are to be protected
- Be worn only once and then placed in a waste receptacle and hand hygiene performed immediately after removal.
**Eye Protection**
The use of eye protection should be considered where there is a risk of contamination of the eyes by splashes and droplets, e.g. blood, body fluids, secretions and excretions, though patient care. Eye protection must always be worn during aerosol generating procedures.

Where such Personal Protection products are disposable, they must be disposed of as clinical waste or, if non-disposable, cleaned with hot water and detergent and then thoroughly dried.

**Respirators Facemasks and Respirators**
Facemasks and respirators have a role in providing healthcare worker protection, as long as they are used correctly and in conjunction with other infection control practices, such as appropriate hand hygiene and, most importantly, vaccination of frontline healthcare workers. However, the Trust’s need for such PPE is likely to be relatively small scale, (only necessary in the relatively rare cases when workers are performing procedures which have the potential to generate aerosols).

Risk assessments will be conducted by the Trust to determine whether and where the provision of facemasks is appropriate for staff. In the event of respirators being required, the ‘fit’ of such equipment is critically important and a ‘fit check’ should be carried out each time a respirator is worn. The respirator must seal tightly to the face or air will enter from the sides. A good fit can only be achieved if the area where the respirator seals against the skin is clean-shaven. Beards, long moustaches and stubble may cause leaks around the respirator.

If breathing becomes difficult, or if the respirator becomes damaged or distorted or contaminated by body fluids, or if a proper face fit cannot be maintained, the wearer must leave the area, following appropriate removal of PPE and hand hygiene and change the respirator immediately. FFP3 respirators must be replaced after each use and disposed of as clinical waste.

The use of such respirators within SLaM is likely to be extremely rare, and in cases where their use is thought to be necessary, advice should be sought from the infection control team on both the appropriateness of use, and the importance of effective fit testing.

In addition to respirators, eye protection must be worn to prevent eye contact with infectious material during such procedures.

**Aerosol Generating Procedures**
Examples of procedures that might generate aerosols include:

- intubation
- nasopharyngeal aspiration
- tracheostomy care
- chest physiotherapy
- bronchoscopy
- nebuliser therapy

The performance of aerosol-generating procedures should be minimised as far as possible without compromising patient care. When they are required they should be undertaken in a single room with the door closed and a properly fit-tested FFP3 respirator and other appropriate PPE MUST be worn throughout the procedure. To avoid unnecessary exposures, only those healthcare workers needed to perform the procedure should be present whilst it takes place.

**Sequence for Donning and Removal of PPE**
Supplies of PPE must be located outside the entrance to the patient’s room/cohort area. Suitable receptacles for the disposal of such PPE once used, should also be readily available and close at hand:
The level of PPE used will vary based on the procedures being carried out and not all items of available PPE will always be required. If full PPE is required, (for example for an aerosol-generating procedure) all staff required to be in the room should wear the following PPE.

The order given here is practical but the order for putting on PPE is less critical than the order of its removal:

- Perform hand hygiene i.e. wash and dry hands thoroughly or use alcohol hand rub
- Gown (or apron if not aerosol-generating procedure)
- FFP3 respirator (or surgical mask if not aerosol-generating procedure)
- Goggles or face shield (for an aerosol-generating procedure and as appropriate after risk assessment)
- Disposable gloves

**PPE Removal**

PPE should be removed in an order that minimises the potential for cross-contamination. Before leaving the area, gloves, gown and eye goggles should be removed (in that order, where worn) and disposed of as clinical (also known as infectious) waste. After leaving the area, the surgical mask or respirator) can be removed and disposed of as clinical waste. Guidance on the order of removal of PPE is as follows:

**Gloves**

- Grasp the outside of the glove with the opposite gloved hand; peel off.
- Hold the removed glove in gloved hand.
- Slide the fingers of the ungloved hand under the remaining glove at the wrist.
- Peel the second glove off over the first glove and discard appropriately.

**Gown or apron**

- Unfasten or break ties.
- Pull gown/apron away from the neck and shoulders, touching the inside of the gown only.
- Turn the gown/apron inside out, fold or roll into a bundle and discard.

**Goggles or face shield**

- To remove, handle by headband or earpieces and discard appropriately.

**Respirator or surgical mask**

- Untie or break bottom ties, followed by top ties or elastic and remove by handling ties only and discard appropriately.
- To minimise cross-contamination, the order outlined above should be applied even if not all items of PPE have been used.
- All PPE must be disposed of as clinical (also known as infectious) waste. After leaving the area, the surgical mask or respirator) can be removed and disposed of as clinical waste.

**Clean hands thoroughly immediately after removing all PPE.**

Relevant guidance on putting on and removing of PPE is contained on the Trust Intranet Infection Control web site:

**Summary of Appropriate Personal Protective Equipment (PPE) Use**

PPE should be worn to protect staff from contamination with body fluids to reduce the risk of transmission of pandemic influenza between patients and staff and from one patient to another. Appropriate PPE for care of patients with pandemic influenza is summarised in Table 2. Standard infection control principles apply at all times. All surgical masks should be fluid
repellent. PPE should comply with the relevant BS EN standards (European technical standards as adopted in the UK) where these apply.

**Personal protective equipment (PPE) for care of patients with pandemic influenza**

<table>
<thead>
<tr>
<th>Personal Protective Equipment</th>
<th>Entry to Cohorted Area but no patient contact</th>
<th>Close Patient contact (within one metre)</th>
<th>Aerosol Generating Procedures¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Gloves</td>
<td>Xᵇ</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Plastic apron</td>
<td>Xᵇ</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Gown</td>
<td>X</td>
<td>Xˡ,ᵉ</td>
<td>Xᶜ</td>
</tr>
<tr>
<td>Surgical mask</td>
<td>✓ᶠ</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>FFP3 respirator</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Eye protection</td>
<td>X</td>
<td>Risk assessment</td>
<td></td>
</tr>
</tbody>
</table>

a) Wherever possible, aerosol-generating procedures should be performed in side rooms or other closed single-patient areas with minimal staff present.
b) Gloves and an apron should be worn during environmental cleaning procedures.
c) Gloves should be worn in accordance with standard infection control principles. If glove supplies become limited or pressurised, this recommendation may need to be relaxed. Glove use should be prioritised for contact with blood and body fluids, invasive procedures and contact with sterile sites.
d) Consider gown in place of apron if extensive soiling of clothing or contact of skin with blood and other body fluids is anticipated (for example during intubation or caring for babies).
e) If non-fluid-repellent gowns are used, a plastic apron should be worn underneath.
f) Surgical masks are recommended for use at all times in cohorted areas for practical purposes. If surgical mask supplies become limited, then use in cohorted areas should be limited to close contact with a symptomatic patient (within one metre).
g) Care must be taken to ensure that PPE is worn and removed correctly, in order to avoid inadvertent contamination – see also instructions on putting on and removing PPE.

**12.4 ENVIRONMENTAL INFECTION CONTROL**

**Premises**
- Tissues and no-touch waste bins should be provided where possible in waiting areas of Trust premises, for patients and visitors
- A wash-hand basin or alcohol hand rub should be available for patient use
- Simple face masks should be offered to patients who are coughing, in order to contain respiratory secretions
- Coughing patients should be segregated from others, where possible, in communal waiting areas

**Linen and Laundry**
- Linen should be categorised as ‘used’ or ‘infected’ as per NHS Executive guidance on *Hospital laundry arrangements for used and infected linen*.
- Linen should be placed in appropriate receptacles immediately after use and bagged at the point of use.
- Linen bags must be tied and sealed before removal from the influenza patient care room/area
- Both ‘used’ and ‘infected’ linen must be handled, transported and processed in a manner that prevents skin and mucous membrane exposures to staff, (including contractors) contamination of their clothing and the environment, and infection of other patients.
- Gloves and aprons must be worn for handling all contaminated linen
- Hand hygiene must be performed after removing gloves

**Environmental Cleaning and Disinfection**

- Patients’ bedrooms and cohorted areas must be cleaned daily by **damp dusting** rather than dry dusting, using disposable cloths to reduce the generation of dust particles.
- Clinical rooms should be cleaned at least daily and between clinical sessions for patients with influenza and clinical sessions for patients not infected with influenza if the same clinical room has to be used.
- Frequently touched surfaces such as medical equipment and door handles should be cleaned at least twice daily and when known to be contaminated with secretions, excretions or body fluids.
- Cloths must be changed for every area cleaned
- Freshly prepared neutral detergent and hot water should be used
- The less contaminated areas should be cleaned first.
- Change cleaning solutions and cloths regularly
- The use of vacuum cleaners must be avoided
- Dedicated or single use equipment must be used
- All non-disposable equipment must be thoroughly washed and dried after use
- Domestic staff must work in specific areas and **must not** move between influenza and non-influenza wards/areas
- The Trust’s cleaning contractor will - taking full account of advice and guidance from the Trust’s Infection Control Team - provide appropriate PPE to all staff undertaking cleaning on wards and actively monitor that such equipment is properly used,
- The Trust’s cleaning contractor will ensure (in conjunction with advice and guidance from the Trust’s Infection Control Team) that all its staff receive all necessary guidance, instruction and training in the safe and correct use of any PPE issued.
- Domestic and other staff will receive training in the appropriate use of PPE before being allowed to work in an influenza area

**Medical Devices**

Effective cleaning of medical devices is an essential prerequisite to decontamination.

- Gloves should be worn when handling and transporting used medical devices
- Medical devices must be cleaned as instructed in the Infection Prevention and Control Policy HS/GS/08
- Reusable equipment (e.g. stethoscopes) must be decontaminated between each patient

**Electric fans, if used, must be cleaned daily**

**Crockery and Utensils**

There is no need to use disposable plates and cutlery. However, dishes and eating utensils must be washed in a dishwasher with a hot rinse. **Do not hand wash these items.**

**Reception and Waiting Areas**

- All non-essential furniture, especially soft furnishings, should be removed from reception and waiting areas in hospitals, GP consulting and treatment rooms, accident and emergency departments and day rooms/lounges.
The remaining furniture should be easy to clean and should not conceal or retain dirt and moisture.

Toys, books, newspapers and magazines should be removed from the waiting and common areas.

**Staff uniforms**

- During a pandemic, healthcare workers who wear uniforms should not travel to and from work or between different Trust premises in uniform.
- Hospitals and other healthcare facilities should provide changing rooms/areas where staff can change into uniforms upon arrival at work.
- Ideally, hospital/facility laundry services should be used to launder uniforms.
- If there are no laundry facilities available then uniforms should be transported home in a tied plastic bag and laundered separately from other linen in a domestic washing machine, washed at the optimum temperature recommended by the detergent manufacturers that is appropriate to the maximum temperature the fabric can tolerate, then ironed or tumble-dried.

**Clinical and non-clinical waste**

- No special handling procedures beyond those required to conform with standard infection control principles are recommended for clinical waste (also known as infectious waste) or for non-clinical waste that may be contaminated with influenza virus.
- Waste generated within the clinical setting should be managed safely and effectively, with attention paid to disposal of items that have been contaminated with secretions/sputum (for example paper tissues and surgical masks) in addition to other routine and domestic waste management.
- All contaminated waste must be disposed of in line with the agreed clinical waste process for the relevant area, with all staff involved, (including those of the Trust’s cleaning contractor(s) receiving all necessary guidance, instruction and training in the safe and correct implementation of these arrangements.

(See also Department of Health has published guidance on the safe disposal of healthcare waste: *HTM 07-01: Safe Management of Healthcare Waste.*

**Infection Control Training**

The Department of Health has produced a range of infection control training materials, including a summary of the guidance for infection control in healthcare settings during an influenza pandemic, as well as posters on the correct use of personal protective equipment (PPE), and a short training video. Also included are posters demonstrating effective hand hygiene to remind staff, patients and the public on how to do this correctly.

The Infection Control Team and Assistant Director of Nursing: Public Health and Physical Health, will assess the training requirements for staff relating to the Trust’s Pandemic response through face to face meetings, team meetings and partnership workshops and assist in making the necessary arrangements to ensure that appropriate training interventions are sourced, or produced in-house, and offered to staff.
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Antiviral medicines</strong></td>
<td>Type of medicines used to treat viral infections such as influenza.</td>
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<tr>
<td><strong>Asymptomatic</strong></td>
<td>Infected but not showing symptoms.</td>
</tr>
<tr>
<td><strong>Cohorting</strong></td>
<td>Separation and caring for flu sufferers in physically separate locations from non-flu sufferers</td>
</tr>
<tr>
<td><strong>Clinical attack rate (Attack rate)</strong></td>
<td>The cumulative proportion of people infected and showing symptoms over a specified period of time.</td>
</tr>
<tr>
<td><strong>Containment</strong></td>
<td>Measures to limit the spread of infection from an affected area(s).</td>
</tr>
<tr>
<td><strong>Countermeasures</strong></td>
<td>Interventions that attempt to prevent, control or treat an illness or condition.</td>
</tr>
<tr>
<td><strong>DATER</strong></td>
<td>The 5 Phase model on which UK Pandemic planning is based</td>
</tr>
<tr>
<td><strong>Epidemic</strong></td>
<td>The widespread occurrence of significantly more cases of a disease in a community or population than expected over a period of time.</td>
</tr>
<tr>
<td><strong>EMIP</strong></td>
<td>The Trust’s Emergency and Major Incident Plan</td>
</tr>
<tr>
<td><strong>Epidemiological models</strong></td>
<td>Mathematical simulations of the spread of a disease and the likely effectiveness of countermeasures.</td>
</tr>
<tr>
<td><strong>Epidemiology</strong></td>
<td>The study of the patterns, causes and control of disease in groups of people.</td>
</tr>
<tr>
<td><strong>FFP</strong></td>
<td>International normative standard for respirators.</td>
</tr>
<tr>
<td><strong>Hand hygiene</strong></td>
<td>Thorough, regular hand washing with soap and water, or the use of alcohol-based products containing an emollient that do not require the use of water to remove dirt and germs at critical times, e.g. after touching potentially infected people/objects and before touching others or eating.</td>
</tr>
<tr>
<td><strong>Incubation period</strong></td>
<td>The period from entry of infection to the appearance of first symptoms.</td>
</tr>
<tr>
<td><strong>Infectivity</strong></td>
<td>The extent to which a given micro-organism infects people (or animals), i.e. the ability of the organism to enter, survive and multiply in people and cause disease.</td>
</tr>
<tr>
<td><strong>IHR</strong></td>
<td>International Health Regulations</td>
</tr>
<tr>
<td><strong>Isolation</strong></td>
<td>Separation of individuals infected with a communicable disease from those who are not for the period they are likely to be infectious in order to prevent further spread.</td>
</tr>
<tr>
<td><strong>NHSE (L)</strong></td>
<td>NHSE England (London)</td>
</tr>
<tr>
<td><strong>Outbreak</strong></td>
<td>Sudden appearance of, or increase in, cases of a disease in a specific geographical area or population, e.g. in a village, town or closed institution.</td>
</tr>
<tr>
<td>Pandemic</td>
<td>Worldwide epidemic – an influenza pandemic occurs when a new strain of influenza virus emerges which causes human illness and is able to spread rapidly within and between countries because people have little or no immunity to it.</td>
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<td>----------</td>
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<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>POCT</td>
<td>Pandemic Outbreak Control Team</td>
</tr>
<tr>
<td>PHEIC</td>
<td>Public Health Emergency of International Concern</td>
</tr>
<tr>
<td>Prophylaxis</td>
<td>Administration of a medicine to prevent disease or a process that can lead to disease – with respect to pandemic influenza, this usually refers to the administration of antiviral medicines to healthy individuals to prevent influenza.</td>
</tr>
<tr>
<td>Respirator</td>
<td>A face mask incorporating a filter. In this document, it implies a particulate respirator, usually of a disposable type, often used in hospital to protect against inhaling infectious agents. Particulate respirators are ‘air-purifying’ respirators because they filter particles out of the air as one breathes.</td>
</tr>
<tr>
<td>Surge capacity</td>
<td>The ability to expand provision beyond normal capacity to meet transient increases in demand, e.g. to provide care or services above usual capacity, or to expand manufacturing capacity to meet increased demand.</td>
</tr>
<tr>
<td>Surgical mask</td>
<td>A disposable face mask that provides a physical barrier but no filtration.</td>
</tr>
<tr>
<td>Surveillance</td>
<td>The continuing scrutiny of all aspects of the occurrence and spread of disease pertinent to effective control in order to inform and direct public health action.</td>
</tr>
<tr>
<td>Symptomatic</td>
<td>Showing symptoms of disease or illness.</td>
</tr>
<tr>
<td>TIRT</td>
<td>Trust Incident Response Team</td>
</tr>
<tr>
<td>Transmission</td>
<td>Any mechanism by which an infectious agent is spread from a source (including another person) to a person.</td>
</tr>
<tr>
<td>Treatment course</td>
<td>The strength of a medicine, number of doses or length of treatment required to treat a disease.</td>
</tr>
<tr>
<td>Virulence</td>
<td>The degree to which a micro-organism is able to cause serious disease.</td>
</tr>
<tr>
<td>Wave</td>
<td>The period during which an outbreak or epidemic occurs either within a community or aggregated across a larger geographical area. The disease wave includes the time during which the disease occurrence increases, peaks and declines back towards baseline.</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
References & Further Information

The Trust Pandemic Influenza Plan has been written with reference to, and taking appropriate account of, the following:

- Health and Social Care Act 2012
- *Guidance on Contingency Planning for a Possible Influenza Pandemic*, Cabinet Office, February and July 2006
- *Explaining Pandemic Flu: a guide from the Chief Medical Officer*, Department of Health, 2005
- *Pandemic Flu: key facts*, Department of Health, October 2005
- Department of Health’s Pandemic Influenza Guidance on preparing mental health services in England
- March 2012 health and social care aspects of PF

**Department of Health**

Further guidance is available in the following documents at [www.dh.gov.uk/pandemicflu](http://www.dh.gov.uk/pandemicflu).

- Guidance on preparing mental health services in England (July 2008)
- A National Framework for responding to an influenza pandemic
- Responding to pandemic influenza – The ethical framework for policy
- Pandemic influenza: Guidance on preparing acute hospitals in England
- Pandemic influenza: Guidance for ambulance services and their staff in England
- Pandemic influenza: Guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting in England
- An operational and strategic framework: planning for pandemic influenza in adult social care

Information available for health professionals:
- GPs/doctors: Royal College of General Practitioners - [www.rcgp.org.uk](http://www.rcgp.org.uk)
- British Medical Association - [www.bma.org.uk](http://www.bma.org.uk)
- Pharmacists: Royal Pharmaceutical Society of Great Britain - [www.rpsgb.org](http://www.rpsgb.org)
- Nurse: Royal College of Nursing - [www.rcn.org.uk](http://www.rcn.org.uk)

**Cabinet Office**

The following documents are available at [www.ukresilience](http://www.ukresilience)

- Overarching Government Strategy to respond to pandemic influenza – Analysis of the scientific evidence base
- Pandemic flu checklist for businesses

**Useful websites:**

- Department of Health: [www.dh.gov.uk/pandemic](http://www.dh.gov.uk/pandemic)
- UK Resilience: [www.ukresilience.info](http://www.ukresilience.info)
- World Health Organisation: [www.who.int](http://www.who.int)
Date of Board meeting: 22 October 2014
Name of Report: Key Points and Minutes from the Quality Sub Committee
Heading: Governance
Authors: Jenny Goody, Governance Manager
Approved by: Neil Brimblecombe, Director of Nursing
Presented by: Neil Brimblecombe

Purpose of the report:
To present a brief summary of the key points discussed at the meeting of the Quality Sub Committee of the Board held on 17 September 2014, drawing the Board’s attention to key points for consideration.
To present the agreed minutes of the meeting of the Quality Sub Committee of the Board held on 13th August 2014.

Action required:
The Board of Directors is asked to note this report and decide whether any further action or briefing is required in relation to the key issues raised.

Recommendations to the Board:
Issues for attention are highlighted within the report.

Trust-wide risk(s) affected by this report and the level of assurance provided (none, low, moderate, high):
The Quality Sub Committee provides assurance to the Board that the principal risks to service quality, recorded within the Assurance Framework and Corporate Risk Log, are being correctly identified, correctly judged and classified and, most importantly, are being actively managed and mitigated by named staff.

Service Quality Implications:
The primary objective of the Quality Sub Committee is to ensure that there are processes in place to monitor service quality effectively.

Summary of Financial and Legal Implications:
The Audit Committee carries out an annual review of the Annual Governance Statement; the work of the Quality Sub Committee informs this review.

Equality & Diversity and Public & Patient Involvement Implications:
Equality & Diversity and Public & Patient Involvement are reviewed by the Quality Sub Committee on a regular basis.
Key points

The Quality Sub Committee draws the following items to the attention of the Board for noting and for consideration as to whether further briefing is required:

- **Policy review and development** – the QSC noted that a sustainable method to allocate ownership and resources to allow regular review to a timetable is required in the context of a significant numbers of policies requiring review. It was also noted as essential that clinical staff are engaged in the development of clinically focused policies process. Forward planner for policies is being reviewed and identified leads are being sought.

- **Policies agreed** -
  - Policy for the Development and Management of Trustwide Procedural Documents
  - Supervision Policy
  - Nutrition Policy

- **Risk** – The QSC discussed the potential risk of some many large scale change programmes happening at one time, which can have the unintended consequence of exposing the trust to additional risk. Issue to be discussed in SMT for potential explicit inclusion in the Risk Assurance Framework.

- **CAG Quality Governance processes** –

  Terms of reference for CAG Quality groups confirmed in line with previous discussions. Compliance with agreed processes will be subject to Internal Audit review by end of December. This will strengthen and align Quality Governance processes across the Trust.

  Escalation of CAG issues – a trial CAG template is to be completed each month and provided to QSC with areas for action, info and escalation. Agreed in principle, to be piloted until Xmas and reviewed. Reporting will highlight areas of significant and changed risk and exceptional positive achievements.

- **CAMHS staffing** – noted challenges in ensuring Safe Staffing in Kent unit, related to recruitment difficulties. Focused recruitment programme underway and monitoring will continue through Safe Staffing processes.

- **Trust Quality Strategy** – a draft Quality Strategy was considered by the QSC following the completion of, and in support of, the Trust’s 5 year strategic plan. It was agreed that further consultations will take place with Stakeholders before consideration and ratification by the Trust Board in December.
MINUTES OF THE
MEETING OF THE QUALITY SUB COMMITTEE
HELD ON: 13th AUGUST 2014 at 14:00
AT: The Boardroom, Maudsley Hospital

Present:
Lesley Calladine (Chair) Non-Executive Director (LC)
Marina Frederick Head of Clinical Pathways, Addictions CAG (MF)
Neil Brimblecombe Director of Nursing (NB)
Cath Gormally Director of Social Care (CG)
Cliff Bean Associate Director Quality & Assurance (CB)
Rosalind Ramsay Acting Clinical Director, Psychosis CAG (RR1)
Hugh Jones Clinical Director, MAPD CAG (HJ)
Ranga Rao Clinical Director, Psych Med CAG (RR2)
Jean O’Hara Clinical Director, B&D CAG (JOH)
Alison Beck Head of Psychology (AB)
Gabrielle Richards Head of Occupational Therapy (GR)
Roy Jaggon Head of Performance Management (RJ)
Rosie Peregrine-Jones Head of Clinical Audit & Effectiveness (RPJ)
Amanda Broughton Head of Nursing, CAMHS (AB)
Jenny Goody Governance Manager (JG)
Sandra Parish Head of Clinical Audit & Effectiveness, MHOAD CAG (SP)
Anne Middleton Assistant Director of Nursing, Physical & Public Health (AM)
Karen Taylor Assistant Director of Nursing, Infection Control (KT)

In Attendance:
Gareth Evans (Minutes)
Kelly Reid Internal Audit, TIAA (on behalf of Nicola Meeks) (KR)

Apologies:
Justin Sauer Consultant Psychiatrist, MHOAD CAG
Martin Baggaley Medical Director
Nick Dawe Interim Chief Operating Officer
Michael Holland Associate Medical Director
Emily Finch Clinical Director, Addictions CAG
Bruce Clark Consultant Psychiatrist / Clinical Director, CAMHS CAG
Ray Johannsen- Chapman PPI Lead
Nicola Meeks Internal Audit, TIAA
Patricia Connell-Julien Public Health England
Amanda Pithouse Assistant Director of Nursing
1. **Apologies**
   As received above.

2. **Declarations of interest / notifications of any other business**
   No declarations of interest were received at this point.
   NB asked to raise issues around the Trust going smoke free under any other business.

3. **Minutes of QSC preparatory meeting held on 11 June 2014**
   Agreed as an accurate record with one correction. From Item 5, at the top of page 3 ‘climate for compassion needs to be incorporated’ should be ‘climate survey’.

4. **Action Point Tracker: Outstanding Actions & Closures**
   JG presented the Quality Sub Committee’s Action Point Tracker. The committee agreed that all green actions can be closed.

5. **Quality Indicator Dashboard**
   CB presented the second iteration of the Trust’s Board level Quality Indicator Dashboard, including the data for July where available. In the future NB requested that the data be presented against a statistical process control or RAG ratings. CB said that updated SPC charts would be put back in next month (they had been removed as they were out of date). RJ noted that data on 7 Day Follow Up’s and HTT gateway had not been included this month. RR hoped that the Dashboard could highlight positive developments, as well as the negative.
   - Violence against staff: CB noted that the data had probably been graded incorrectly and he expected the figures to fall significantly.
   - Care Delivery System: figures have stayed static for some time due to the current lack of resources for the project. NB has raised the issue with the Senior Management team. They have asked for a quote on the amount of money required to keep the project going meaningfully. There is also one major bid for charity money and an older bid is being rewritten, with a view to funding the project.
   - QUEST tool: This data is new to the dashboard. Teams scoring at a level 2 or 3 suggest reason for concern which the CAG is then required to plan action to address
   - Safe Staffing: the number of Wards breaching the Safe Staffing levels has gradually decreased over a three month period.
   - Inpatient Physical Health Screening is marked as red as the threshold is 95% and the Commissioner will be applying financial penalties to the Trust. By September the Trust should be using a simpler Physical Health Screen on EPJS so the hope is it will be more accurate and there will be less duplication. Data has also been skewed by one particular AWOL patient in Southwark, who cannot be removed for legal reasons.
   - Social Care Indicators – this is a small section at the moment. CB would like to develop these with CG.
   **Action:** comments on the Dashboard to be emailed to CB and RPJ

6. **Assurance Framework Review**
   JG has asked the CAG’s to send a monthly return on their updates, based on the eight strategic risks. She had originally been requesting these at the beginning of the month but as the meetings will take place later in the month she would be asking for updates on the second
<table>
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<th>Item</th>
<th>Business Item</th>
<th>Action by</th>
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<td></td>
<td>Monday of every month (although for September she will still be asking for updates on the 1st). The Committee agreed to try this system out. <strong>Action:</strong> NB to have a conversation with Senior Management Team about processes for updating the Risk Assurance Framework. RR and RJ were concerned that absconsion was not on the Assurance Framework Register. JG suggested that it should be on the Corporate Risk Register and it be put on the Operational Risk Register for next time. It should also be passed onto Estates. LG proposed that, in future, the committee discusses Risk’s that are not represented and decide on the correct place to assign them. The ICT infrastructure is still in red as the Trust feels it needs action. JG suggested it should be moved to the Corporate Risk Log.</td>
<td>NB</td>
<td>Sept-14</td>
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<tr>
<td>7.</td>
<td>Corporate Risk Log</td>
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| | The log has been split into four sections to make it manageable with summarised responses from the Trust Leads. JG highlighted three risks that she thought could come off the register:  
- Misplaced naso gastric tubes, which had been deemed a never event. NB had met with the CAG’s and was expecting a report with assurances. The risk was now rated a 10 so it should go back onto the inherent risk list and be reviewed annually. NB would be happy to sign this off when the policy on this is ratified in the autumn.  
- Incorrect Medication List  
- Inaccuracies on EPJS Medication Records - these two need David Taylor to agree to their removal. There was a general agreement that as long as the individuals attached to these risks were happy, they could be signed off. | JG | Sept-14 |
<p>| | | | |
| | | | |
| 8.  | Compliance Issues | | |
| | CB presented a round-up of quality governance issues that don’t appear anywhere else on the agenda. CB updated the Committee on the Two Preventing Future Deaths notices that have been received from the coroner. One had been dealt with by the Southwark Coroners. The one recent relating to specialist physicians visiting inpatient units when there are patients with severe physical issues has been more problematic. CB had been working on improving the process around the physical care of patients. NB would be facilitating a three way meeting on this between the Trust, The Commissioners and the District General Hospital’s. <strong>Action:</strong> CB to move discussions forward and to ask Clinical Directors to nominate a Senior Consultant to be involved. RR suggested Fiona Gauchran from the Psychosis CAG, as she was working on reverse liaison. CB reported that Estates were working on the environmental issues highlighted by the CQC at Ladywell House in Lewisham and Douglas Bennett House at the Maudsley and there was a lot of work being done on the Trust approach to ligature attachments. | CB | Sept-14 |
| 9.  | Transportation of Inpatients Policy | | |
| | CB introduced the Transportation of Inpatients Policy, which had been considered at the last meeting. Bruce Clark had questioned whether | | |</p>
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<th>Item</th>
<th>Business Item</th>
<th>Action by</th>
<th>Date</th>
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<td>using transport with a separate driver’s compartment has been stipulated, in response to a recent BLI recommendation. CB had checked the recommendation and the policy was entirely compatible. He had fed back to BC was happy for the policy to be ratified. <em>After due consideration, the QSC ratified the Transportation of Inpatients Policy.</em></td>
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<td>10.</td>
<td><strong>Incident Policy</strong>&lt;br&gt;SP found a number of staff members listed in the policy as leads who had actually left the Trust. The group would accept the policy once this is resolved, &lt;br&gt;<strong>Action:</strong> Update the Incident Policy and present it to the next meeting of the QSC for ratification.</td>
<td>RPJ</td>
<td>Sept-14</td>
</tr>
<tr>
<td>11.</td>
<td><strong>Investigation of Incidents, Complaints and Claims Policy</strong>&lt;br&gt;SP found a number of staff members listed in the policy as leads who had actually left the Trust. The group would accept the policy once this is resolved, &lt;br&gt;<strong>Action:</strong> Update the Investigation of Incidents, Complaints and Claims Policy and present it to the next meeting of the QSC for ratification.</td>
<td>RPJ</td>
<td>Sept-14</td>
</tr>
<tr>
<td>12.</td>
<td><strong>DNAR Policy</strong>&lt;br&gt;Oliver Bashford had made some minor amendments to this policy. A new leaflet from the MHOAD CAG had been included in the Appendices. NB requested that this leaflet be brought to the attention of the Family and Carers Committee. The British Medical Association is reviewing their joint statement with the Resus Council so this will come back again then. &lt;br&gt;<em>In the meantime and after due consideration, the QSC ratified the DNAR Policy,</em> subject to anything raised by the Family &amp; Carers Committee.</td>
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<td>13.</td>
<td><strong>Clinical and Patient Safety Policies – risk log and update</strong>&lt;br&gt;RPJ introduced the Policy Risk log. The first item on the log was six policies that require new clinical leads &lt;br&gt;<strong>Action:</strong> RPJ/Grace Drewell to write to Clinical Directors inviting them to suggest new Clinical leads &lt;br&gt;The second item was a list of policies with an expired review date as of 30th June. &lt;br&gt;<strong>Action:</strong> All to ensure re-ratification of all out of expired policies by December 2014. NB stressed the importance of this, due to the impending CQC visit. RPJ to bring a Forward Planner/timetable of future ratifications up to December 2014 to the next Committee meeting.</td>
<td>ALL</td>
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<td>RPJ</td>
<td>Sept-14</td>
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<td>14.</td>
<td><strong>Violence &amp; Aggression – CDS Update</strong>&lt;br&gt;Amanda Pithouse was unable to attend the meeting. &lt;br&gt;<strong>Action:</strong> AP to come to the Committee at a later date to make this presentation.</td>
<td>AP</td>
<td>Sept-14</td>
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<td>15.</td>
<td><strong>Serious Incidents</strong>&lt;br&gt;CB presented his report on Serious Incidents.</td>
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<td>16.</td>
<td><strong>Patient Thermometer</strong>&lt;br&gt;AM gave a presentation to the group on current developments with the Patient Thermometer. &lt;br&gt;<strong>Action:</strong> AM and CG to meet and have a conversation re. robust</td>
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<td>17.</td>
<td>Infection Control Annual Report</td>
<td>CG</td>
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<td>KT ran the Committee through the Infection Control Annual Report. She requested that any questions be emailed to her.</td>
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<td>18.</td>
<td>Sub-committee highlights</td>
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<td>The Sub-Committee highlights were taken as read, for information, and there were no comments from the Committee.</td>
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<td>19.</td>
<td>CAG Highlights (Verbal Updates)</td>
<td>ND</td>
<td>Sept-14</td>
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<td></td>
<td>1. B&amp;D had a security breach at River House when a master key was accidently flushed down the toilet. All keys and locks were changed.</td>
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<td>2. MHOAD have a new Safeguarding Lead, Adella Habib. This was highlighted as there had been a long gap before a new lead was appointed. Work has finished on two ligature free rooms at Chelsham House, after two years.</td>
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<td>Abscondions from the Ladywell site are a continuing concern for the MHOAD CAG, as well as other CAG’s. Patients have been able to use a shed by the outer wall as a climbing point to escape. There are also issues with the main entrance. These issues have been highlighted for the last four years, and Nick Dawe is aware.</td>
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<td><strong>Action:</strong> Nick Dawe to be asked to update on this at the next meeting.</td>
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<td>20.</td>
<td>Quality Governance Terms of Reference for CAGs</td>
<td>ALL/ CB</td>
<td>Sept-14</td>
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<td>Terms of Reference were presented by CB to be taken up by each CAG to standardise the way their Quality meetings are conducted. CB had received mostly positive feedback and one or two queries such as whether the Quorum was realistic, and whether they had to change the names of pre-existing meetings to fit the Terms of Reference. LC stated that the CAG meetings should be in the spirit of the Terms of Reference. CB presented two templates, one for a detailed Annual report and the other could either be a monthly or quarterly report. There was a discussion over how often the report should be presented. CG noted that the feedback from the Heads of Social Care was that Social Care data was reported in a Borough based fashion, rather than a CAG based, so the templates need to be simple enough to accommodate this.</td>
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<td><strong>Action:</strong> All CAG’s to send comments to CB as soon as possible. CB to bring the template back next time for sign off. NB to report to the Board that this has been agreed in principal</td>
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<td>21.</td>
<td>Forward Planner</td>
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<td>The Forward Planner was taken as read, due to time constraints.</td>
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<td>22.</td>
<td>Any Other Business</td>
<td>NB</td>
<td>Sept-14</td>
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<td>NB quickly mentioned the key dates for the Trust going smoke free, and that members of the Smoke Free Committee would be invited to this Committee to report progress over time</td>
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<td><strong>Action:</strong> NB to forward the Committee the key dates via email and invite the Smoke Free lead to a future meeting</td>
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<td>23.</td>
<td>Feedback to Board of Directors &amp; Audit Committee</td>
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<td>The Board of Directors and Audit Committee will receive a highlight report comprising a précis of the meeting minutes for information.</td>
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| 24.  | Dates of next meeting:  
      Wednesday, 17 September at 9:30am to 11:30am  
      Future meeting dates to be confirmed by the QSC Chair | All meetings will be held in the Board Room at the Maudsley Hospital |      |
<table>
<thead>
<tr>
<th>Date</th>
<th>Reports and Updates</th>
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<tbody>
<tr>
<td>25th Nov</td>
<td>Finance Report Tim Greenwood/Gus Heafield, Performance &amp; Activity</td>
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<td></td>
<td>Safe Staffing Report – Update Neil Brimblecombe/Matthew Patrick, Performance &amp; Activity</td>
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<td>Performance Report Roy Jaggon/Nick Dawe, Performance &amp; Activity</td>
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<td>Estates Operational Standards Report Nick Dawe/Matthew Patrick, Performance &amp; Activity</td>
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<td>Update – Associate Hospital Manager Paper Reviews (action from Jun) Neil Brimblecombe/Kay Burton, Governance</td>
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<td>Council of Governors Update Paul Mitchell/ Matthew Patrick, Governance</td>
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<td>Chief Executive Report Paul Mitchell/ Matthew Patrick, Governance</td>
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<td>Caldicott Guardian Report Dele/Martin Baggaley, Governance</td>
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<td>Key issues and Minutes from Quality Committee October Meeting Neil Brimblecombe/Lesley Calladine, Governance</td>
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<td></td>
<td>Re-Appointment of SLaM Trustees Paul Mitchell/Victoria Northwood, Governance</td>
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<td>R&amp;D Annual Report Gill Dale/Tom Craig, Presentation</td>
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<td>16th Dec</td>
<td>Performance Management Framework Roy Jaggon/Nick Dawe, Performance &amp; Activity</td>
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<td>KHP Update Robert Lechler/Madeliene Long, Governance</td>
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<td></td>
<td>Key issues and Minutes from Quality Committee November Meeting Neil Brimblecombe/Lesley Calladine, Governance</td>
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<td>HR Annual Report Louise Hall/Matthew Patrick, Governance</td>
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<td>Jan 2015</td>
<td>Maudsley International (Tracey Power to confirm date) Prof. Graham Thornicroft/Tracey Power, Presentation</td>
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<td>Finance Report Tim Greenwood/Gus Heafield, Performance &amp; Activity</td>
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<td>Key issues and Minutes from Quality Committee January Meeting Neil Brimblecombe/Lesley Calladine, Governance</td>
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<td></td>
<td>Assurance Framework Report Gus Heafield/Jenny Goody, Governance</td>
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<td>Talent Management Report Louise Hall, Strategy</td>
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<td>Equality Annual Report Zoe Reed/Matthew Patrick, Strategy</td>
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<td>Equality Annual Report Zoe Reed/Kay Harwood, Strategy</td>
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<td>Feb</td>
<td>Medicines Management Report</td>
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<td>March</td>
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<td>Risk Management Strategy Review</td>
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<td>Risk Management Committees</td>
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<td>April</td>
<td>Finance Report</td>
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<td>Performance Report</td>
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<td>Staff Survey Annual Report</td>
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<td>Assurance Framework Report</td>
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<td>Family and Carers Strategy</td>
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