MS2. Fiona Cameron

Fareham and Gosport NHS
Primary Care Trust

file

FAREHAM AND GOSPORT PRIMARY CARE TRUST

A meeting of the Gosport G.P Group will be held at 12.30 – 2.00pm on Thursday 3rd July 2003 in the Seminar Room, Gosport War Memorial Hospital

(Lunch Provided)

AGENDA

1.	Apologies for absence	
2.	Minutes of the meeting held on Thursday 8th May 2003 (attached)	
3.	Matters arising:	
	▪ Provision of radiology and pathology services – update	Rachael Boyns
	▪ G.P Beds (Sultan ward) - update	Jan Peach
4.	PCT Escalation Policy (attached)	Caroline Harrington
5.	CHD Specialist Nurse Led Clinic – transfer of activity to Practices	Vanessa McMahone
6.	Prescribing:	
	▪ Prescribing budgets 2003/04	Nic Allen
	▪ Prescribing incentive scheme	Nic Allen
7.	Future G.P Group meetings – discussion	Gordon Sommerville
8.	A.O.B	
	▪ Primary care based physiotherapy	
9.	Date of next meeting:	
	Thursday 4th September 2003, 12.30 – 2.00pm	

For information: Practice Link Nurse Initiative (paper attached)

FAREHAM AND GOSPORT PRIMARY CARE TRUST

GOSPORT GP GROUP

Minutes of the Meeting held on Thursday 8 May 2003 at Thorngate Hall, Gosport

PRESENT:

Dr Bob Pennells
Dr David Young
Dr Peter Lacey
Dr John Bassett
Dr Tony Knapman
Jayne Coulborne
Dr Stuart Morgan
Jan Peach
Margaret Smith
Sue Halewood
Dr Nic Allen
Rachael Boyns
Peter King

IN ATTENDANCE:

Elaine Taylor
James Barton
Ben Genevieve

APOLOGIES FOR ABSENCE:

John Grocock
Declan Lynch
Tony Evans

		ACTION
1	**Minutes of the Meeting held on Thursday 6th March 2003** These were agreed.	
2	**Matters Arising** General Physician enquiry BP agreed to collate the responses, which will be circulated to all members of the group for information.	**BP**
	Guidelines for assessment and admission to the GP Beds Guidelines for assessment and admission to the GP Beds (Sultan Ward) have been circulated to all members of the GP Group. The guidelines were agreed and will be actioned immediately. Jan Peach reported that	

there is currently capacity of approximately 5 to 6 beds on Sultan Ward for GP admissions.

3 **Provision of Radiology and Pathology Services for Gosport Residents**

Ben Genevieve gave a short presentation on the future proposed plans for Radiology and Pathology Services. For pathology, it is proposed that specimens from Gosport and Fareham practices should be sent to Haslar Hospital instead of Queen Alexandra Hospital. The potential advantages are, the quicker transportation of results to the laboratory and decreased deterioration of specimens due to quicker analysis as a result of lighter workloads in comparison to QAH. The transfer of work to Haslar will also enable the department to retain accreditation. The department will ensure that a biochemist is available during normal hours to address GP queries. **BG**

The GPs queried the availability of results via GP links. Ben Genevieve confirmed that this issue is currently being explored but that if tests cannot be provided through GP links, then the transfer of work will not occur. The GPs also queried the impact on the availability of phlebotomy services. It was confirmed that the proposal would have no impact on the current phlebotomy services. Dr Stuart Morgan also raised the issue that Haslar could not maintain the anti-coagulation service over the Christmas period. It was agreed that prior to the transfer occurring, this issue needs to be addressed.

For radiology, Ben Genevieve explained that the Trust wanted to increase the provision of imaging services within the community to utilise of spare capacity at Gosport War Memorial Hospital, (as a result of the introduction of the IRMER guidelines) and the the X-Ray Department at Haslar. The service will be provided for Gosport residents and the patients of some Fareham practices who choose to attend Gosport War Memorial Hospital or Haslar, instead of St Mary's Hospital. Either an appointment system or a walk-in service can be operated. There is potential to also provide MRI and ultrasound services from Haslar. Confirmation would be required that the quality of the service would be guaranteed prior to the proposal being accepted by the PCT. It was noted that information sheets detailing the venues and times that the services were available would also be required, to enable GPs to promote the usage of the service to their patients.

Ben Genevieve reported that a paper is to be produced outlining the proposals for the future provision of Radiology and Pathology Services for consideration by the PCT Professional Executive Committee. If the proposals are approved by the PCT, and the issues regarding the reporting of results resolved, implementation could occur in September 2003.

4 **Inpatient Policy – Portsmouth Hospitals NHS Trust**

James Barton circulated a copy of the Inpatient Policy to the group. The policy covers the following key areas:

- Adding patients to the waiting list

- Suspending patients from the waiting list

Patients are suspended because the patient is medically unfit or for a social reason. Trusts are allowed to suspend patients for a maximum of 6 months and then review, (exceptions are pregnancy and deployment).

- Selection of patients for treatment

Patients are selected based on clinical urgency and then in turn.

- Cancelled operations

If a patient is cancelled on the day of admission, the hospital has a responsibility to recall that patient within 28 days. PHT is achieving this target. If a patient cancels the appointment on 2 occasions, then the standard policy is to refer the patient back to their GP.

- DNAs

If a patient DNAs, then the patient can be removed from the waiting list. In reality, each case is reviewed by the consultant and a decision taken. The GP is informed of this decision.

The importance of having a clear review process when a patient was on the suspended list was stressed. This needs good communication between the Trust and the patient's GP.

If GPs have any further queries regarding the Inpatient Policy, James Barton can be contacted on Code A

5 **Prescribing**

Prescribing Budgets 2002/03
Peter King reported that based on month 11 data, the PCT was showing an overspend of £1,055,121 across Fareham and Gosport Practices. The forecast overspend for 2002/03 is £1,156,987.

Prescribing Budgets 2003/04
Peter King explained the rational between the three models proposed for setting the 2003/04 practice prescribing budgets. It was agreed that model 3, incorporating equity and historical spend, was the preferred model for calculating practice prescribing budgets. It was agreed that the split should be 20% equity, 80% historical spend. **PK**

Prescribing Incentive Scheme 2003/04
Sue Halewood outlined the proposed Incentive Scheme for 2003/04. The following 3 targets have been suggested:

- Individual Antibiotics Prescribing – volume of antibiotics prescribed
- Antibiotics Prescribing – cost of antibiotics prescribed
- Practice Targets (linked to practice prescribing variances).

It was noted that the PCT is currently exploring whether practices that deliver the targets but still overspend, can still receive an incentive payment.

Sue Halewood reported that information regarding performance against the 3 targets can be provided by practice and GP, if required. Practices were asked to inform Sue Halewood if the information is not required by GP. **ALL**
It was noted that the Prescribing Incentive Scheme payment is £400 per partner per target.

District Formulary
Sue Halewood reported that the District Formulary is available under **http:nww.ports.nhs.uk.** The formulary can be accessed through clinical

information/district formulary.

6 **Any Other Business**

Emergency Planning Policy
The PCT Emergency Planning Policy was distributed to the group. This will be discussed at the next meeting of the Gosport GP Group. Any queries regarding the policy can be raised with Caroline Harrington prior to the meeting.

7 **Date of Next Meeting**

Thursday 3 July 2003, 12.30 – 2.00 p.m., Seminar Room, Gosport War Memorial Hospital.

EMERGENCY PLANNING & MAJOR INCIDENT RESPONSE POLICY

1. PURPOSE

1.1. This Policy sets out the joint arrangements that will ensure an effective response to a Major Incident by East Hampshire Primary Care Trust, Fareham & Gosport Primary Care Trust and Portsmouth City Primary Care Trust (hereafter referred to as *the PCTs*).

1.2. It accords with national guidelines and procedures, and has been agreed with other statutory agencies in the Portsmouth and South East Hampshire area, e.g. Hampshire Ambulance, Hampshire & Portsmouth Social Services, other Primary Care Trusts, West Hampshire Mental Health Trust and Portsmouth Hospitals NHS Trust.

Legal Considerations

1.3 If a PCT fails to plan for, or respond effectively to, a major incident, it could lead to at best, adverse publicity and criticism at an inquest or public inquiry and at worst, a breach of civil or criminal law and subsequent prosecution. To minimise the risk of litigation, the PCTs must ensure that all of the requirements of this Policy are met and in particular, that staff who are required to respond to a major incident are properly trained, briefed and supported.

2. SCOPE

2.1. This Policy covers:

a) what constitutes a Major Incident
b) the role of the PCTs in the event of a Major Incident, and relationships with other key agencies (e.g. Primary Care Trusts, West Hampshire Mental Health NHS Trust, Portsmouth Hospitals NHS Trust, Social Services, fire, ambulance and police services)
c) the procedures for communicating and co-ordinating the actions required
d) the roles of employees with specific responsibilities in managing the response to a Major Incident
e) links between this Policy and Escalation Plans
f) links between this Policy and the Serious Untoward Incident Reporting procedure
g) links between this Policy and supporting on-call/duty management systems within PCTs

3. WHAT IS A MAJOR INCIDENT?

3.1. A widely accepted definition of a Major Incident is **"any incident that requires the implementation of special arrangements by one or more of the emergency services, the NHS, or the local authority."**

3.2. For NHS purposes a Major Incident is defined as **"any event that presents a serious threat to the health of the general public, disruption to health services, or causes such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance services, other health care providers, or health authorities."**

3.3. Possible incidents which could arise in Portsmouth & South East Hampshire are risk assessed each year by the PCTs and include:

- major road traffic accident on M27, A3, A3(M)etc
- an incident involving a ferry or other large vessel in the Solent
- an air disaster over the area (Portsmouth is on the Gatwick/Heathrow flight path)
- a radiation incident at Portsmouth Naval base
- a significant incident on the local rail network
- a major infection or infectious disease outbreak
- drinking water contamination
- terrorism – chemical, biological, radiological or nuclear

3.4. The events listed above may generate a large number of casualties, however there are other events that may place a significant burden on local health services and/or impact on their ability to deliver normal services. These include but are not limited to civil emergencies (e.g. petrol crisis, flooding, terrorist threats, etc), public health scare, etc, and in such circumstances a major incident could be declared.

3.5. On a larger scale 'mass' casualty incidents resulting from chemical, biological, radiological or nuclear (CBRN) incidents could result in thousands rather than hundreds of affected people.

3.6. A major incident could also be 'internal' to an NHS Trust or PCT e.g. a significant event such as a fire, chemical exposure, etc, which significantly disrupts business or there is an incident which will attract significant media or public attention such as a public health, infection, screening or communicable disease event.

3.7. Most crises should be handled through extending normal day-to-day arrangements and referring to business continuity plans and contingency arrangements. The emphasis should be on responding to an emergency regardless of its cause. Plans should be flexible to deal with a range of situations which are likely to increase in magnitude, duration or complexity, and which may affect areas covered by more than one health region. Specialist arrangements may be required in the event of unusual incidents, e.g. communicable disease, biological threats and radiation.

3.8. There is a vast range of possible scenarios and it is not possible to have specific plans for them all. Plans need to be flexible and based on integrated emergency management which means that the planning emphasis is on the consequences and not the cause of the incident.

4. ROLES & RESPONSIBILITIES

4.1. The **Chief Executive** of each PCT has overall responsibility for emergency planning and is accountable to the PCT Board for ensuring systems are in place to facilitate an effective major incident response.

4.2. **Board Leads** are also identified in each organisation, they are:

East Hampshire Primary Care Trust	Director of Public Health
Fareham & Gosport Primary Care Trust	Operational Director, Community Services
Portsmouth City Primary Care Trust	Director of Community Services

Within each PCT there will be a forum where emergency planning matters are raised, discussed and agreed with relevant staff (e.g. Emergency Planning Group, Senior Management Team meetings, Risk Management Committee, etc).

4.3. East Hampshire Primary Care Trust will be the **Lead PCT** across the local health economy and will undertake the emergency planning functions of the former Health Authority. This will include co-ordinating the planning process, arranging joint meetings, maintaining a central register of plans and liaising with external agencies such as the local authorities, police, Health Protection Agency (after 1st April 2003) and other emergency services and PCTs/Trusts in neighbouring districts and counties. A detailed specification for the Lead PCT role is available from the EPLO at East Hampshire PCT.

4.4. The Lead PCT will co-ordinate a multi-agency **Joint Health Emergency Planning Group** which meets every quarter to ensure local emergency planning arrangements are robust. Terms of Reference are attached as **APPENDIX A**.

4.5. Relevant PCT staff will also be members of the Hampshire & IOW Health Emergency Planning Group (chaired by the Strategic Health Authority) and the Major Emergencies Co-

ordination Committee (MECC) which involves the emergency services, and the LA (PCC) forum which leads planning for radiation incidents and develops the PORTSAFE plans.

4.6. An **Emergency Planning Liaison Officer** (EPLO) will be designated in each PCT. EPLOs have responsibility for co-ordinating emergency planning arrangements, including maintaining HQ call-in and out of hours contact lists, and acts as the named link (Responsible Officer) with Portsmouth Hospitals NHS Trust and other Trusts/Agencies and with the Regional Health Emergency Planning Adviser.

EPLOs are:

East Hampshire Primary Care Trust	Risk & Governance Manager
Fareham & Gosport Primary Care Trust	Risk & Litigation Manager
Portsmouth City Primary Care Trust	Business Assurance Manager

4.7 **Other PCT staff** that will take part in the planning and execution of the emergency response plan as required, may include:

a) Senior managers and other staff in each PCT's Headquarters office
b) Directors of Public Health
c) Radiation Protection Adviser (from Portsmouth Hospitals Trust)
d) Communications Managers
e) Estates Managers
f) Service Managers & Duty Managers
g) Community hospital managers and staff
h) Children's Services managers and staff
i) Managers and staff in the Department of Medicine for Elderly People
j) Community nursing managers and staff
k) Secretarial and support staff

4.8 Individual members of staff are responsible for reporting any change in their home address or home telephone and mobile telephone number to the EPLO to enable out of hours contact lists to be maintained.

5. DECLARING A MAJOR INCIDENT

5.1. Usually first at the scene of a casualty related incident, the Ambulance Service is responsible for assessing the situation and declaring a major incident by selecting and alerting the most appropriate receiving hospital(s).

5.2. Chief Executives of NHS Trusts and PCTs (or their designated deputies) also have the prerogative to declare an internal major incident if the need arises e.g. if the emergency presents via other sources, e.g. at the hospital itself or there is a major local public health outbreak.

5.3. Depending on the nature and circumstances, other agencies such as the Police, Local Authority and Coastguard could also declare a major incident.

5.4. Queen Alexandra Hospital (QAH) in Cosham is designated as the receiving Hospital in Portsmouth & South East Hampshire area for Major Incidents, although more than one receiving hospital may be designated depending on the nature and location of the incident.

5.5. Whichever agency declares the major incident, the system of notification (to QAH) and cascade method is the same and once declared, the Switchboard at QAH will activate their cascade notification system. Each PCT will be notified of the incident as part of this cascade and will receive a telephone call from switchboard staff.

5.6. Arrangements are in place 24 hours a day 7 days a week to ensure PCTs can be alerted of a major incident. During office hours (9am-5pm Monday to Friday) the Switchboard at QAH will call each PCT Headquarters office. Out of office hours, the Switchboard will contact the senior manager on-call from each PCT by pager or mobile. All members of PCT senior management on-call teams will be provided with up to date copies of policies, procedures, telephone and contact lists to allow them to effectively respond to a major incident alert out of hours.

6. THE PCT RESPONSE

6.1. As a provider of primary care, community health, mental health and elderly medicine services, the PCTs are required to respond in a number of ways:

a) To manage and co-ordinate activities and information to/from PCT services in order to:
- provide inpatient capacity to support providers involved in the immediate response
- provide on-going support to patients in the community
- provide information to members of the public about the incident
- support General Practices who may be contacted or be involved in responding to the incident
- contribute to the psychological welfare support provided to victims, their families and relatives

b) To contribute to the district and if necessary, Hampshire-wide incident management arrangements by, if requested, providing staff to attend and liaise with Strategic, Operational and Tactical command posts and the local PCT Joint Incident Co-ordination Centre.

c) As soon as a major incident is declared and details/scale/impact have been assessed, PCTs should assess their ability and capacity to provide an effective response to the incident AND continue to provide their full range of normal services. PCT Chief Executives may decide that non-urgent and routine services will be suspended during the major incident and post incident recovery period.

d) In responding to a major incident PCTs will not expose their staff to unnecessary health and safety and other risks. For example PCTs will ensure that if protective equipment is needed, it is provided, that staff are not expected to work or treat patients in dangerous or unsafe environments, that adequate shift and rota breaks are built into prolonged incident management arrangements, etc.

Incident Management

6.2. Depending on the nature and scale of an incident staff from any of the three PCTs could/will contribute to the management of a major incident at a number of levels – by providing representation at Strategic, Tactical and Operational commands, at the Joint PCT Co-ordination Centre and at each PCTs own Control Room. **CHART 1** (page 11) summarises the role and responsibilities for co-ordinating the response of PCT services.

Action Cards

6.3. The Action Cards appended to this Policy set out roles and responsibilities and detailed instructions for each PCT Service that may be involved in responding to a major incident.

6.4. **Action Cards are for guidance, they are not prescriptive. Their instructions should be tailored to meet the circumstances of the incident.**

6.5. Not all of the Action Cards will be needed for every type of incident, e.g. the Radiation Response Action Card is only activated in the event of a major incident involving radiation exposure or threat of exposure.

6.6. Action Cards will be held at relevant locations across each PCT, e.g. the Community Hospitals Action Card and associated call-in lists and contact lists must be held at each Community Hospital.

6.7. Each PCT EPLO is responsible for ensuring the relevant staff in their PCT have access to an up to date version of the relevant Action Card/s at all times in accordance with the following:

Action Card		Copy to be held by:
1	Joint PCT Incident Co-ordination Centre	▪ Joint PCT Co-ordination Centre ▪ Central file in each PCT Headquarters office ▪ Each PCT Director On Call
2	PCT Headquarters Office	▪ Joint PCT Co-ordination Centre ▪ Central file in each PCT Headquarters office ▪ Each PCT Director On Call
3	Department of Elderly Medicine	▪ Joint PCT Co-ordination Centre ▪ Central file in each PCT Headquarters office ▪ Each PCT Director On Call ▪ Elderly Medicine Divisional Manager ▪ Portsmouth Hospitals EPLO/Co-ordination Centre
4	Media & Communications	▪ Joint PCT Co-ordination Centre ▪ Central file in each PCT Headquarters office ▪ Each PCT Director On Call ▪ Communications Manager/s
5	Psychological & Welfare Response	▪ Joint PCT Co-ordination Centre ▪ Central file in each PCT Headquarters office ▪ Each PCT Director On Call ▪ Designated Health Lead ▪ Lead Clinicians from relevant PCT & MH Trust services
6	Community Hospitals & Community Nursing	▪ Joint PCT Co-ordination Centre ▪ Central file in each PCT Headquarters office ▪ Each PCT Director On Call ▪ Community Service Duty Managers ▪ Clinical Managers in each Community Hospital ▪ Community Nursing Service Managers ▪ Portsmouth Hospitals EPLO/Co-ordination Centre
7	Children's Services	▪ Joint PCT Co-ordination Centre ▪ Central file in each PCT Headquarters office ▪ Each PCT Director On Call ▪ Community Service Duty Managers ▪ Children's Service Service Manager
8	Radiation & Chemical Incidents	▪ Joint PCT Co-ordination Centre ▪ Central file in each PCT Headquarters office ▪ Each PCT Director On Call ▪ Radiation Protection Adviser ▪ Community Nursing Service Managers
9	Public Health/ CCDC	▪ Joint PCT Co-ordination Centre ▪ Central file in each PCT Headquarters office ▪ Each PCT Director On Call ▪ Each PCT Director of Public Health ▪ Consultant's in Communicable Disease

Communications

6.8. Action Cards set out the communication requirements at each level of the organisation and it is the responsibility of the staff designated within each PCT to ensure call-in lists and contact numbers associated with each Action Card are kept up to date.

6.9. The telephone and fax numbers of each PCTs sites including community hospitals, health centres, clinics, etc, and the home telephone numbers of senior managers, service managers

and other key staff, are protected under the **Government Telephone Preference Scheme (GTPS)**. In the event that telecommunications infrastructures become overloaded, provider companies can withdraw the facility to make outgoing calls from domestic and commercial numbers. Only telephone numbers listed on the GTPS will retain normal telephone and fax services.

Media & Public Liaison

6.10. All media and public enquiries received by services will be directed to the relevant PCT Headquarters office. Unless authorised by PCT HQ, individual members of staff must not make statements or provide information to the media. Depending on the nature of the incident and what arrangements have been agreed locally, the PCTs may deal directly with media enquiries or refer them to the Communications Manager who will liaise with the Strategic Health Authority, local authorities, the Police and other health agencies to identify a media spokesperson.

6.11. Depending on the nature of the incident, providing information to the general public may also be required. On behalf of the local health economy, the Communication Manager/s will liaise with NHS Direct and a local authority to establish a helpline or information line facility. The PCT will not normally make independent helpline arrangements.

Record Keeping

6.12. **APPENDIX B** is a contacts and action log pro forma for keeping a record of all instructions received, action taken and rationale for actions/decisions and other information that will enable the PCTs to assess the success of the emergency response. All staff responsible for initiating any of the Action Cards must complete a pro forma. After the incident, all pro formas must be forwarded to the EPLO for review and safekeeping.

6.13. Following a major incident the PCTs may be invited to attend an inquiry or provide evidence to an enforcement agency such as the Health & Safety Executive, Coroners Inquest, the Police or a civil court hearing. The PCTs may be obliged to provide access to documents produced prior to, during or as a result of the incident and under no circumstances, should any document that relates to the incident be destroyed.

Independent Contractors – GPs & Community Pharmacists

6.14. Not all those people involved in a major incident will need hospital treatment. Some people, their family and friends, uninjured survivors, and people who have been evacuated from the area of the incident, may need support to aid their recovery, which could be long term.

6.15. This could impact on GPs and community pharmacists in the form of an increased demand for services or information. The role of the PCT is to support independent contractors should the need arise by (for example) providing public health and self-help information for patients, arranging GP cover, organising a telephone helpline (via NHS Direct) and increasing the availability of administrative, community nurses and primary care counselling services to GP Practices.

Post Incident Action

Stand Down

6.16. As the incident draws to an end, a positive decision will be made to 'stand down'. In the event of a casualty related incident, the Ambulance Service and Queen Alexandra Hospital (as the receiving hospital) will normally liaise to determine when the stand down is appropriate. Portsmouth Hospitals Switchboard at QA Hospital will then cascade this

message to all wards/departments and organisations on their original notification list. PCTs in turn will notify their staff and services and GP practices of the stand down.

Debriefing & Staff Support

6.17. Once the incident is at an end, those involved will be invited to attend optional debriefing sessions, organised either by the PCT, their department or Service. The purpose of debriefing is to a) provide immediate post-incident reflection and discussion for the staff concerned and b) evaluate each aspect of the PCTs response to the incident to identify and address areas that may need improvement.

6.18. Senior PCT staff will also be invited to attend multi-agency debriefing sessions.

6.19. In some circumstances, an independent facilitator (such as the PCTs Employee Assistance Provider) may be asked to assist with the debriefing process and individual support and advice will be offered to any member of staff who feels they have been personally affected by the incident.

Learning from the Incident

6.20. Each PCT Emergency Planning Liaison Officer is responsible for preparing an incident report which sets out what has been learnt from the incident within their PCT, sharing with relevant PCT staff, other agencies and the HEPA, and updating the Major Incident Policy and Action Cards as appropriate.

7. STAFF TRAINING & EDUCATION

7.1. At Induction with their Line Manager, new staff in each Trust will be issued with a leaflet (**APPENDIX C**) that explains the role of local health services and specifically PCTs, in the event of a major incident.

7.2. Staff with a specific role (senior managers, bleep holders, etc) will receive appropriate training commensurate with their role in a major incident.

7.3. Front line staff will also receive training through participating in exercises that test out this plan, and in joint training events organised with other NHS organisations and external agencies e.g. social services.

7.4. Key staff from the PCTs will attend the annual Emergency Planning Seminar held by the Regional Health Emergency Planning Adviser and may also attend relevant courses held at the Home Office Emergency Planning College as required.

7.5. The Emergency Planning Liaison Officer in each PCT will ensure that records of staff trained within their organisation are maintained and retained for future reference.

8. TESTS AND EXERCISES

8.1. The PCTs will conduct internal communications tests every six months.

8.2. The PCTs will participate in multi-agency communications tests and other exercises including LIVEX (organised by the local authorities and emergency services) and any exercises (communications or live exercises) organised by Portsmouth Hospitals Trust.

8.3. Following a Major Incident test, the PCTs ability to comply with each element of the policy will be analysed and evaluated and response arrangements amended to reflect lessons learnt if necessary.

EMERGENCY PLANNING & MAJOR INCIDENT RESPONSE POLICY

9. PERFORMANCE INDICATORS & BOARD REPORTING

9.1. The following key performance indicators are designed to test that plans and procedures for responding to a major incident are working satisfactorily:

9.1.1. This policy and procedure will be assessed annually against the Organisational Controls Assurance Standard in Emergency Planning. Each PCT will demonstrate a year-by-year improvement in their compliance with the Standard.

9.1.2. PCTs will submit annual returns to the Health Emergency Planning Adviser and report on training, exercises and response to actual incidents during the year.

9.1.3. The Lead PCT EPLO will ensure the Major Incident Policy & Procedures is updated at least annually.

9.1.4. The PCTs will participate in at least six monthly internal communications tests and will participate in the six monthly communications test initiated by Portsmouth Hospitals Trust.

9.1.5. The PCTs will participate in at least one live exercise each financial year (PCT exercise, PHT live exercise, LIVEX, etc).

9.1.6. All staff with a role in emergency planning will receive training commensurate with their role.

9.2. The Lead Director and PCT EPLO is responsible for ensuring that each PCT Board receives an annual report so that it may monitor and review all aspects of the system for emergency planning including accountability arrangements, planning arrangements, capability, performance against key indicators. Reports should include any independent assurances on received by such bodies as Internal/External Audit, CHI, Health & Safety Executive, Health Emergency Planning Adviser, etc.

9.3 The Hampshire and Isle of Wight Strategic Health Authority (StHA) is responsible for monitoring the performance of the PCTs in relation to their emergency planning responsibilities. This will normally done through the Regional Health Emergency Planning Adviser (HEPA). The PCTs will provide any information required by the StHA and HEPA to enable them to fulfil this performance monitoring responsibility.

10. RISK ASSESSMENT

10.1. The PCTs will complete an annual risk assessment, which will consider possible major incident scenarios that could arise locally and their potential impact on local services.

10.2. Each ward/department/area with a role in the implementation of the Major Incident Plan will assess its compliance with this policy as part of the annual risk assessment process by completing **APPENDIX D** of this policy. An Action Plan to address the deficiencies identified on the risk assessment must be developed and implemented in each area.

11. LINKS TO OTHER PCT PROCEDURES

Serious Untoward Incident Reporting

11.1. A major incident is classed (for reporting purposes) as a Serious Untoward Incident and must be reported immediately to the Strategic Health Authority as per instructions in the latest guidance *Interim Serious Untoward Incident Guidance* issued by the Hampshire & Isle of Wight Health Authority (dated 1 April 2002).

EMERGENCY PLANNING & MAJOR INCIDENT RESPONSE POLICY

Escalation Plans

11.2. A major incident may result in sufficient numbers of casualties and admissions so as to invoke the escalation plans of any of the health care providers in the district. Escalation plans of each PCT will include capacity planning and plans will be retained with major incident plans for cross-referencing where applicable. Escalation plans should include triggers for escalation beyond the organisation/s immediately involved, e.g. to other PCTs and mutual support arrangements with other PCTs in Hampshire should be in place.

Joint Health Advisory Plan (JHAC)

11.3. A separate document sets out Hampshire-wide arrangements for providing public health and NHS management input into strategic (Gold), tactical (Silver) and operational (Bronze) incident command levels. The JHAC and Health Management Team will provide strategic co-ordination of the integrated NHS response across the local health economy. The contents should be familiar to PCT senior management teams and a copy held by each PCT Director of Public Health, the Joint PCT Co-ordination Centre and at each PCT Headquarters Office.

Fire Safety, Bomb Alert, Post Opening and related internal security procedures

11.4. Each PCT has internal security plans for each of the topics above with which all relevant staff must be familiar.

12. POLICY REVIEW & AUDIT

12.1. Each PCT will review contact and telephone call in-lists every 6 months and this policy/plans annually and after each test/exercise or actual incident.

12.2. As part of the Controls Assurance process, each PCT will arrange for the policy to be audited by Internal Audit or District Audit periodically and a report presented to the Risk Management Committee and the PCT Board.

13. REFERENCES

13.1. Planning for major incidents: the NHS Guidance -The Primary Care Trust (September 2002)
13.2. Emergency Planning & Response to Major Incidents: Summary of Roles & Responsibilities (September 2002)
13.3. Organisational Controls Assurance - Emergency Planning Standard (October 2002)
13.4. Health Emergency Planning Standards - Emergency Planning Co-ordination Unit, Department of Health (April 2000)
13.5. EL(96)79 :Emergency Planning In The NHS, Health Service Arrangements For Dealing With Major Incident (11 October 1996)
13.6. Psychological and Psychiatric (Phase II) Response To Major Incidents, A Guide To Operational Planning : (Wessex Regional Health Authority)
13.7. Portsmouth Hospitals NHS Trust Major Incident Plan
13.8. Preparing For Your Role In An Emergency: Emergency Planning College 1995/96

14. DISTRIBUTION

14.1. All Policy Holders in each PCT
14.2. Executive Directors On Call in each PCT
14.3. PCT Duty Managers in each Service
14.4. Lead PCTs for North & Mid Hampshire, Southampton, Chichester and the Isle of Wight
14.5. Portsmouth Hospitals NHS Trust - Emergency Planning Liaison Officer
14.6. Isle of Wight Health Care Trust – Emergency Planning Liaison Officer
14.7. Isle of Wight PCT – Emergency Planning Liaison Officer

14.8. Hampshire Ambulance Service – Emergency Planning Officer
14.9. Strategic Health Authority – Director of Public Health
14.10. Regional Health Emergency Planning Adviser
14.11. Social Services – Hampshire County Council & Portsmouth City Council
14.12. Independent General Practitioners and Community Pharmacies

15. DOCUMENT CONTROLS

Policy author	Julie Jones, Risk & Governance Manager, East Hampshire PCT in consultation and agreement with Portsmouth City PCT and Fareham & Gosport PCT.
Previously approved by Portsmouth HealthCare Trust	Version 1.0 - January 1997 Version 2.0 - July 1999 Version 3.0 - November 1999 Version 4.0 - April 2001
Version 5.0 approved by each PCT	March 2003
Date of next Review	March 2004

CHARTS & APPENDICES:

Chart 1	PCT Co-ordination Arrangements
Appendix A	Joint Health Emergency Planning Group Terms of Reference
Appendix B	Contacts & Action Log
Appendix C	Staff Information Leaflet
Appendix D	Annual Risk Assessment Checklist

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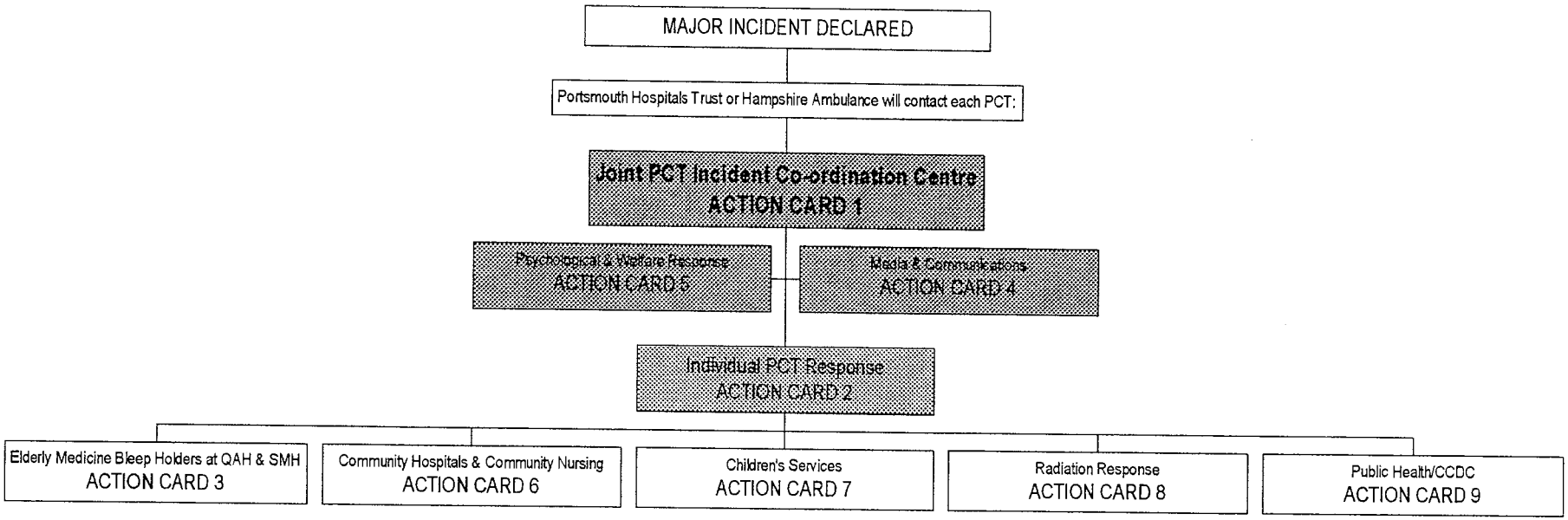
EMERGENCY PLANNING & MAJOR INCIDENT RESPONSE

CHART 1

INCIDENT CO-ORDINATION ARRANGEMENTS



EMERGENCY PLANNING & MAJOR INCIDENT RESPONSE

Portsmouth & South East Hampshire
JOINT HEALTH EMERGENCY PLANNING GROUP

APPENDIX A

MEMBERSHIP

Core members

Julie Jones, Emergency Planning Liaison Officer	East Hampshire PCT **(Lead PCT)**
Sue Galley, Communications Manager	East Hampshire PCT
Nick Hicks, Director of Public Health	East Hampshire PCT
Caroline Harrington, Emergency Planning Liaison Officer	Fareham and Gosport PCT
John Henly, Joint PCT Emergency Planning Co-ordinator (**Chair**)	Hampshire & Isle of Wight StHA
John Dyer, Emergency Planning Officer	Hampshire Ambulance Trust
Phil Griffiths, Emergency Planning Officer	Hampshire County Council
Paul Bingham, Emergency Planning Liaison Officer	Isle of Wight PCT
Jane Greening, Emergency Planning Officer	Portsmouth City Council
Dr Edmundo Neira, Consultant in Communicable Disease	Portsmouth City PCT
Susannah Long, Emergency Planning Liaison Officer	Portsmouth City PCT
Dr Simon Mullet, Clinical Director, A&E Department	Portsmouth Hospitals Trust
Glen Hewlett, Emergency Planning Liaison Officer	Portsmouth Hospitals Trust
Nick Bishop, Emergency Planning Officer	Portsmouth Social Services
Steve King, Risk Services Manager	West Hants Mental Health Trust

For information/invited as appropriate

Chris Gundry, Health Emergency Planning Adviser	Hampshire & IOW and Surrey & Sussex HAs
Simon Tanner, Director of Public Health	Hampshire & Isle of Wight StHA

Terms of Reference

1. To co-ordinate and monitor the development and regular updating of the major incident and other emergency plans of local health organisations

2. To ensure that plans of local health organisations are compatible with each other and also with those of related agencies, in particular social services and other local authority departments

3. To ensure the regular testing of plans is undertaken by the organisations involved and, where appropriate, to test plans on a cross-agency basis

4. To learn and share lessons from tests and actual incidents when all or some of the existing plans are implemented

5. To ensure the local implementation of national and regional guidance and requirements relating to emergency planning

6. To identify issues requiring discussion with the emergency services (Police, Fire, Coastguard) and with other health organisations or local authorities, in order that these may be raised at the Hampshire/IOW Major Emergencies Co-ordination Committee

Frequency of Meetings

The Joint Emergency Planning Group will meet at least every three months. A special meeting will be arranged to review lessons learned from any actual incident when emergency plans are implemented.

APPENDIX B

EMERGENCY PLANNING & MAJOR INCIDENT RESPONSE

CONTACTS & ACTION LOG

(This log must be retained and forwarded to PCT Emergency Planning Liaison Officer after the incident

Date notified of incident	
Time notified of incident	
By whom ?	
Description/details of the incident: **Check:** **Where?** **When?** **No/type of casualties?** **No of children?** **Action needed?**	
Name and Job Title of person completing this Log	

Continue with details of contacts made, action taken, etc, on sheet overleaf.

EMERGENCY PLANNING & MAJOR INCIDENT RESPONSE

Name of person completing this log		Organisation & Role		Page ( ) of ( )				
WRITE DETAILS OF: persons contacted, action taken, instructions given, decisions agreed and rationale	Contact Telephone Number/s	Date	Time	Notes / Comments	Advised to Stand Down	
					Date	Time

Photocopy this side if more Action Logs are needed.

PLANNING & PREPARATION

To ensure local health services are ready to respond if a major incident is declared, there are a number of things we must do:

- Make sure Major Incident Plans, call-in lists and telephone numbers are kept up to date at all times
- Ensure relevant staff know their role and attend any training that is provided
- Collaborate within the health service and with other organisations (such as Social Services) in developing joint response plans and maintaining ongoing communications
- Participate in communications tests and live exercises organised within the health service or by other agencies whenever possible
- Following tests, exercises and actual incidents, relevant staff attend de-briefing sessions to review performance and amend local Plans accordingly

SUPPORT FOR STAFF

Being involved in a major incident can be very traumatic, not just for those people hurt or injured, but also for staff from emergency and health services who deal with the aftermath.

CoreCare, the PCTs Employee Assistance Provider, can offer individual support and group de-briefing to NHS staff if it is needed and this can be arranged by Line Managers or Occupational Health.

POLICY AND PROCEDURES

The following documents set out procedures in detail:

"EMERGENCY PLANNING & MAJOR INCIDENT RESPONSE: POLICY AND PROCEDURE"
- the joint major incident plan for Fareham & Gosport PCT, East Hampshire Primary Care Trust and Portsmouth City Primary Care Trust

More information is available from :

East Hampshire PCT
Risk & Governance Manager
Raebarn House
Tel: Code A

Portsmouth City PCT
Business Assurance Manager
St James Hospital
Tel: Code A

Fareham & Gosport PCT
Risk & Litigation Manager
Fareham Reach
Tel: Code A

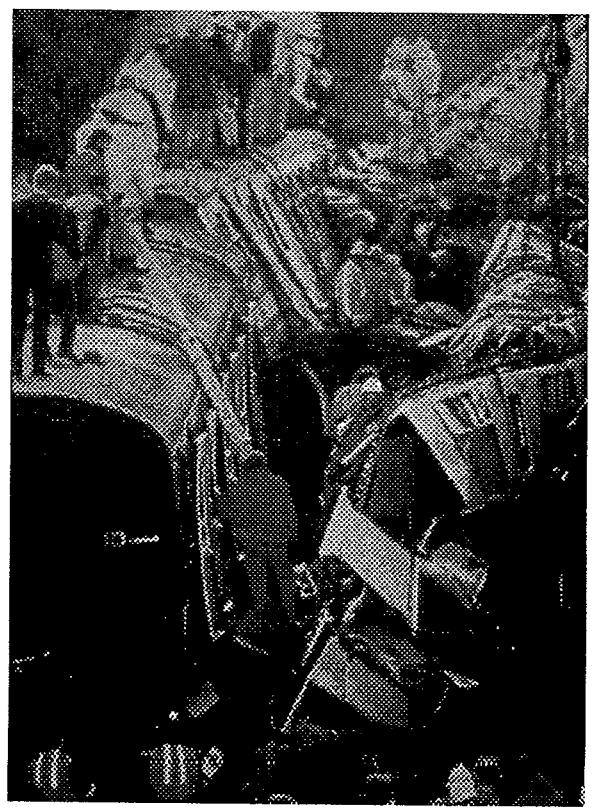
Julie Jones, Risk & Governance Manager
East Hampshire PCT

February 2003

A leaflet

APPENDIX C

MAJOR INCIDENT RESPONSE



WHAT IS A MAJOR INCIDENT?

A major incident in the NHS is an event which impacts on the ability of local health services to provide normal day to day services.

Often it is an incident or accident that results in a large number of casualties, but could also be disruption within a hospital itself, a public health scare or civil emergency.

Recent examples include.....

Kings Cross Underground Fire in 1987 - 31 people died and there were over 60 casualties

Clapham train crash in 1988 - 35 people died and over 120 people were injured

University College Hospital in London 1996 when the hospital generator failed and 202 in-patients were evacuated

A12 in Essex in 1997 when fog caused 26 separate road accidents in two hours resulting in 157 casualties but no deaths

In each of these cases, local health services activated their Major Incident Response Plans.

LOCAL ARRANGEMENTS

In Portsmouth and South East Hampshire, the following health organisations work closely to plan and if necessary provide, an effective response to a major incident:

- Hampshire Ambulance Trust
- Portsmouth Hospitals Trust
- East Hampshire Primary Care Trust
- Portsmouth City Primary Care Trust
- Fareham & Gosport Primary Care Trust

Also involved in developing and implementing joint plans are Portsmouth City Council, Hampshire County Council, Hampshire Fire Service, Hampshire Constabulary and voluntary organisations

HOW IS A MAJOR INCIDENT DECLARED?

The **Ambulance Service**, usually the first on the scene, will declare a Major Incident.

Queen Alexandra Hospital is the receiving hospital in this area and most casualties will be taken there.

Large numbers of casualties and injured people arriving at QA will impact on their services and this in turn, will impact on community services.

WHAT IS YOUR ROLE?

If an incident occurs, the following staff may have a part to play....
(The nature and circumstances of the incident will determine which staff are involved)

Senior managers will co-ordinate activities and receive and distribute information to front-line staff

Duty & Service Managers will mobilise staff and collect and disseminate information

Staff working in the Department of Medicine for Elderly People will support Queen Alexandra Hospital and St Mary's Hospital by assessing bed availability and discharging patients if requested

Staff working in Community Hospitals will, if necessary, assess bed availability and receive discharged patients from acute wards

Community Nurses will support hospital services by providing care to discharged patients and attending rest centres and evacuation centres if necessary

Psychological and counselling staff will provide longer term emotional support to victims, relatives and other people directly affected by the incident

Support and administration staff will provide support to medical, clinical and nursing staff.

ANNUAL RISK ASSESSMENT CHECKLIST

APPENDIX D

MAJOR INCIDENT

This checklist summarises the requirements of the **Emergency Planning & Major Incident Response** Policy & Procedure and applies to all staff working in the following areas:

- PCT Headquarters Office
- General Managers, Service Managers & Duty Managers across the PCT
- Staff working in Community Hospitals
- Staff working in Community Nursing
- Staff working in Elderly Medicine
- Staff working in Children's Services
- Staff working in Communications
- Staff working in Public Health

1.	Is the role of the area in a Major Incident explained to all new staff as part of their Induction with their Line Manager?	YES	NO
2.	Are the specific responsibilities of individual members of staff (bleep holders, Ward Managers, Duty Managers, Executive Directors, etc.) clearly explained and understood by these people?	YES	NO
3.	Where applicable, are relevant staff offered any additional training which may be required to help them fulfil their role in the event of a Major Incident (i.e. members of the psychological response team).	YES	NO
4.	Are call-in and home telephone number lists kept up to date at all times?	YES	NO
5.	Is the location of the departmental Major Incident Plan/Procedures known and accessible to relevant staff, both during and out of office hours?	YES	NO
6.	Is each element of the Major Incident Plan/Procedures reviewed annually and following every test, exercise or actual incident?	YES	NO

Proposed Prescribing Incentive Scheme 2003-4

The GPs, at the Medicines Group Meeting on June 4th 2003, decided that the existing proposals for the prescribing incentive scheme would not motivate the practices. The scheme was based on the volume and the cost per item of drugs prescribed for infections plus a practice specific target. The overall target was to stay within the figures for 2002-3 or show a reduction.

The GP proposal is along similar lines but aims at reducing the rate of overall growth. For example:

Practice growth 2002-3	12%
Practice growth 2003-4	11%

The practice has "saved" the PCT 1% and that money would then go to the practice.

A meeting was held to look at ways of implementing this scheme. The proposal was that practices would be "rewarded" up to £10,000 and any "saving" above that figure would be split 50/50 with the PCT. The calculations would be based on the practice prescribing budget excluding the expensive drugs allowance but including the end of year adjustment for list size changes.

The pharmaceutical advisers discussed the matter further and produced the following recommendations:

- The practices look at the following areas:
  - Repeat prescribing
  - Medication reviews
  - Specific high cost therapeutic areas
- Each practice has a multidisciplinary meeting to consider the areas above and produce an action plan for the rest of the financial year.
- The pharmaceutical advisers are available to facilitate such meetings and also advise on ways to improve the quality of prescribing overall or in specific areas. Assistance is also available from the practice support pharmacists and the PCT clinical governance team.
- Practice progress reports will be requested.

Hazel Bagshaw
24.06.03

PRACTICE LINK NURSE INITIATIVE

Report to the Fareham and Gosport GP Steering Groups

'Background

This scheme has been running for eighteen months within the Fareham practices and for six months in Gosport. At the PEC meeting in April agreement was reached to fund the continuation of this initiative for 6 hours per practice link nurse per month for the year 2003/04. As part of the agreement to funding PEC stipulated that there needed to be clear outcomes and auditable processes produced for the next 12 months.

The paper presented to PEC included the following, showing areas of achievement over the last year.

Achievements to date

- **It has greatly improved communication**

The data collected from a baseline questionnaire was compared to data collected a year later. This shows that there is now a greater awareness of the extended team.

- **Joint focus on key population groups**

There was a need to understand each other's roles and responsibilities, by having a greater awareness it has smoothed the patient's experience. There has also been an increased awareness and understanding of other public health roles and how practices can be part of the multidisciplinary public health agenda.

- **Integrated planning**

By looking at the traditional professional demarcations it has given an opportunity to challenge these and influence change; when required it has given team members confidence in referring and delivering services more flexibly. E.g. a link nurse with an interest in asthma set up a link meeting to look at asthma management and through discussion they believe it will now be possible to save both on GP time and money spent on the prescribing budget (initial estimate is a saving of £20,000).

- **Lessened isolation**

Traditionally practice nurses have been quite isolated, this initiative has not only raised awareness of the extended team but has also brought staff from different surgeries together. In this way we learn of others experiences and develop in the light of things heard. This could be the further developed for Essence in Care work that the PCT is now backing.

- **Interagency development**

Professionally and personally staff have benefited by having updates on a variety of subjects e.g. continence, diabetes, leg ulcers treatment etc. this has supported the NSF's and led to the implementation of working protocols. This has improved access and strengthened the service given to the local population. E.g. the link nurses will promote the recommendations from the Victoria Climbie inquiry, this will assist with breaking down inter agency barriers.

- **Newsletters and surgery directories**

Many link nurses have produced a surgery newsletter as a way of cascading information and many have developed a surgery directory that includes contact numbers for the extended team.

❖ **Developed guidelines**

Fareham link nurses, by virtue of the fact that they have been meeting longer, have begun to develop guidelines on minor illnesses and conditions. These are evidence based and they are currently peer reviewed within each surgery, this includes being checked by one of the GP's in the practice. These are now being presented to the PCT Clinical Governance Steering group and once agreed will be shared widely throughout the community nurse teams. This will directly benefit and help work with patients. Developing a common approach to shared guidelines and care pathways will reduce conflicting advice given to patients.

Guidelines in draft state are:

Provision of care and management for in-growing toenail
Effective management and treatment of scabies
Temperature protocol
Adult patients complaining of low back pain
Nurse management of varicose eczema
Chicken pox in children
Chicken pox in adults (including pregnant women)
Shingles
Patient group directions for primary ear care
Non-pregnant woman with cystitis
Nurse management of insect bites and stings
Care and management of allergic rhinitis

(*Attached to this paper is an example of one of these guidelines*)

❖ **Health Promotion**

Some surgeries have provided health promotion boards and the link nurses update these with information on national and local initiatives, e.g. No smoking day, depression etc.

❖ **Established a learning network**

It is vital for nurses working in primary care to look at recent research to be able to give a clear evidence based response to their problems. Establishing a learning network across disciplines with the availability of both theirs and other expertise will improve health care. This gives an opportunity to share best practice.

❖ **Leading change**

The link nurses have developed personally, by planning and leading meetings, being the spokesperson for their surgery (within this initiative), and this has increased their confidence. They have been involved in leading change, planning new ways of working, developing both their own and others clinical roles.

All of the above are part of the Governments agenda to strengthen the nurses' contribution to health and health care. Whilst it is sometimes difficult to quantify what this initiative has achieved in the last year, it is hoped that this report shows that the quality of nursing care in Fareham and Gosport is improving. It supports the PCT nursing strategy by implementing changes, joined up and interdisciplinary working, and is a demonstration of the Essence of Care agenda in that it raises awareness of the quality agenda by promoting and standardising advice

This has been achieved in 6 hours per surgery per month.

Future developments for 2003/04

1. Consolidate the work that is currently being done and shared across the nursing disciplines

2. To further develop the nursing guidelines and disseminate these throughout the nursing teams within the PCT.

3. Within Essence of Care arena:
   Give nurses an opportunity to discuss best practice
   Establish a process of clinical review within and across practices
   To look at risk and incident reporting
   Develop clinical supervision

4. Look to develop more initiatives to save both GP time and money on prescribing budget

5. Engagement with the Nursing Strategy Development

6. Linking into the Local Delivery Plan (LDP) and NSF's

Anne Hollis
Executive Committee Nurse
May 2003

CHICKEN POX (CHILD) PROTOCOL

DR BELLENGER & PARTNERS
FAREHAM HEALTH CENTRE

IMPLEMENTATION DATE.....

REVIEW DATES
Annual, or earlier, of new knowledge guidelines or research becomes available

WITHDRAWAL DATE
In the event of a complaint or claim, a protocol can be a valuable document

TEAM SIGNATURES
Should be signed by multi-disciplinary group

....

....

....

....

....

....

....

AIMS & OBJECTIVES

- To help alleviate severity of symptoms
- Prevention/minimisation of complications with minimum adverse effects
- To educate carers/parents

EVIDENCE BASED THEORY

1 DOH Guidelines 1996 – Immunisation Against Infectious Diseases, HMSO London
2 Greenwood et al 1992 Medical Microbiology Edinburgh
3 Shawson 1989
4 Minor Illness Manual 2nd Edition – Johnson/Hullsworthy/Chris Ellis

TRAINING REQUIREMENTS

- The nurse must be working within the scope of professional practice
- The nurse must have the knowledge and approval of her employer

PATIENT ACCESS

- GP Referral
- Self Referral – usual referral via appointment system
- Other – carer

APPOINTMENTS

- Named nurse(s) – those qualified to offer this service
- Session times : 08.40 –12 and 4-6.30 Monday to Friday
- Length of appointment – 10 minutes

PATIENT HISTORY

1 Document past medical history

- How many weeks pregnant?
- Is patient having chemo/radiotherapy or within 6/12 of finishing a course.
- Has patient had organ transplant or are they on current immuno-suppressive therapy.
- Bone marrow transplant in past 6./12.
- Steroids within past 3/12 at a dose of 2mg/kg for 1/12.
- Steroid in combination with cytotoxic drugs.
- Impaired cell-mediated immunising.
- HIV infection.
- Gamma globulin deficiencies

2 Type of rash – Usually most dense on trunk/head. Macular rash → papules → vesicular and erupts into itchy clusters.

3 During viraemic stage patient may experience fever, headache, sore throat, general malaise. The true rash is a pink/red rash of small raised spots followed by vesicles (small blisters) → scabs. Fully developed chicken pox will show all stages – may also occur on mucus membranes of mouth/throat/conjunctiva – will subside as disease subsides.

CRITERIA FOR REFERRAL / TO WHOM

GP if chest infection, chemo/radiotherapy, HIV, immuno compromised

P/N for routine chicken pox advice/confirmation

CONSENT FOR TREATMENT / PROCEDURE

Verbal
Written

TREATMENT / PROCEDURE DETAIL

Child may feel unwell with pyrexia/headache before spots appear, commonly a dry cough

- Give plenty of fluids to avoid dehydration (eg. Drinks/ice lollies/ice cubes/ice cream)
- Analgesia – paracetamol to ease aches/pains/pyrexia (2-5mls – 10mls as to age appropriate)
- Calamine lotion/cream applied to spots may ease itching
- Sodium bicarbonate powder for spots – put in bath
- Anti-histamine tablets/medicine may be given at bedtime to help sleep if itching is a problem
- Make sure nails are cut short to avoid deep saturating/scoring/skin infections
- Re-assure parents
- Give PILS – EMIS

EMERGENCY PROCEDURE

- Immediate Action – Refer to GP (see criteria sheet)
- Access to medical back up – Duty Dr, depending on time of presentation

DOCUMENTATION

- Medical Notes
- Computer Records – read codes on computer to aid audit
- Practice Administration

EQUIPMENT / PATIENT LEAFLETS / HEALTH TAPES

1. Maintenance — Availability of PILS from EMIS
NHS Direct
Health Information Service
0800 665544

EVALUATION / AUDIT

- Method – information from computer read codes
- Content
- Interval

SUGGESTED SOURCES OF TRAINING

Relevant post-registration courses – information from:
School of Nursing and Midwifery
University of Southamptom
Nightingale Building
67 University Road
Highfield
Southampton

SUPPORTING TRAINING

From medical and nursing colleagues

REFERENCES

See Evidence Based Theory

INTEREST GROUPS

DOCUMENTATION

- Medical Notes
- Computer Records – read codes on computer to aid audit
- Practice Administration

EQUIPMENT / PATIENT LEAFLETS / HEALTH TAPES

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- Method – information from computer read codes
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