George Eliot Hospital NHS
NHS Trust

MAJOR INCIDENT PLAN
(PUBLIC FACING DOCUMENT)

'Our vision is to EXCEL at patient care'

Document Control

Version History

Version	Status*	Author	Reasons for issue	Date
1.0	Draft	Adam Biggs	Revised and updated Major Incident Plan incorporating EPRR Framework 2015, and supporting guidance.	May 2017
1.1	Draft	Adam Biggs	Revised and updated action cards	June 2017
1.2	Approved	Adam Biggs	QAC approved revised MIP	July 2017

Distribution List

Copy	Name	Position/organisation	Method of issue
1.2	Kath Kelly	Chief Executive Officer	Email
1.2	Shahana Khan	Deputy Chief Exec / Director of Finance	Email
1.2	Gordon Wood	Medical Director	Email
1.2	John Thompson	Director of Operations	Email
1.2	Michelle Norton	Director of Nursing	Email
1.2	Claire Campbell	Director of Governance	Email
1.2	Andy Laverick	Director of IT and Estates	Email
1.2	Sue Wakeman	Director of Human Resources	Email
1.2	Ian O'Conner	Director of Operational Finance	Email
1.2	Martina Morris	Deputy Director of Nursing	Email
1.2	Clair Hayward	Head of Patient Safety	Email
1.2	Laura Gibson	Associate Director of Operations – Surgery	Email
1.2	Liz Mathers	General Manager CBU6	Email
1.2	Jo Williams	General Manager CBU2	Email
1.2	Jane Sibson	General Manager CBU4	Email

1.2	Richard Harding	General Manager CBU5	Email
1.2	Paul Sylvester	LSMS	Email
1.2	Dawn Baraclough	Capacity Team Manager	Email
1.2	Sarah Hall	Associate Director of Operations – Medicine	Email
1.2	Dawn Roberts	Head of EPRR – NHSE West Midlands	Email
1.2	Dave Yates	Head of Resilience and Emergency Planning - CWCCG	Email

Foreword

George Eliot Hospital (GEH) has a significant role in preparing for, responding to and managing major incidents. The objective of the Trust Emergency Preparedness, Resilience and Response (EPRR) framework is:

To ensure that George Eliot Hospital is capable of responding to incidents, major or otherwise, in a way that delivers optimum care and assistance to patients affected, that maintains, wherever possible, "business as usual", minimises the consequential disruption to NHS services and that brings about a speedy return to normality. It will endeavour to do this by enhancing both its own services, capabilities to respond in addition to ensuring it is prepared to work within a multi-agency response across organisational and geographic boundaries.

The purpose of this document is to provide detail in how 'major incidents' are managed both within the Trust, wider NHS and in a multi-agency environment, and to give some guidance as to roles and responsibilities in a major incident.

Please take the time and trouble to familiarise yourself with the information contained within this plan.

Kath Kelly

Chief Executive Officer

George Eliot Hospital

Glossary of Terms

Action Cards	Cards at the back of the Major Incident Plan for every role in the event of a major incident to provide prompts for the actions that should be taken during the course of the response.
AEO	Accountable Emergency Officer – Executive lead
AMU	Acute Medical Unit
BC	Business Continuity
BCM	Business Continuity Management – a management process that helps manage the risks to the delivery of normal service, ensuring it can continue to operate to the extent required during a disruption.
C4	Command, Control, Communication & Co-ordination
Cat 1 Responder	An organisation as designated by the CCA 2004 that is in a support and co-operating role during a major Incident. They are subject to a range of civil protection functions under the CCA.
Cat 2 Responder	An organisation as designated by the CCA 2004 that is at the core of the response to a Major Incident. They are required to partake in planning activities and co-operate with Cat 1 responders.
CB	Casualty Bureau (police)
CBRN	Chemical, Biological, Radiological, Nuclear – incidents that involve the contamination of people or places with chemical, biological radiological or nuclear materials. CBRN incidents will often involve the decontamination of casualties.
CCA 2004	Civil Contingencies Act – the legal framework that sets the structure for civil protection and governs the response to major incidents in the UK.
CCG	Clinical Commissioning Group – NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services across England.
CRR	Community Risk Register – an assessment of risks within a local resilience area agreed by the Local health resilience partnerships as a basis for supporting the preparation of emergency plans.
DH	Department of Health – the government department responsible for the NHS and the protection and improvement of public health.
DPH	Director of Public Health – exec director responsible for public health within their area
ED	Emergency Department
EMS	Escalation Management System – an online system that allows you to view the escalation levels relating to capacity issues at acute trusts across the West Midlands
EPO	Emergency Planning Officer – member of staff with delegated responsibility for planning for emergencies and ensuring those involved in the response are competent in their role.
EPRR	Emergency Preparedness Resilience and Response
GEH	George Eliot Hospital NHS Trust

GSB	3 tier command structure: Gold, Silver, Bronze (Strategic, Tactical, Operational)
HACO	Hospital Ambulance Capability Officer
HALO	Health Ambulance Liaison Officer
HAZMAT	Terminology used by the Fire Service in relation to hazardous
HSE	Health & Safety Executive
IEM	Integrated Emergency Management
IH&SCT	Integrated Health & Social Care Team
LHRP	Local Health Resilience Partnerships is a strategic forum for organisations in the local health sector, which facilitates health sector preparedness and planning for emergencies.
Lorenzo	ED system used to capture the status of patients on site
LSMS	Local Security Management Specialist
METHANE	**M**ajor incident, **E**xact location, **T**ype, **H**azards, **A**rrival time, **N**umber of casualties, **E**mergency services activated.
MI	Major Incident
MIDT	Major Incident Documentation Team (police)
NAIR	National Arrangements for Incidents Involving Radioactivity
NHSE	NHS England
NHS LAT	NHS England Locality Area Team for Coventry and Warwickshire
PALS	Patient Advice & Liaison Service
PAS	Patient Administration System
PHE	Public Health England who is responsible for protecting the public's health from infectious diseases and CBRN related incidents.
PLO	Press Liaison Officer
PPE	Personal Protective Equipment
RCMT	Regional Capacity Management Team
SITREP	Situation Report, a briefing, either written or verbal, given to update an individual or organisation of the issues and actions taken by the individual or organisation giving the report.
STAC	Scientific & Technical Advice Cell that advises incident commanders on issues relating to public health.
UCC	Urgent Care Centre
VIP	Very Important Person
WMAS	West Midlands Ambulance Service – responsible for casualty/patient transport during a major incident.
WMFS	West Midlands Fire Service
WMP	West Midlands Police

- The above Glossary covers terms used within this plan. For the full list of multi-agency terms please refer to the Government LEXICON document at: https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon

- Copies are also held within the Incident coordination Centre

Contents

PART 1 – GENERAL INFORMATION

1.1 Strategic Aim

The strategic **aims** of George Eliot Hospital (GEH), and of its services, with respect to a major incidents and disruptive challenges are:

- Maintain patient care
- Save lives
- Minimise ill health
- Mitigate the adverse impacts of major incidents that cause (or have the potential to cause) significant disruption to the health of the population and/or normal NHS business

The aim of this plan is to provide a framework for GEH to respond to local incidents, support the NHS England (NHSE) Arden and, where necessary, co-ordinate internal response in the event of a critical or major incident.

1.2 Strategic Objectives

The above aims will be achieved through the following **objectives**:

- Provide strong, local leadership and organisational co-ordination with clear lines of communication during preparedness; response; and recovery phases
- Coordinate provision of swift and effective patient care to those affected escalating as necessary in light of subsidiary and mutual aid needs
- Provide a local supporting role for NHS England Arden in the event of a "level 2[1] or above" incident
- Maintain critical business functions and core service delivery through dynamic business continuity management
- Restore Trust services to "normality" as soon as possible
- Contribute appropriately to the overall multi-agency effort
- Work with partners to mitigate disruption to society
- Provide a robust EPRR contractual process to ensure that all commissioned services achieve appropriate capability.

The **objectives** of this plan are to:

- Establish when the plan should be activated
- Define what the GEH incident management structure should be in relation to:
    - A locally managed incident
    - An NHS England Arden managed incident

[1] See Figure 2 – Incident Response Levels – Page 26

- Define what a major incident is and outline the types of emergency that the local NHS might be expected to respond to;
- Outline the command, control and co-ordination arrangements internally, within in the local NHS and in the multi-agency context by identifying stakeholders and operational plans, including the decision making process;
- Identify the arrangements for communicating information to staff, patients and stakeholders both prior to, during and after a major incident;
- Outline the process for recovery from a major incident.

1.3 Legal Framework

The Civil Contingencies Act 2004 (CCA) establishes a statutory framework of roles and responsibilities for local responders and is supported by Regulations (The CCA 2004 (Contingency Planning) Regulations) and statutory guidance (Emergency Preparedness). NHS organisation specific responsibilities are set out in section 46 (9, 10) of the Health and Social Care Act 2012, NHS England Core Standards for EPRR and NHS England EPRR Framework.

The Health and Social Care Act 2012 provides that the Secretary of State for Health (and thus Public Health England) and NHSE will be Category 1 responders under the Civil Contingencies Act. Acute Trusts are Category 1 responders. Category 1 responders are those organisations at the core of emergency response (e.g. emergency services, local authorities). Category 1 responders are subject to the full set of civil protection duties being:

- Assess the risk of emergencies occurring and use this to inform contingency
- planning;
- Put in place emergency plans;
- Put in place Business Continuity Management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency

1.4 Joint Emergency Services Interoperability Program (JESIP)

This plan has been written in line with JESIP principles now codified in the JESIP Joint Doctrine - Interoperability Framework.

(http://www.jesip.org.uk/home)

The Joint Doctrine focuses on the interoperability of Police, Fire and Ambulance services in the early stages of a response to a major or complex emergency. It is also acknowledged that emergency response is a multi-agency activity and the resolution of an emergency will usually involve collaboration with other Category 1 and 2 responders.

The Joint Doctrine sets out what responders should do and how they should do it in a multi-agency working environment to achieve a successful joint response.

The Joint Doctrine and the principles contained within it are equally applicable to the wider range of Category 1 & 2 response organisations. The Joint Doctrine has been designed so that it can be applied to smaller scale incidents, wide-area emergencies and pre-planned operations

1.5 Defining a Major Incident

The CCA defines an emergency (revised by Cabinet Office in 2016) as:

> *An event or situation, with a range of serious consequences, which requires special arrangements to be implemented by one or more emergency responder agencies.*

For the NHS however the following definitions are detailed by the NHS England EPRR Framework:

1.5.1 Critical Incident

A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

1.5.2 Major Incident

A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS this will include any event defined as an emergency as in section 6.4.

It therefore follows that a critical or major incident is any event where the impact CANNOT be handled within routine service arrangements.

What is a major incident to the NHS may not be a major incident for other responding agencies. The NHS, or any part of it, can therefore declare a major or critical incident when its own facilities and/or resources or those of partner organisations are overwhelmed.

1.6 Types of Incidents

The following list provides commonly used classifications of types of incident

Business continuity/internal incidents	Fire, breakdown of utilities, significant equipment failure, hospital acquired infections, violent crime
Big bang	A serious transport accident, explosion, or series of smaller incidents
Rising tide	A developing infectious disease epidemic, or a capacity/staffing crisis or industrial action
Cloud on the horizon	A serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action
Headline news	Public or media alarm about an impending situation, reputation management issues
Chemical, biological, radiological, nuclear and explosives (CBRNE)	CBRNE terrorism is the actual or threatened dispersal of CBRN material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent
Hazardous materials (HAZMAT)	Accidental incident involving hazardous materials
Cyber attacks	Attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality
Mass casualty	Typically events with casualties in the 100s where the normal major incident response must be augmented with extraordinary measures

1.7 Risk Assessment

Risks are assessed at national, regional and locals levels and are used to direct specific planning, where appropriate.

This plan is generic, all risks plan to enable GEH to respond to, and/or support NHSE AT in responding to, any significant incident or emergency at a local, regional or national level.

In the event of a specific risk being identified then a sub-plan or process may be prepared, however the major incident management and response process outlined in this plan will overarch any response. For specific plans please refer to the table below.

A copy of the Warwickshire Conurbation Community Risk Register can be accessed at the following link:

https://www.warwickshire.gov.uk/communityriskregister

Table 1: GEH Specific Incident Plans

Plan	Description	Held
Bomb Threat	Policy sets out the structured response in dealing with a bomb threat	[redacted]
Business Continuity Plans	Plans that outline how internal incidents e.g. electrical failure, are responded to ensure critical services are maintained within the Trust.	[redacted]
CBRN & HAZMAT Plan	This outlined the Trusts response to chemical, biological, radiological or nuclear incident whether accidental or provoked.	[redacted]
Cold Weather Plan	This forms part of the national plan in how vulnerable people are protected during times of severe cold weather.	
Communication in a Crisis Plan	Supports GEH communication procedures during a Major or Critical incident in how media outlets bother social media and mainstream are coordinated. This includes how patients, families and the public are warned and informed via the communication team.	
Heatwave Plan	Forms part of the national plan in how vulnerable people are protected during times of severe cold weather.	
Lockdown	Outlines GEH lockdown process in response to an incident that requires a Total, Partial or Controlled lockdown of the Hospital.	
Mass Casualty Plan	Outlines the Trust response with Multi-Agency partners in response to a Mass Casualty event	
Pandemic Influenza Plan	Outlines the Trust response with Multi-Agency partners in response to a Pandemic event	

Note: The above list is not exhaustive taking account of national, regional and local expectations in EPRR planning requirements.

[2] External access to all plans is through Resilience Direct website that is a secure site provided to all emergency responders by the Cabinet Office. All On-Call managers and Directors have access via the Emergency Planning Manager

1.8 Warning and Informing

Under the CCA the Trust is responsible to advise the public of risks to help prepare the against possible emergencies, including warn and inform in the event of an emergency.

The Trusts has the following areas in helping the support this statutory requirement being;

- The Trust website contains an Emergency Planning page giving up to date content of current information with links to relevant supporting material. Webpage can be found in the below link;

- In collaboration with Warwickshire Local Resilience Forum, a leaflet has been compiled to help give top tips to the public in preparing against potential emergencies. This leaflet can be found within the below link;

  https://www.warwickshire.gov.uk/communityriskregister

- GEH has an outlined 'Communication in a Crisis' plan that outlines the Trusts warning and informing response through the Communication Team.

1.9 Sharing Information

Under the CCA all responders have a duty to share information with other responders in being able to fulfil a range of duties under the act, including emergency planning, risk assessment and Business Continuity Management. The Trust will endeavour to respond to all informal requests for information made by partner agencies and will comply with formal requests for info within a responsible time period in line with the Trust's Information Sharing policy, yet it must also maintain some control over and sensitive info it shares. (Appendix 1 outlines this process further)

1.10 Audit and Assurance

On behalf of the Accountable Emergency Officer (AEO), the Emergency Planning Manager will monitor GEH level of compliance within the duties and statutory provisions of the CCA, Standard Condition Contract (SC30) and national guidance.

A 6 monthly update report will be presented to the Quality Assurance Committee (QAC) for scrutiny, including the annual NHS Core Standard report and any ad hoc reports required e.g. Post Incident Report.

Further information is contained within GEH EPRR Policy (LINK)

PART 2: ROLES AND RESPONSIBILITIES

2.1 NHS Organisations

2.1.1 NHS Providers

The Trust is responsible to:

- Support CCGs and NHS England, within their health economies, in discharging their EPRR functions and duties, locally and regionally, under the CCA 2004
- Have robust and effective structures in place to adequately plan, prepare and exercise the tactical and operational response arrangements both internally and with their local healthcare partners
- Ensure business continuity plans mitigate the impact of any emergency, so far as is reasonably practicable
- Ensure robust 24/7 communication "cascade and escalation" policies and procedures are in place, to inform CCGs and healthcare partners, as appropriate, of any incident impacting on service delivery
- Ensure that recovery planning is an integral part of its EPRR function
- Provide assurance that organisations are delivering their contractual obligations with respect to EPRR
- Ensure organisational planning and preparedness is based on current risk registers
- Provide appropriate director level representation at LHRP(s) and appropriate tactical and/or operational representation at local health economy planning groups in support of EPRR requirements

2.1.2 CCGs

The EPRR role and responsibilities of CCGs are to:

- Ensure contracts with all commissioned provider organisations (including independent and third sector) contain relevant EPRR elements, including business continuity
- Monitor compliance by each commissioned provider organisation with their contractual obligations in respect of EPRR and with applicable Core Standards
- Ensure robust escalation procedures are in place so that if a commissioned provider has an incident the provider can inform the CCG 24/7
- Ensure effective processes are in place for the CCG to properly prepare for and rehearse incident response arrangements with local partners and providers
- Be represented at the LHRP, either on their own behalf or through a nominated lead CCG representative
- Provide a route of escalation for the LHRP in respect of commissioned provider EPRR preparedness
- Support NHS England in discharging its EPRR functions and duties locally, including supporting health economy tactical coordination during incidents (Alert Level 2-4)
- Fulfil the duties of a Category 2 responder under the CCA 2004 and the requirements in respect of emergencies within the NHS Act 2006 (as amended).

2.1.3 NHS England

The generic EPRR role and responsibilities of NHS England are:

- To set a risk based EPRR strategy for the NHS
- To ensure there is a comprehensive NHS EPRR system and assure itself and DH that the system is fit for purpose
- Lead the mobilisation of the NHS in the event of an emergency
- Work together with PHE and DH, where appropriate, to develop joint response arrangements
- Undertake its responsibilities as a Category 1 responder under the CCA 2004

Full list of Responsibilities can be found within the EPRR Framework
https://www.england.nhs.uk/wp-content/uploads/2015/11/eprr-framework.pdf

2.2 Internal

2.2.1 The Chief Executive

The CEO must ensure that GEH has a major incident plan that meets the criteria set out in the CCA and NHS EPRR Framework 2015. CEO has overall responsibility for ensuring appropriate arrangements are in place to support the emergency planning process and that these arrangements are adequately resourced in terms of funding, management time, equipment and any other essential elements. CEO will designate a senior and experienced manager with adequate support to lead a planning team referred to as the Accountable Emergency Officer (AEO).

2.2.2 The Accountable Emergency Officer (AEO) – Director of Operations

Responsible for ensuring that GEH is compliant with the emergency planning requirements as set out in the CCA, the NHS EPRR framework and the NHS Standard Contract (SC30) as applicable. Ensuring the Trust is properly prepared for dealing with a Major or Critical incident including robust business continuity planning arrangements in place. The AEO is a member of the Local Health Resilience Partnership (LHRP) Co-chaired by Locality Director of NHS England and Director of Public Health.

2.2.3 The Emergency Planning Manager is the Lead for the Trust

The Emergency Planning Manager will have designated responsibility for emergency preparedness on behalf of the organisation and will support the Accountable Emergency Officer (AEO).

2.2.4 Directors

Responsible for ensuring that all staff and services within their area of responsibility are included as appropriate in the emergency planning process and they arrange for, encourage participation in and monitor, appropriate training in this regard for all their staff.

2.2.5 All Staff

Should familiarise themselves with the content of this document and role expected during a Major or Critical incident.

2.3 External – Partner Organisations

2.3.1 Public health England

The primary role of Public Health England (PHE) is to provide advice, assistance on aspects of health protection and specific scientific advice in communicable disease incidents. PHE have expertise in communicable disease control, chemical biological radiological and nuclear explosives (CBRNe), poisons and microbiology.

2.3.2 Police

The police will normally have overall responsibility for coordinating the response to an emergency including scene management and evidence preservation (except where the scene is too hazardous, in which case the fire service will maintain control. The police will also normally lead on communicating with the public.

2.3.3 Fire Service

Fire are responsible for a range of response functions including; search and rescue, decontamination and identification of hazards. The fire service would also be responsible for scene management in the case of the scene being particularly hazardous.

2.3.4 WMAS

WMAS are responsible for conveying casualties from the scene of the incident to receiving hospitals they are also the NHS reps at the scene. They also have responsibilities for decontamination.

2.3.5 Voluntary Organisations

Voluntary orgs such as the British Red Cross, RVS, St John ambulance and the Salvation Army are all organisations that have trained personnel and high quality equipment that can be requested in an emergency. Some of the services they provide include; humanitarian relief, first aid provision of food and transport services.

2.3.6 Local Authority

Local authority is responsible for the medium/long term management and recovery from the incident. They also have a duty to provide emergency centres as required, including rest centres and humanitarian assistance centres. NHS England will take an oversight of any major incident that has national implications such as terrorist attacks. They will also assist in the management of specialist/limited resources such as burns.

2.3.7 Environment agency

The Agency is responsible for the protection of the environment (land, air and water) in England and Wales. They are also responsible for flood warning and informing.

2.3.8 Cabinet office

The government response arm during a significant major incident is via the Cabinet Office Briefing Room (COBR) that will coordinate the national response.

PART 3 – NOTIFICATION AND ACTIVATION

3.1 Notification

Notification of an incident can come from a variety of internal or external sources. The Trust major incident plan can be activated when a situation arises that meets either or both of the following criteria;

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

- Where GEH considers it necessary to act to prevent, reduce, control or mitigate the effects of an emergency and would be unable to act without changing the normal deployment of resources, including support to services

This is shown in Figure 1: Incident Activation Flowchart (page 24)

3.2 METHANE

In the event you receive a call regarding a potential incident then it is critical that you record as much information as possible. The accepted mnemonic used is as follows:

M	Major Incident – Has major incident, or standby, been declared and by whom?
E	Exact location -
T	Type – e.g. mass casualty; CBRN; terrorism; infectious disease outbreak etc.
H	Hazards – e.g. fire, plume, flooding, contamination etc.
A	Access – Access and egress routes to scene or rendezvous points
N	Number of casualties, and type (estimated)
E	Emergency services – At scene or required

There is a further information gathering template that can be used in addition to the above at Appendix 1.

3.3 Trust Response to a Major or Critical Incident

3.3.1 Incident Response

This section describes the roles and responsibilities required to deliver the response to a critical incident or major incident. For full details of the responsibilities and associated actions, please refer to the action cards.

Note: Critical incidents or emergencies that occur IN-HOURS will be responded to by Director of Operations or deputy, and Emergency Planning Manager. However, in the unlikely event that neither the appropriate staff is available IN-HOUR leads will revert to OUT Of HOURS process with 1st and 2nd on-call for the day.

3.3.2 Incident Manager (1st On Call out of hours)

1. Assess the initial information received in respect of a potential or actual significant / major incident and escalate to the on call Director/2nd on call as indicated.

2. Manage the incident as tasked by the Incident Director (when activated).

3.3.3 Incident Director (2nd On Call out of hours)

1 In liaison with the GEH On Call Incident Manager/1st on call, assess the initial information received in respect of a potential or actual critical / major incident and determine the appropriate initial course of action to be taken.

2 Direct all subsequent actions including stand-down decisions.

3 Coordinate the Trust response as appropriate.

4 The Incident Director/2nd on call has full authority to respond to the incident on behalf of the Accountable Emergency Officer.

3.3.4 Incident Management Team (IMT)

1. To provide GEH with an overall management of the response
2. To provide support to both CCG and NHSE AT, as required, in addition to collating information regarding the operational/tactical response across the local NHS. This will include gathering intelligence from wider sources relating to the incident and ensuring the efficient flow of information between the chain of command and partner agencies.
3. Determine prioritise in allocating resources
4. Obtain further resources as required
5. Plan and coordinate when tasks will be undertaken
6. To take appropriate risk reduction measures and give due regard to health and safety requirements

Table 2: IMT membership

Staffing	Role	Action Card
Direct or Ops / 2nd On-Call	**Incident Director**	**Action Card 2**
General Manager / 1st On-call	**Operations Officer**	**Action Card 3**
Ops Manager / Corporate Team member	**Critical Information Officer**	**Action Card 4**
Communications Team / CSU	**Communication Lead**	**Action Card 5**
Capacity Team	**Capacity Lead**	**Action Card 6**
EP Manager	**Tactical Advisor**	**Action Card 7**
Administration Support	**Loggist**	**Action Card 8**
Administration Support	**ICC Administration**	**Action Card 9**

Further IMT membership (required dependent on severity/type of incident)

Staffing and Role	Action Card
Director of Estates/IT	**Action Card 10**
Director of Nursing	**Action Card 11**
Lead Physician	**Action Card 12**

NOTE: Further Internal Trust Roles during a Major Incident is outlined on page 55

3.4 Incident Coordination Centre (ICC)

The ICC serves as a focal point for the Trusts response and all liaison with NHS and partner agencies regarding the incident, and is established in the Capacity Lounge. Alternatively, it could be co-located through mutual aid agreements with another organisation if required. The ICC will be staffed by the Incident Management Team, and other relevant personnel.

Refer to the flow chart at Fig. 1 below and the **ACTION CARD in Appendix A.**

3.5 Call Out Cascade

During a Major or Critical Incident the majority of staff on duty should be performing their normal functions as far as possible, preferably in their normal locations.

It is the responsibility of all staff to ensure that line managers have current contact details and telephone numbers, as well as ensuring all Trust mobile contact lists are kept up to date and switchboard is informed. An update on contact details/numbers should be annually as a minimum for all staff, Trust mobile number changes to be notified to switchboard as when changes occur.

If you are off duty you may hear about an incident via the media - Please do not come to the hospital unless contacted – you may be needed later, or the following day.

The Switchboard is responsible for commencing call out cascade for all services and departments in the event of a Major Incident. Switchboard will use either the standby or declared call out lists, dependent upon the command (see Table 3 below).

If the Emergency Services have contacted ED direct via the emergency (red) telephone, then ED will call Switchboard to activate the call out. The employment of this system activates everyone in the hospital that needs to respond to a Major or Critical incident.

The nature of the incident or emergency will determine the level of Call Out Cascade required IN and OUT OF HOURS.

All cascade cards and arrangements are held with Switchboard, with all departments holding individual cascade process for staff.

The departments who have been alerted in turn will call their colleagues and support areas to respond to the major incident. It is the responsibility of each ward or departmental manager to keep up-to-date and accurate contact lists for their staff members who may be required to attend a major incident, these lists should be held by the individual departments/services areas and only used when an incident is declared, based on the time of day and business continuity needs.

Note: if an incident occurs during the day it is counterproductive to call in night staff as they will be required to fulfil their normal duties.

3.6 Onward Alerting

The on-call Director will be responsible for ensuring key partners like WMAS, CCG and the LAT Director on-call are alerted in line with the **ACTION CARD**.

3.7 Incident Levels

Incidents require management at different levels according to the exact nature, scale or location involved and the first underlying principle for the NHS England EPRR Framework 2015 is as follows:

The management of an incident should be at the level closest to the people affected by the incident as is practical

In the event of an incident requiring additional resources the route of escalation will be to the NHS England West Midlands Director on-call who will consider whether to assume command and control of the incident. Equally West Midlands Incident Manager or CCG on-call may contact the Trust to mobilise, respond or coordinate the local NHS response. The AT and CCG will determine at what point command of the incident passes to the NHS.

This is illustrated in Figure 2 (page 25) below

Figure 1: Incident Activation Flowchart

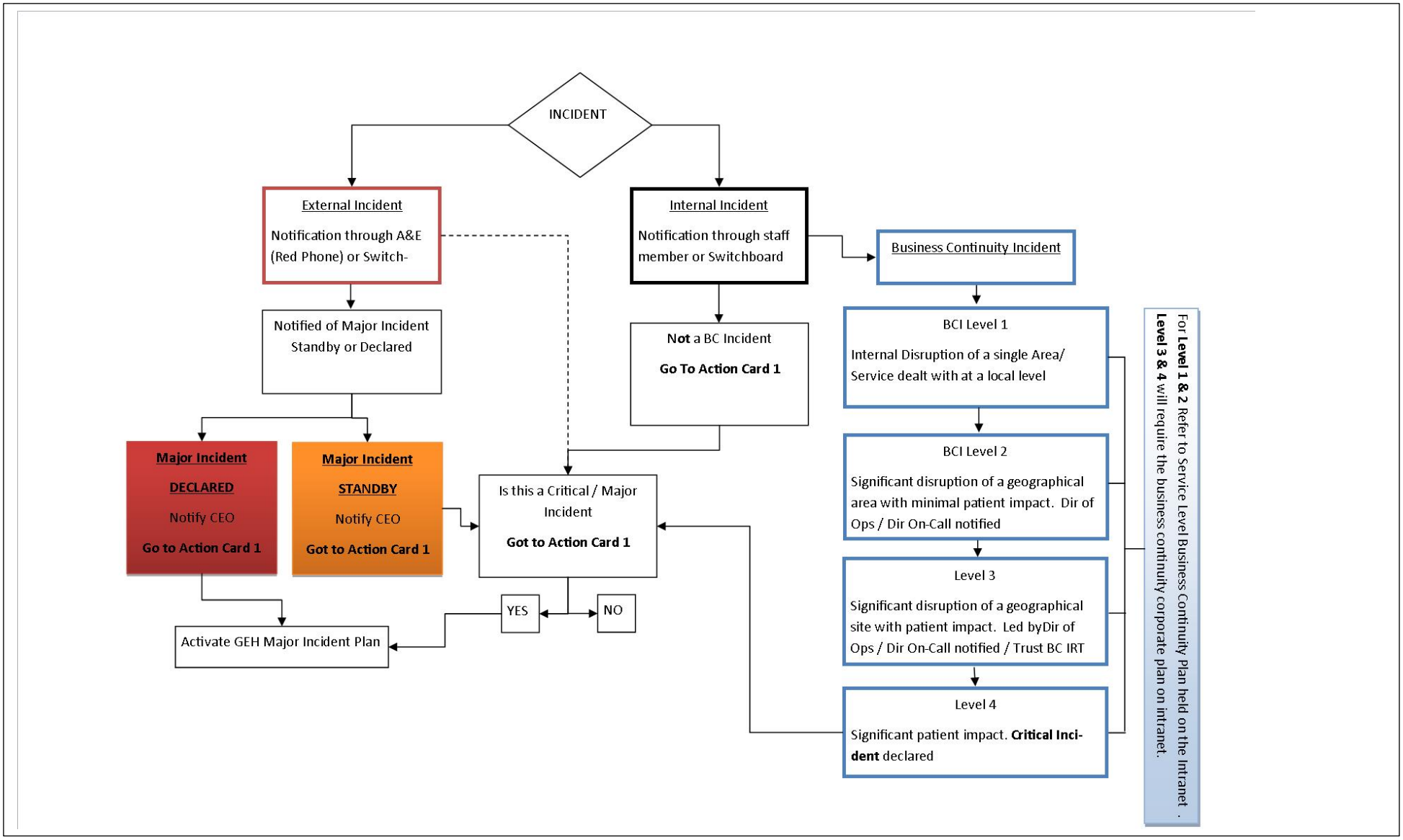


Figure 2: Incident Response Levels

Response Level	Definition and Description of Level
1	• **A health related incident that can be responded to and managed by single local health provider organisations within their respective business as usual capabilities.** • **Local lead arrangements are in place, however the Director in charge at this level needs to contact the NHS England West Midlands Incident Director and agree the incident is to be dealt with at this level.** • **Escalation of the incident will be agreed between the local lead and the NHS England West Midlands Incident Director**
2	• **A health related incident which requires the response of a number of health provider organisations across the Birmingham, Solihull & Black Country Locality boundary and will require NHS England Response Arrangements coordinate local NHS support and respond accordingly.** • **The On Call NHS England West Midlands Incident Director will lead the NHS response to the incident within the Locality and wider NHS England West Midlands sub region boundary and take responsibility for directing NHS resources.** • **The NHS England West Midlands Incident Director will be responsible for contacting the On Call Regional Incident Director to agree the level at which the incident will be dealt with and therefore who is in command**
3	• **A health related incident that requires the response of a number of health provider organisations that spans across the boundaries of several NHS England WMidlands- Sub Regions that requires NHS England – Midlands & East Region will require NHS England regional coordination to meet the demands of the incident** • **The On call Regional Incident Director will lead the NHS response to the incident and be responsible for directing the resources of NHS England – Midlands & East.** • **The Regional Incident Director will be responsible for notifying all other On Call within the NHS England – Midlands & East region that an incident has happened and at what level the incident is being managed. They are also responsible for notifying neighbouring NHS England regions as well as NHS England – national.**
4	• **A health related incident that requires NHS England national coordination to support the NHS and NHS England response** • **The On call National Incident Director will lead the NHS response to the Incident and be responsible for directing the national NHS resources.** • **They are responsible for notifying all other NHS England regions an incident has happened and at what level the incident is being managed.**

3.8 Command and Control

Command and control mechanisms within the NHS, and wider, are based upon the following levels.

3.8.1 Strategic (Gold)

Refers to those responsible for determining the overall management, policy, and strategy for the incident whilst maintaining normal services at an appropriate level. They should ensure appropriate resources are made available to deliver the tactical plan and enable and manage communications with the public and media. Additionally they will identify the longer term implications and determine plans for the return to normality (recovery) once the incident is brought under control or is deemed to be over. In complex, large scale incidents, there is a need to co-ordinate and integrate the strategic, tactical and operational response of each responder organisation.

A. Multi-Agency Strategic Coordination Group (SCG)
The **STRATEGIC CO-ORDINATING GROUP** (SCG) is usually chaired by the Police, with the NHS usually represented at SCG by NHSE LAT.

B. George Eliot Strategic (Gold) Command
GEH Strategic (Gold) equivalent internally is Chief Executive who takes overall strategic lead

3.8.2 Tactical (Silver)

Refers to those who are in charge of managing the incident on behalf of their organisation. They are responsible for making tactical decisions, determining operational priorities, allocating staff and physical resources and developing a tactical plan to implement the agreed strategy.

A. Multi-Agency Tactical Coordination Group (TCG)
The **TACTICAL CO-ORDINATING GROUP** (TCG) is usually chaired by the Police, with the NHS usually represented at TCG by either NHSE LAT or CCG.

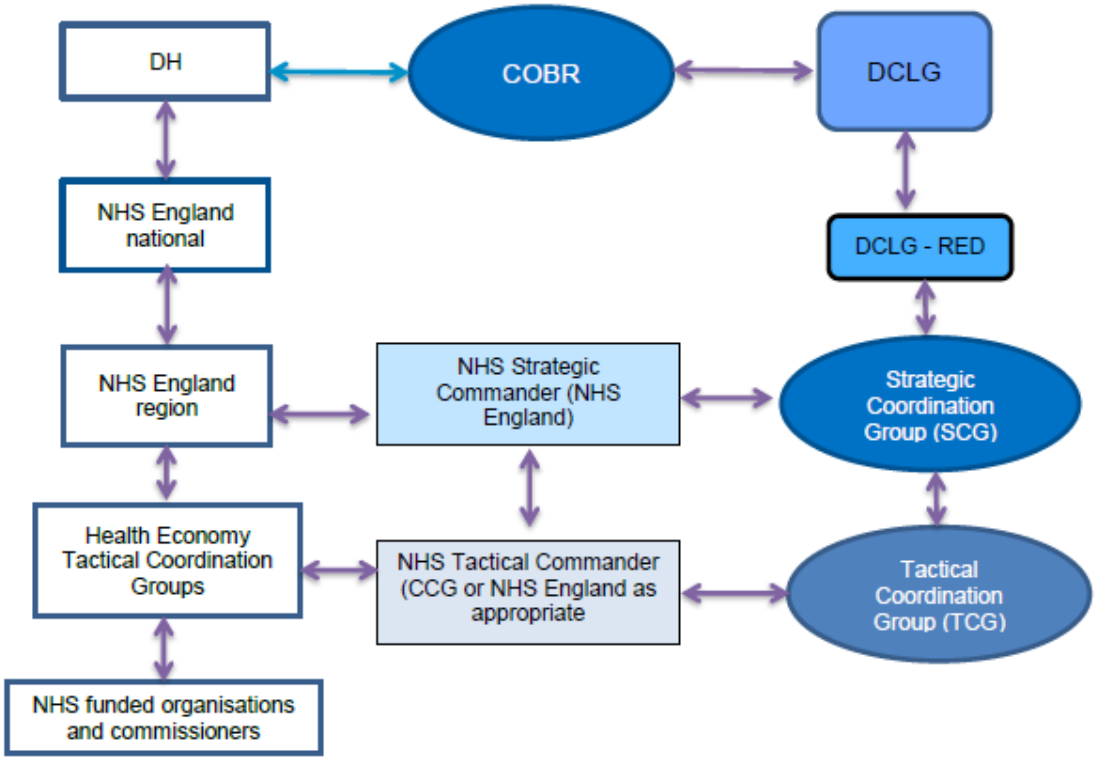
C. George Eliot Tactical (Silver) Command
GEH Tactical (Silver) Command will be through the Incident Management Team (IMT), chaired by the Incident Director.

3.8.3 Operational (Bronze)

Refers to those who provide the immediate ‘hands on’ response to the incident, carrying out specific operational tasks either at the scene, or at a supporting location such as a hospital, as directed by tactical/silver.

NB: Not all these command levels are necessarily activated - depending on the scale of incident and response. The general approach is to escalate the levels with the increasing size and complexity of the response required. Figure 3 below outlined the response structure for the NHS in England.

Figure 3: EPRR response structure for the NHS in England



PART 4: GEORGE ELIOT MAJOR INCIDENT RESPONSE

4.1 GEH Patient Triage

The Trust is outlined as a Local Emergency Hospital under current planning arrangements with multi-agency partners. The expectation is that the Trust will receive predominately P3 patients from the incident, as WMAS will assess and triage all patients to designated hospitals from scene.

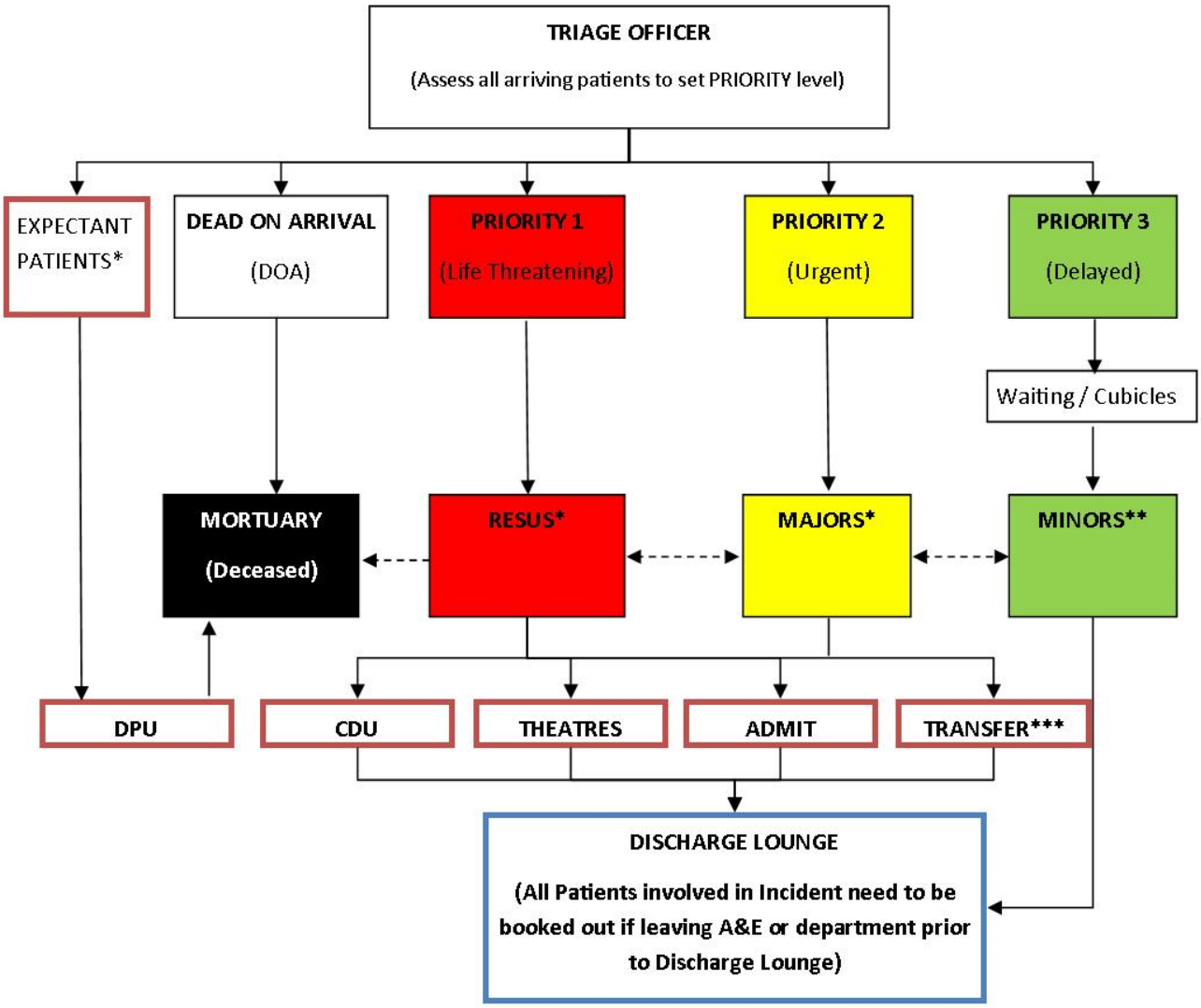
However it is recognised that at times of extreme circumstances this Trust will require flexibility to deal with small number of P1 and P2 that may self-present.

For any incident resulting in >100 casualties please refer to GEH Mass Casualty Plan (LINK)

CATEGORY	DEFINITION	ACTION/DESTINATION
IMMEDIATE P1	casualties with life threatening conditions	Casualties will be taken to Resuscitation/overflow Area
URGENT P2	casualties who need to be seen within 30 minutes	Casualties will be taken to the Majors
DELAYED P3	casualties with conditions which are less severe; the 'walking wounded'	Casualties will be taken to A&E Department waiting area/cubicles.
DOA	Dead on Arrival	Deceased to be taken to Mortuary
EXPECTANT PATIENTS **P4**	patients who will die even if they receive optimal treatment	Casualties will be transferred to the DPU to be cared for

See Figure 4 below for GEH Patient Triage

Figure 4: GEH Patient Triage Flow Diagram



*Patients who are not expected to survive even with medical intervention

**Patient may require to be moved from initial triage dependent on further clinical reviews

**TRANSFER will require A&E notifying ICC urgently to ensure appropriate Transfer is obtained as usual procedures may not be in place during a Major Incident

4.2 Emergency Department (ED) Response

4.2.1 Existing Patients

All patients being treated in ED will be notified that a Major Incident has been declared, and patients with non-life threatening conditions notified of potential long delays or alternative healthcare advice e.g. walking centre or other Trusts.

All patients within ED waiting room are notified and asked to attend tomorrow or give alternative healthcare advice.

4.2.1 Flow of Incident Patients

Majority of patients from the incident will arrive directly to A&E entrance via ambulance, with access controlled by a Triage Officer (ED Consultant / Senior Doctor), Triage Nurse/s and clerk.

Patients who self-present will be triaged at the main entrance to ED and directed to the most appropriate area in ED for further treatment if required.
Patients will be triaged and treated as necessary by the ED staff supported by 'surgical triage' undertaken by the On Call Consultants for General Surgery, Orthopaedics and Cardiac Surgery.

Patients from the incident requiring admission will be sent to Victoria or Alex Wards (Acute Surgical Unit), where ongoing assessment will be undertaken by the Consultant Surgeon in relation to treatment/surgery. Children requiring admission from the incident should be sent to same wards.

Some patients may be sent directly to Theatre or ITU dependent upon their injuries. In the event of a mass casualty incident, ED will lead the clinical response, but will alert other clinical leads across the Trust to request support to ensure effective triage and patient flow.

Where language difficulties present the Trust's usual methods of contacting interpreting service shall be used.

4.2.2 Paediatrics

All children will be assessed and treated in the designated paediatric area within ED, unless their injuries require resuscitation facilities. Whenever possible, paediatric trained staff should be made available to assess and manage the children.

4.2.3 Consultants

The ED Consultant on duty will lead the clinical departmental response supported by on call consultants undertaking surgical triage who if appropriate [s]he will alert other clinical departments upon the type of injuries, e.g. trauma, general surgical or respiratory, etc., so that they can make the most effective arrangements for patient care.

The Incident Management Team (IMT) should be given general information of the same nature. The Consultant Paediatrician on call will be available to give advice if children are involved.

If the major incident is declared when the consultant is not in the hospital, the registrar or most senior clinician will lead the department until the consultant arrives.

4.2.4 ED Nurse in Charge

The Nurse in Charge announces the major incident across the Emergency Department calling all staff to the nursing station to be assigned duties and tasks. ED will be cleared in a timely professional manner to prepare for incident patients arriving. Action or Prompt cards will be issued appropriately to all staff working in the department.

Switchboard as part of the call out, will inform the charge hand porter to dispatch porters to ED to assist with the transferring of patients.

4.2.5 Emergency Department Health Records

Reception staff are responsible for recording the demographic details as the incident patients arrive at ED, to facilitate this, a temporary reception desk is set up at the Ambulance Entrance. A pre-numbered casualty card will be issued to each incident patient.

The clerks will obtain as much detail as possible from the patients and / or ambulance crews this will then be entered onto LORENZO within 24 hours after discharge as well as updating the paper copy with Hospital Numbers.
If any patients are admitted the patient administration system (PAS) must be used to enter the patient as an admission noting that they are part of a major incident.

Non-incident patients requiring immediate treatment will continue to be triaged through the ambulance entrance, other attendees will be redirected to their own GP or to another Hospital.

A status report should be issued on the hour to the IMT giving detail of the number of casualties, staffing availability and capacity of the department. This is emailed or taken to IMT.

Any "patient identifying" data MUST NOT be transmitted or verified to any external agency or person not authorised to receive it.

4.2.6 Police Incident Information Centre/Casualty Bureau

The Casualty Bureau (CB) is the single point of contact for receiving and assessing information about people believed to be involved in an incident led by the Police. A national telephone numbers for CB will be publicised via various media sources, and all media and public enquiries concerning the incident should be directed to there.

Note that the Casualty Bureau will take time to set-up and the management of relatives will need to be handled by the following actions;

- Until the Bureau is established the IMT will identify a Relatives' Liaison Co-ordinator who will set up an Information Centre in the Staff Grade Office in A&E co-opting the help of administration staff as required.

- This Team will take enquiries about incident victims from Switchboard. Details will be collected from relatives about the patient they are enquiring about.

- Potential victim details will be collated with the documentation of the Police Documentation Team.

- If positive identification is known and a definite outcome, relatives should be informed sensitively and re-directed.

- Relatives and friends will want to see patients as soon as Clinical Staff feel it to be appropriate. This should be supported as it will aid positive identification of casualties and this will assist the Police Casualty Bureau.

- Relatives and friends are likely to be arriving at the Hospital soon after the incident. All reception areas should direct them to GETEC

4.2.7 Police - Major Incident Documentation Team (MIDT)

The police Major Incident Documentation Team (MIDT) will record details of all known casualties, including fatalities and details will be passed to the main Casualty Bureau. The object is to identify all persons involved in the incident and ensure relatives and friends are contacted and informed. The team will only be requested to pass general information to the Police MIDT, giving patients name and whether they are:

- Dead
- Injured and detained for treatment or observation, transferred to another hospital
- Injured but not detained
- No physical injuries

Information on the death of a casualty will be given direct to relatives via a personal visit by a Family Liaison Officer (where relatives are not already in attendance with the patient). Death messages will **NOT** be passed to relatives by telephone.

The Police MIDT may attend ED to interview patients involved at the scene and may also be reviewing patients of the possibility in identifying perpetrator[s] attending for treatment. This will be done with staff and patient safety as paramount, with ED staff assisting Police matters, such as allocating an office in ED or come to cubicles to interview patients.

The Police may also require patient property as forensic evidence. A discussion must take place with them before property is returned to patients.

Table 3: Police MIDT Room

Room needs to be secure, with external Telephone line and Fax **Rooms identified – ED Secretary Officer / Reception Office**

4.2.8 Discharged & Relatives Area

Outpatient A will be utilised for all incident patients discharges, with relatives area held within designated GETEC area.

4.3 Clinical Department Response

4.3.1 Wards

All Wards will review current patients to support rapid discharge, utilising appropriate discharge lounge and areas.

Wards such as AMU will be the admissions area for non-incident patients who are awaiting admission from ED. They will take immediate acceptance of patients, making space as appropriate.

4.3.2 Theatres

The Practitioner in Charge for Theatres, upon receiving the major incident call from Ward, will determine the next available operating theatre and make arrangements to cancel forthcoming cases. They will ensure that the staffing for each theatre is adequate and prepare for potential surgical cases.

In order to keep the IMT fully briefed Theatres is required to submit a status report every ***45 MINUTES*.** This should be emailed or a runner giving information on available capacity, staffing issues, and any other pertinent data.

4.3.3 Imagine and Pathology

Dependent on time of incident, all on-call staff will be contacted to ensure emergency imagine and pathology support is actioned, with cascade for staff to come in and support the departments appropriately. IMT will review if day appointments will be cancelled to ensure those departments are not over stretched with patients effected by the incident depending on the scale and requirements to respond.

4.3.4 Urgent Care Centre

The Urgent Care Centre (UCC) service will be notified by ED that a major incident has been declared with a view to the centre receiving non incident patients with minor injuries from ED. The UCC will need to make staffing arrangements dependent on the time of the day when the incident occurs. Should the incident occur outside of normal operating hours mutual support must be requested through IMT.

- Assessment of patients and treatment of illness/ injury to prevent unnecessary attendance at ED. Instigation of defective triage for non-urgent cases and assess/treatment/transfer as required.

4.4 Non-Clinical Departments Response

4.4.1 General Health Records (Admissions/Outpatients)

On notification from the IMT Health records managers will be responsible for co-ordinating staff to suspend Out Patients and Waiting List admissions for the duration of the incident or until advised to stand-down.

A written record of all contacted patients will be maintained so that appointments can be rescheduled.

4.4.2 Information Technology

During an incident IT will play a key supporting role to keep information flowing around the hospital both during the day and the night. IT will provide support to IMT command as required.

4.4.3 Hotel Services (Catering)

Additional catering facilities may be required for patients and relatives in the form of snacks, sandwiches and beverages during this incident with designated catering areas to support relatives.

4.4.4 Portering

The ED will call the Charge hand Porter upon standby or declaration to request assistance in the immediate movement of patients to Acute Medical Unit or Surgical Wards. The Charge hand porter will dispatch 4 porters to ED. A call will also be instigated by Switchboard as part of their cascade list in the event of a major incident.

Upon a full declaration of major incident, porters will be dispatched as follows:
4 to ED
2 to Acute Medical Unit
2 to Surgical Wards (Victoria or Alex Wards)

They will assist in moving patients to wards and departments to enable ED to make ready for the incident patients due to arrive.

4.4.5 Estates

The Estates lead is responsible to ensure patients, staff and emergency partners have access to facilities etc. during a major incident both in and out of hours. Estates will have a business continuity plan for premises and support services that ensure services can continue to be delivered in the event that a MI renders one of Trusts buildings/premises unavailable and allow for flexible use of premises during a MI.

4.4.6 Engineer

The on call Engineer and Building on call Manager ensures that the appropriate temporary signs are erected to direct people appropriately around the site. The Press Centre (WMI)

and Discharge and Relatives Centre (OPD) will have signposting for traffic and to indicate the relevant buildings.

The Engineer will also check with the IMT to provide additional beds from the bed store should these be needed.

4.4.7 Procurement & Stores

The procurement team will liaise closely with IMT to understand stock replenishment requirements for consumables and 'ad hoc' matters. The receipts and distribution part of procurement will regularly report back to IMT for procurement with regard to the availability of suitable equipment and vehicle (s) to deliver stores to critical areas designated e.g. ED.

4.4.8 Security

Trust security will be responsible for maintaining staff and patients safety, with actions to restrict access to visitors, with assisting traffic flow and car parking.

Normal duties will be suspended and concentration will be on providing support to the affected Area/Department, providing a lock-down facility if needed. It may also be necessary to restrict access to the department from the press. The Security Guard will also control entrances to the Hospital as required.

4.4.9 Internal & External Lockdown

The lockdown procedure will be implemented by the security department on the instruction of IMT. The Trust Lock Down policy and procedure are available from the following LINK.

4.4.10 Traffic Management – External Lockdown

At times dependent on the nature of the Major Incident external Lock Down may be required to reduce potential harm to visitors and to maintain safety of staff.

4.4.11 Media

During a Major Incident the Incident Management Team will review the response required to handle media enquires activating GEH Communication in a Crisis plan led by the Communication Team. This plan covers internal and external communications process, and media liaison e.g. Media Briefing Centre.

4.4.12 Welfare Support

Spiritual, Religious and Pastoral support and counselling is offered to incident patients and relatives where this has been requested from department staff for patients who have been discharged from ED. The Chaplain on call will determine whether the multi-faith community needs to be contacted to give appropriate support. [S]he will be centrally based in their office near the chapel, who will attend wards and the outpatient department as necessary.

4.5 GEH Major Incident Internal Structure

FUNCTION	LOCATION	TELEPHONE NUMBERS	RESPONSIBILITY	STAFFING
Incident Coordination Centre	Capacity Lounge	**0247686 5555**	Incident Manager (On-Site until Director of Operations arrives)	Incident Management Team members
Police Casualty Bureau / MIDT	A&E Office	Confirmed during time of Incident	Confirmed during time of Incident	Confirmed during time of Incident
Relatives Information Centre	A&E Secretaries Office	**02476153765**	Incident Manager delegates until police arrive	Relatives Liaison Co-ordinator Identified by Incident Director
Media Centre Press Room	Outlined within the GEH Communication Crisis Plan led by the Communication Team who will deal with all media enquiries.			
Relatives Room	GETEC	Confirmed during time of Incident	PALS	Chaplain, Social Worker, Psychology Services, Catering
Staff Assembly/Briefing Area	Lecture theatre, GTEC	Confirmed during time of Incident	Clinical Controller and General Manager on Instruction from Incident Director	
Documentation point for patients leaving A&E	Alcove opposite Consultants Office		A&E Nurse-in-Charge	Receptionist/ clerical officer

PART 5: LOGISTICS

5.1 Logging and Records management

An essential element of any response to an incident is to ensure that all records and data are captured and stored in a readily retrievable manner. These records will form the definitive record of the response and may be required at a future date as part of an inquiry process (judicial, technical, inquest or others). Such records are also invaluable in identifying lessons that would improve future response. The Incident Director is formally responsible for signing off the decision log, electronic or otherwise, and all briefing papers and documents relating to the incident.

5.2 Shift arrangements

In the event of a critical/major incident or emergency having a substantial impact on the population and health services, it may be necessary to continue operation of the Incident Management Team for a number of days or weeks. In particular, in the early phase of an incident, the Incident Management Team may be required to operate continuously 24/7. Responsibility for deciding on the scale of response, including maintaining teams overnight, rests with the Incident Director.

A robust and flexible shift system will need to be in place to manage an incident through each phase. These arrangements will depend on the nature of the incident, may involve deploying staff to provider trusts affected and must take into consideration any requirements to support external meetings and activities. The Incident Manager is accountable for ensuring appropriate staffing of all shifts. During the first two shift changes 1-2 hours of hand over time is required.

PART 6: STAND-DOWN

The GEH Incident Director will decide when an emergency or incident stand down should be declared for the Trust, which may be long after the emergency services response is over. If the AT are in command of NHS resources they will determine at what stage stand down occurs and when command returns to local trusts. This could be either a full or partial stand down with one or more individuals monitoring the situation.

6.1 Initial "STAND DOWN"

All response level changes need to be communicated both internally and externally as appropriate. A brief description of the resource implications of the new level should be included.

6.2 Administration

Once the decision has been taken, the Trust Incident Director will ensure that all appropriate elements of the local response are stood down. This may be a staged process. It is important to ensure that where communication channels have been specially created for the incident, forwarding mechanisms are in place to ensure that no traffic is lost. This will also ensure that people trying to contact the ICC, if established, have an alternative communications route.

6.3 Records Management

All logs, records and other details from the incident will be collected and secured from all personnel involved and kept safe in line with GEH data retention protocol.

6.4 Debriefs and Reports

The aim of any debrief is **not** to apportion blame but to identify areas for improvement and ensure that future responses benefit from lessons identified.

A hot debrief will be held within 24 hours of the close down of the incident. A full, internal debrief will be held within 14 working days of the incident. The initial incident report will be produced within 28 working days.

Structured debriefs should be held with involved staff as soon as possible after de-escalation and stand down. Participants must be given every opportunity to contribute their observations freely and honestly. The Incident Director must ensure that the full debriefing process is followed.

As part of the debriefing process a post incident report will be produced to reflect the actual events and actions taken throughout the response. Typically this will include:

- Nature of incident;
- Involvement of the Trust;
- Involvement of other responding agencies;
- Implications for strategic management of the NHS;
- Actions undertaken;
- Future threats/forward look;
- Chronology of events.

6.5 Lessons Identified Process

All lessons identified from the Post Incident Report will be embedded into the annual EPRR work plan that is presented to the Quality Assurance Committee (QAC) every 6 months.

Further information of lessons learnt will be cascaded down to staff through a wash-up process via team meetings, with all post incident reports to be published on the Trust intranet page available to all staff.

6.6 Review, Maintenance, Training and Exercise

Within the regulations of the Civil Contingencies Act (CCA) (2004) every plan maintained by a general Category 1 responder under section 2(1)(c) or (d) of the regulations must include provision for:

a) the carrying out of exercises for the purpose of ensuring that the Plan is effective;
b) the provision of training of:
    - an appropriate number of suitable staff; and
    - such other persons considered appropriate, for the purposes of ensuring that the Plan is effective.

To meet these requirements, this Plan will be exercised to ensure its effectiveness and validity. Staff with emergency response roles in the Plan and those who potentially have a role within an emergency response will participate in a targeted training programme to ensure competency in those roles. This will involve both initial training for those staff new to the on call rota and refresher training for other appropriate staff.

The maintenance of the document is the responsibility of the Trust Resilience Lead; it will be reviewed as required by the AEO Director. The AEO Director is also responsible for ensuring the training requirements of the Trust are maintained.

6.6.1 Training and Exercising

All plans and staff with roles and responsibilities for incidents are trained and exercised to ensure robustness, understanding and development of key skills that are underpinned by the National Occupational Standards (NOS).

6.6.2 Types of Exercises

The following exercises are outlined requirements on all NHS funded organisation by NHS England EPRR Framework 2015 covering:

6.6.1 Communication exercises

To be conducted every 6 months testing organisation communication methods in hours and out on a rotational basis.

6.6.2 Table top exercises

To be conducted every 12 months being relevant staff and partners together to test specific plans or process.

6.6.3 Live play exercise

To be conduct within every 3 years as a live test of arrangements and includes the operational and practical elements of an incident response.

6.6.4 Command post exercise

To be conducted within every 3 years testing the operational elements of command and control, requiring the setting up of the Incident Coordination Centre (ICC).

INCIDENT MANAGEMENT TEAM

ACTION CARDS

ACTIONS CARDS HAVE BEEN REMOVED FROM PUBLIC FACING DOCUMENT DUE TO SENSITIVITY OF THE INFORMATION IT COVERS

APPENDIX 2: METHANE Template for On-Call / Switchboard / ED

Name of Caller:		
Originating Organisation:	Police / Fire / Ambulance / Other State Other:	
Date & Time of call:	/ /	:
Contact Number:		

Major Incident	STANDBY / DECLARED/ STAND DOWN
Exact Location of Incident	
Type of Incident: i.e. Road Traffic Collision (RTC) CBRN (Chemical, Biological, Radiation, Nuclear), Terrorism, Disaster	
Hazard: To rescuers, general population, A&E Departments, the need to evacuate	
Access / Egress To scene, to hospitals & general movement (Hospital A= Estimated Arrival time of first casualties)	
Number of casualties involved or likely to be affected: ASK for PRIORITY Type (1-3) numbers being triaged to GEH Trust:	Adult: Children: ETA for patients being triaged to Trust: :Hours :Minutes
Emergency Services Activated and Responding: Please tick appropriate box	Ambulance / Fire / Police State Other:

Completed by (NAME)	
Completed by (Signature)	

ACTION: NOTIFY ED VIA EMERGENCY PHONE AFTER COLLATING INFORMATION IF THEY HAVE NOT ALREADY BEEN NOTIFIED

APPENDIX 3: SBAR for Communicating Internal Incidents

SITUATION WHAT IS GOING ON?	• Identify yourself and where you are calling from • Describe the incident/issue and the reasons for the call • Location of incident • Emergency services called or at the scene	
BACKGROUND WHAT HAS HAPPENED?	• Suspected cause of the incident • Any secondary causes	
ASSESSMENT WHAT YOU FOUND/ THINK IS GOING ON?	• What are the likely impacts of doing nothing • Likely duration of the incident • Likely service delivery impacts	
RECOMMENDATION WHAT YOU WANT TO HAPPEN	• What I need from you is……. • Be specific about a timeframe • Suggestions for preventative/ mitigating actions • Requirement to invoke local procedures/ continuity arrangements.	
DECISION WHAT YOU HAVE DECIDED TO DO	• I have decided to…….	

APPENDIX 4: INCIDENT MANAGEMENT TEAM AGENDA

Incident Management Team Agenda

Time/Date

Venue/Teleconference Details

1. **Current situation report**
2. **Impact on the NHS**
3. **Current multi-agency command arrangements**
4. **Communications**
    - Reporting arrangements (NHSE AT; DH; TCG; DPH)
    - Public information and media strategy
    - Internal NHS communications and staff briefings
5. **Staff and other resources required**
6. **Authorisation of expenditure**
7. **Horizon scanning**
8. **AGREED**
    - NHS command arrangements
    - NHS Strategy and/or objectives (depending on level of incident)
    - NHS Actions
    - NHS Battle Rhythm (linked to AT/ SCG/ national rhythm if established)
9. **Meeting Schedule**

A signed attendance sheet **must** be completed for every meeting detailing who was present and which role they performed.

APPENDIX 5: MAJOR or CRITICAL INCIDENT SITUATION REPORT

SITUATION REPORT – SITREP TEMPLATE

Note: Please complete all fields. If there is nothing to report, or the information request is not applicable, please insert NIL or N/A.

Organisation:		**Date:**	
Name (completed by):		**Time:**	
Telephone number:			
Email address:			
Authorised for release by (name & title):			

Type of Incident (Name)	
Organisations reporting serious operational difficulties	
Impact/potential impact of incident on services / critical functions and patients	
Impact on other service providers	
Mitigating actions for the above impacts	
Impact of business continuity arrangements	
Media interest expected/received	

Mutual Aid Request Made (Y/N) and agreed with?	
Additional comments	
Other issues	
NHSE Arden Incident Coordination Centre contact details: **Name:** **Telephone number:** **Email:**	

APPENDIX 6: Battle Rhythm Template

	Strategic			Tactical			Operational		
Time	**Meeting**	**Activity**	**Output**	**Meeting**	**Activity**	**Output**	**Meeting**	**Activity**	**Output**

APPENDIX 7: Information Recording Template

Date/Time	Who From	Information Received	Priority Rating	Action Taken	Date/Time
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		
			Choose an item.		

APPENDIX 8: IIMARCH BRIEFING MODEL

Element	Key questions and considerations	Action
I	**Information** **What, where, when, how, how many, so what, what might?** Timeline and history (if applicable), key facts reported using METHANE	
I	**Intent** **Why are we here, what are we trying to achieve?** Strategic aim and objectives, joint working strategy	
M	**Method** **How are we going to do it?** Command, control and co-ordination arrangements, tactical and operational policy and plans, contingency plans	
A	**Administration** **What is required for effective, efficient and safe implementation?** **I**dentification of commanders, tasking, timing, decision logs, equipment, dress code, PPE, welfare, food, logistics	

Element	Key questions and considerations	Action
R	**Risk assessment** **What are the relevant risks, and what measures are required to mitigate them?** To reflect the JESIP principle of joint understanding of risk. Use the ERICPD hierarchy for risk control as appropriate. Use Decision Controls	
C	**Communications** **How are we going to initiate and maintain communications with all partners and interested parties?** Radio call signs, other means of communication, understanding of inter-agency communications, information assessment, media handling and joint media strategy	
H	**Humanitarian issues** **What humanitarian assistance and human rights issues arise or may arise from this event and the response to it?** Requirement for humanitarian assistance, information sharing and disclosure, potential impacts on individuals' human rights	