Part 4 – Act
Resource A
Business Continuity Debrief Template

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Introduction

After an incident a de-brief should be carried out within two weeks. The After-Action Review (AAR) process is a structured approach to undertaking a de-brief and constructive way of identifying lessons identified from the incident. The AAR process detailed below has been adapted from the national process to assist with the de-briefing of business continuity related incidents.

An After-Action Review is constructed using the following questions:

1. What was expected to happen?
2. What actually occurred?
3. Why was there a difference?
4. What can be learned?
5. What was your role in the incident?
6. What is your current role (If differs)?
7. Timeline of events.
8. What went well
9. What didn't go well?
10. What can be improved?

AARs are usually conducted by an experienced facilitator/debriefer from within or external to your organisation, who was not involved in the incident and usually ensures that there is:

- An open discussion held
- Everyone in the room participates
- Development of learning points

Time allowance

The time required to undertake an AAR can be 15 minutes to two hours long.

Planning an AAR

Once a facilitator has been identified, they should be provided with an overview of the incident prior to the AAR.

It is important that the correct amount of time has been allocated to the AAR and that a suitable venue is available to conduct the AAR in.

Conducting an AAR

There are a number of ground rules that all participants in the AAR should be aware of and agree to, prior to the start. These include:

- Leave hierarchy at the door
- Everyone should contribute and everyone's contribution should be respected
- To pursue personal, group and organisational understanding as well as learning.
- No blame, discussing any potential mistakes made should not lead to blame
- Identify any learning from the event which can be used to improve future responses.
- Everyone will have a different truth to share of the same event
- Contributions should be through what people know, feel, and believe but not hearsay.
- Respect time pressures but all must be fully present - no use of mobile phones
- Make no assumptions, be open and honest

- Confirm the mechanism to highlight any points outside of the AAR, should colleagues wish to discuss matters in a private setting.

The AAR discussion

What is expected in the opening of the AAR?

The following headings should be used when opening a AAR:

- Welcome
- Brief overview of exercise
- Overview of debrief aim
- Overview of the debrief method including potential actions following the debrief, i.e. what written outcomes will be produced and how will the recommendations be acted upon.
- Participants to introduce themselves and their role in the exercise.
- Ground rules for the debriefing process.

What was expected to happen?

This question is asked to the group for their discussion. The following sub questions could be utilised (if suitable) to aide group discussion:

- Was there a planned response?
- What was the planned response?
- What was your personal expectation to happen in this type of incident
- What was the expected timeline?

What actually occurred?

This question is asked to the group for their discussion. The following sub questions could be utilised (if suitable) to aide group discussion:

- Each participant should describe - what they did, saw or experienced, during the incident.
- The participants should not be discussing what was good or bad at this stage.

Was there a difference?

This question is asked to the group for their discussion. The following sub questions could be utilised (if suitable) to aide group discussion:

- Was there a difference between what was expected and what actually happened?
- What were the good points and what didn't work so well?

What can be learned or identified?

This question is asked to the group for their discussion. The following sub questions could be utilised (if suitable) to aide group discussion:

- With the benefit of hindsight - what could have been done differently/better?
- Does anything need to be changed to improve future responses?

Closing the AAR

The key learning points should be summarised from the discussion held, focussing on what lessons have been identified.

Inform participants of what are the next steps i.e. report writing. If actions have arisen in the AAR, it is the responsibility of the AAR participants to take the actions forward and ensure they are brought into the existing reporting mechanisms within their organisation.

Sharing the Report

Once the report has been completed share it with members of the AAR to confirm accuracy of the content prior to sharing more widely.

Further examples of a report template can be seen below:

After Action Review Report Template – Example

Name of Facilitator – Attendees – Apologies –

Overview of the incident:

Overview of the discussion at the AAR:
Lesson Identified – To be actioned by (if required) – Date for completion (if required) -

Lesson Identified – To be actioned by (if required) – Date for completion (if required) -

Lesson Identified –

To be actioned by (if required) –

Date for completion (if required) -

Provided by University College London Hospitals NHS Foundation Trust

After Action Review Report Template – Example Fire

The below demonstrates a completed form following a debrief of a small fire in a hospital unit which was contained.

Name of Facilitator	A N Other
Attendees	Nurse 1 Nurse 2 Sister Estates Lead Senior Manager
Apologies	Director on call (sent form via email)
Date of AAR	1 July 2022
Overview of the incident	At 2230 on Friday 1 July 2022 a small fire was started within a storage cupboard in the Emergency Department. The fire alarm was triggered, due to smoke spreading into the receiving corridor and sounded throughout the Majors area. The intermittent alarm sounded across the Minors unit and resus areas. Staff within the department began evacuation procedures and escalated to the site team.
Overview of the discussions at the AAR:	The Emergency Department staff responded in accordance with the local response arrangements, however there was concern about how the incident should be escalated beyond the clinical site team. Staff locally did not realise there was a separate fire compartment in the area causing them to start full activation of other areas. Once the fire was out there was no plan for the restoration of the services to normal and no one could locate the Business Continuity Plan.
Lessons identified	- Clinical Site team did not know who to escalate the fire to after contacting switchboard to issue the fire alert. - Business Continuity Plans were difficult to source for the Emergency Department. - Staff didn't understand the fire separation within the department.
Lesson identified To be actioned by Date for completion	- EPRR review Clinical Site action card and check escalation to on call is clear - EPRR 1 August 2022
Date for completion (if required)	All actions to be completed within 6 months
Lesson Identified To be actioned by Date for completion	Emergency Department Matron and Business Continuity Manager to meet to discuss the local business continuity plan and where it can be made accessible to staff Emergency Department Matron and BC Manager 1 September
Lesson Identified To be actioned by Date for completion	Emergency Department Matron to ensure all ED staff undergo Fire Safety training. ED Matron and Fire Safety Advisor 1 December

You may also use the AAR process to gain written responses to understand the incident response, the questions can be used in various ways to help structure your debrief. See example questionnaire below:

Name	
Date	
Incident role	
Last date trained in incident role	
What was expected to happen? • Include any additional prompts e.g. was the BCP used?	
What actually occurred?	
Was there a difference?	
What can be learned or identified? • Worked well • Didn't work well?	
Any other issues to report regarding the incident	

Loss of Domestic Water Supply - System Wide Friday 20th May 2022

Present

Introduction

This debrief was organised to look at the incident from a system response angle and to also to help the affected organisation further develop their response to system issues and incidents.

Questions asked included:
- What went well?
- What didn't go well?
- What could be done to improve?
- How could the system be further prepared if this type of incident was to happen again?
- Identify **common themes and trends** to help improve processes/ roles and responsibilities

Timeline of incident from the Clinical Commissioning Group (CCG) perspective

- 09:05 - The Emergency Preparedness Resilience Response (EPRR) manager for the ICB was made aware of an initial issue with a water processing plant that could cause a loss of water to several postcodes across the system.
- 09:10 – The SURGE team were advised to ensure continuity, should an incident be declared.
- 09:15 - These postcodes were checked, and those GP or NHS based services were made aware of a possible disruption to the water supply
- 10:00 – Contact from NHS Regional Team to advise that the problem would now affect further postcodes, this now included an Acute Hospital and Mental Health Provider.
- 10:05 – EPRR team contact for both locations to advise of the current situation, ask was made to ascertain if they had a header tank that was useable and whether there was clear access for a water tanker to attend if needed.
- 10:35 – Decision made to advise all Acute, Mental Health Providers, Community Providers and Primary Care providers that there was likely to be a disruption to the water that had the possibility to cause a widespread disruption to water across the system. They were also for the hospital and larger sites asked to check the header tank provisions.
- 11:15 – Update given from Regional team that this issue was being worked on and the likely period of disruption would be Saturday between 0800 – 1200, but there were actions going on that may prevent this from happening.
- 14:00 – Advised by the regional team that the area identified now included the entire system postcodes.
- 14:05 – Message relayed across the system
- 15:00 – Emails from larger providers collated and details shared with regional team regarding header tanks and likely disruptions to patients if the disruption did unfold.
- 18:00 – Regional Team provide update that there would be no disruption for the rest of today and that there were no further meetings schedule with the water company for the day. This message was distributed across the system.
- 08:00 – Call received from Regional Team that the problem was now resolved.

What went well?

All felt that they had been informed in good time to be able to put plans in place.
Communication between providers was useful, especially around understanding
requirements for header tanks and types of equipment or processes that required different
water pressures.
Communication from the System Surge Team and EPRR team was clear and concise, with
realistic time scales.

What didn't go well?

From an initial response, the process of identifying those services within the postcodes
provided was time consuming, this was because some of the community services and acute
providers had satellite services in a number of locations, that were not documented at a
system level.
Acute and Mental Health MH providers would have preferred to be pre alerted that there was
an issue when the system was first aware.
From providers point of view the collation of all the water-based information was tricky, as
finding the people that had the expertise was not clearly apparent.

What could be done to improve

- Alerting all Acute, MH and Community Providers as soon as there is a possible
  incident on the horizon – being clear who is currently impacted and for who the
  information is an early head up.
- A concise document of all those satellite services, noting location, contact number
  and any other relevant information (for example services requiring pressurised water)
- All larger sites to have the details of the site header tanks – capacity and locations,
  ensuring that access is regularly checked.

Lessons Learnt

Lesson	Action	By whom	Date Required
There is a need for a directory of satellite services locations provided by the System	To create a list of all satellite services across the system to include full address, contact name and number for the site. Once compiled the list will be circulated. The list will be stored by the EPRR team and updated quarterly or on notification	**Integrated Care Board EPRR Lead** will coordinate this piece of work.	1st July 2022
The ICB will ensure that the system is made aware of incidents as they arise, clearly noting for action or for information.	To ensure that there is a process in place to ensure that the system is made aware of incidents, either for action or for notification. This process will then be embedded into the Integrated Care Board EPRR processes and Surge arrangements.	**Integrated Care Board EPRR Lead** will coordinate this with Surge Lead	1st June 2022

There is a need to understand the water requirements and contingencies in place for the larger sites across the system.	Larger sites are required to undertake an analysis of their sites to ensure there is information available for; • Header tank capacity and access. • Services likely to be affected by loss of water pressure. • Tolerable periods of disruption for these services. • If there is a backup available for these services.	**System EPRR leads**	15th June 2022
That discussing with other experts and making collaborative decisions makes for decision that are defendable and workable	As a system we will continue to encourage working groups, collaborative decision-making processes.	**System**	As needed