Agenda item 4.iii

Report to:	Trust Board	**Date:** 7 December 2023
Report from:	Accountable Emergency Officer Operational Lead EPRR	
Principal Objective/ Strategy and Title	After Action Review – 12 months of Industrial Action	
Board Assurance Framework Entries	N/A	
Regulatory Requirement	Civil Contingencies Act 2004	
Equality Considerations	Equality has been considered, there are no concerns.	
Key Risks	Patient safety, increasing waiting times for electives, financial impact, staff wellbeing, reputational harm to the organisation	
For:	Information	

1) Purpose of Paper

The purpose of this paper is to set out the process for undertaking the After-Action Review (AAR) post industrial action (IA), for the periods December 2022 – October 2023.

To learn from incidents including internal critical and major incidents affecting the operational running and performance of Royal Papworth Hospital NHS Foundation Trust (RPH) an After-Action Review (AAR) should be completed where there is significant impact requiring use of Business Continuity Plans (BCPs).

It is best practice that immediate learning should be shared, and appropriate actions undertaken to mitigate or reduce risk as well as share learning from the event with key personnel.

2) Process

An AAR group meeting is set up post incident, including IA, to review the event. For industrial action, this has taken place after a set period of workforce strike action. Beginning in December 2022 up to the last IA period in October 2023. A total of five have taken place in the last ten months. These IA AARs cover strike action from the Royal College of Nursing (RCN), Society of Radiographers (SoR), British Medical Association (BMA) and Hospital Consultants and Specialists Association (HCSA).

Members on the invite list are those that are also invited to the planning phases of IA, which represents a fair and diverse selection of key individuals. These include representation from cardiology, thoracic and surgical, transplant and anaesthetics (STA) divisions, Estates and Facilities, Workforce representation, Communications and Digital, medical, and nursing colleagues. A medical director, Heads of Nursing, Operations Directors, Matron Teams and ALERT or representatives on their behalf attend. The chair is usually the Chief Operating Officer or on occasion the Operational Lead EPRR.

At each review meeting, attendees are reminded that the meeting forum is a safe space for providing feedback but also given the option to complete an anonymous questionnaire

should they prefer. The meeting and questionnaire follow the same questioning set, then an action plan is formed following the results where necessary.

The questions asked were:

1) What went well?
2) What could we have done better / consider for the future?

There were zero responses to the MS Forms questionnaire, which is a positive interpretation for the Trust as everyone was comfortable discussing the feedback openly in this forum. There was a good attendance at the AAR meetings, usual attendance numbers are approximately 15-20 attendees.

3) What went well?

There was an overall acknowledgement for the successful efforts of colleagues in planning the IA phases, which has allowed staff to exercise their right to strike without compromising on patient safety during the period. Staffing backfill has not been without its challenges, which Royal Papworth Hospital (RPH) handled effectively by the formation of the Safer Staffing Hub. Nursing staffing gaps during the Royal College of Nursing (RCN) IA periods were covered by colleagues that had a clinical background, but do not work in patient facing roles at present, these staff worked in supporting roles to assist on the ward areas. There were volunteers from administrative roles that had stepped up to support where clinically safe to do so within the wards and junior doctors filled staffing gaps for the ALERT Team exercising the right to strike.

Royal Papworth Hospital was recognised at a regional level during IA for our implementation of a Safer Staffing Hub for the Royal College of Nursing (RCN) strike periods. The blueprint of which was shared across partner sites via the Integrated Care Board (ICB).

Later, during Society of Radiographers (SoR), British Medical Association (BMA) and Health Consultants and Specialists Association (HCSA) IA periods, advanced nurse practitioners and ALERT supported gaps in junior doctor roster cover. Senior consultant colleagues under-took junior doctor shift patterns to support safe clinical cover and emergency pager response Trust wide. SoR strike action has a potential for a substantial impact on patient flow, to support colleagues, medical staff supported the services by covering gaps allowing emergency pathways remaining open.

Our communication strategies were highly effective, with targeted messaging and a central contact point for up-to-date information. Senior administrative support colleagues, with input from the IATF group and clinical leads, efficiently collected essential information for an over-arching matrix which helped with planning, and assurances internally and to regional partners. This matrix contains a quick reference guide of named key personnel covering emergency pathways, emergency pagers, on-call rota, IMT attendees, anaesthetics, ICU and ECMO rota and services that we can provide from the planning phases. This is useful for an overall picture and to support easy and early escalation of incident and resolution thereafter.

Our command-and-control systems, supported by senior leadership, ensured effective management of the incidents and avoidance of crisis or critical incident. A hybrid approach to communication and coordination, with both in-person and remote elements, was felt inclusive and effective for all.

Welfare of staff was supported by Mental Health First Aiders and senior colleagues walking the wards during the strike periods, providing several avenues for colleagues to access should it be required. AARs also serve as a debrief post incident which supports well being of the staff involved.

4) What could we have done better/consider for the future?

Discussions initially around the scheduling of IATF meetings being changed to accommodate other activity in the day and the external meetings with partner agencies that RPH must attend, timings have been adjusted and adapted to suit maximum attendance where possible. Consideration raised for the timings of command-and-control (C&C) internal meetings to change by fifteen minutes, so that there is no clash with health ICS system calls. Command and control (C&C) timings happened simultaneously with Health Industrial Action IMT System calls (System calls); it is therefore difficult to attend both. The System calls are for escalation of information to and from, this process is hindered in the current set up of C&C timings. It is also not possible to find appropriate cover to attend both calls when Operational Lead EPRR is unavailable.

A risk was identified during BMA and HCSA IA, where no central roster is held for these staff groups. This risk has been entered on the register and acknowledged as an urgent need to resolve. This risk sits with the Workforce Directorate. Workforce staffing figures for medical colleagues during IA was achieved via a laborious and manual process but was provided promptly once this manual system was set up. This manual system is only active for IA, which leaves the organisation open to risk should further incidents occur.

This manual process, undertaken by Workforce leads, is effective in providing staffing updates at the first IA meeting of the day during incident. This information is requested by the Integrated Care Board (ICB) for the first meeting of the day at 09:00hrs. RPH are the only providers with this information at this hour. This is recognised by the ICB and has been shared with regional operational command.

During the last period of BMA, HCSA and SoR IA, there was a change to the operational procedure for working during normal business as usual hours. There was some feedback given about this; where some confusion as to expectations of roles for operational teams arose, leading to confusion and uncertainty during IA. More specifically the Matron Teams advocated they felt the impact the most as their role had been more heavily involved in previous IA but felt there was less need for them in the last period of IA. During the changes to operational procedure, all staff groups were supported by a regular open forum for discussion and feedback, chaired by RPH Chief Operating Officer and Chief Nurse.

During the NMC IA, junior doctors were rostered to cover the ALERT Team rota. This highlighted a role expectation difference between ALERT and the junior doctors. Highlighting a need for a standard operating procedure (SOP) written by ALERT to support roster fill by clinicians not normally assigned to the post. It was discussed in the IA AAR where feedback was provided to ALERT Team Leads. An SOP was subsequently developed. There were no direct patient safety concerns, this was a role expectation difference which was swiftly addressed.

During the RCN IA RPH submitted for derogation. RPH had not effectively communicated its intent to submit derogations to the wider staff groups outside of IA planning groups. Due to the system delay in the process of receiving and providing a result of the derogation requests, RPH did not receive notification of the approved derogations until the morning of the IA period. There were approved derogations for most inpatient wards, with the addition

of emergency pathways remaining open. This meant that nursing colleagues who had planned to strike and walk out at the planned IA time, were coming to work that morning and being told of the derogations in place. A more robust communication process and a communication of intent was recommended for future strike periods. This issue did not occur a second time.

The Society of Radiographers IA periods were reported as well led, however feedback from area leads suggests that not enough emphasis on the significance of the IA impact from this area was considered during the planning phase by the Industrial Action Task Force Group. It was felt that if the area were to close more services because of IA, then there would be a larger impact across the Trust than IATF group had considered, including a compromise to emergency pathways. There may be a need to consider derogations in future action for SoR.

It was recommended that communication of IA times and dates during the earlier periods was unclear, with multiple sources of information being available for staf internally and externally. The Communications Team developed and provided a 'single point of truth' to support accurate and timely information relating to IA that our staff could trust. This became a central online hub for staff to access on the intranet.

It highlighted regionally that teams dealing with the booking of patients on their pathways, were being subjected to disgruntled patients which took the form of verbal abuse. This was brought back to the RPH AAR for highlighting and consideration to the welfare of our booking team colleagues. These staff are exposed to repeated conversations with patients cancelling and re-booking them. No reporting of incidence around this has been raised at AAR so no further escalation of concern from RPH, the matter Is highlighted to safeguard our staff.

5) Recommendations and Next Steps

Recommendations	Next Steps
Continued practice of adjusting IATF meeting times to maximise attendance for the planning stages. Coordinate the timings of the afternoon and evening C&C meetings to prevent clashes with other critical IA meetings. 14:00 hrs to 13:45hrs and 20:00hrs to 19:45hrs.	Formalise a process and set precedence for timings, that can be enacted at all incidents requiring a C&C. It is likely that the System calls will remain static, so coordinating and formalising a process for RPH calls to occur prior to System calls will foster resilience and provide support. For Approval by COO, MD, and Chief Nurse Information of changes shared with IATF administrative colleagues for actioning and agenda. Timeline for completion – End November 2023
Clarify role expectations for staff affected by the new ways of working and operational procedure changes.	Continue to develop and communicate the new standardised operational procedures to mitigate confusion as far as possible.

	Ongoing Operational Change meetings – monthly Expectation for full integration of operational changes – End December 2023 Concluding meeting and further communications Trust wide – January 2023 Timeline for completion – End January 2023.
Implement a central roster for medical staff. Risk to the organisation exists here outside of IA. There is also staff welfare and incident resilience impact here.	Risk 3374 (Medical Staffing Rostering - No centralised roster) has been approved. The timeline for completion is under workforce work plan. Workforce to continue work developing a centralised roster for resolution to the organisation risk. IA roster data collection process review by workforce, to support further IA periods. Expected Timeline information held by Workforce. Suggested completion estimation March 2023.

The Board are requested to:

- Note the contents of the AAR and recommendations for information.

Appendix 1

Industrial Action Dates RCN:

15th December & 20th December 2022 RCN

18th -19th January 2023 RCN

6th -7th February 2023 RCN

1st-3rd March 2023 RCN

30th April – 1st May 2023 RCN

6th-7th June 2023 RCN

Industrial Action Dates BMA, HCSA, SoR:

13th-18th July 2023 Juniors

20th-22nd July 2023 Consultants

25th-27th July 2023 SoR

11th-15th August 2023 Juniors

24th-26th August 2023 Consultants

19th-20th September 2023 Consultants

20th September 2023 Juniors with Christmas Day level cover

21st-22nd September 2023 Juniors

2nd-5th October 2023 Juniors (Christmas day level cover)

3rd-4th October 2023 SoR