Incident Response Plan:

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Authors Name:			
Authors Job Title:	Emergency Planning Officer		
Authors Division:	Corporate Services		
Departments/Group this Document applies to:	Trust wide		
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Guideline to be followed by (target staff):			
To be read in conjunction with the following documents:			
Are there any eCARE implications? No			
CQC Fundamental standards: Regulation 9 – person centered care Regulation 10 – dignity and respect Regulation 12 – Safe care and treatment Regulation 15 – Premises and equipment			

Contents

Document History

Version	Date	Name	Reason
0.1	08/2014	Emergency Planning Officer	Re-configuration of Trust Incident Response Plan to bring it in line with NHS England national guidance and Thames Valley Local Resilience Forum response plans.
0.2	07/2015	Emergency Planning Officer	Finalize the reconfiguration of version 0.1 and To separate out the Action Cards to form an Annex to the plan document
1.0	09/2015	EPO	To publish final approved version
1.1	02/2018	EPO	Completion of scheduled review of the plan. Also to incorporate lessons learnt from recent major incidents and exercise undertaken
1.2	12/2018	EPO	Reviewed due to re-configuration of hospital areas and to incorporate changes in Government advice
1.3	08/2021	EPO	IRP has been amended to align against national best practice and current guidance

How to use this document

This is a working document.

This Incident Response Plan is designed to provide staff with a framework for the Trust's response in the event of an Internal Incident (Critical incident) or Major incident.

Staff must be familiar with its contents and requirements.

It is designed to be used in conjunction with the Trust's other plans and response and escalation policies.

If a Major Incident has been DECLARED DO NOT read this document now. Go to relevant action cards outline held in following areas

GOLD Command ➡ Elm Room, Oak House

SILVER Command ➡ Site Office

BRONZE Teams ➡ Major Incident Cupboard outside Site Office

Electronic access via https://intranet.mkuh.nhs.uk/major-incident

Glossary of Abbreviations

AEO	Accountable Emergency Officer
ASC	Adult Social Care
ANP	Advanced Nurse Practitioner
BCP	Business Continuity Plan
BF&R	Buckinghamshire Fire and Rescue Service
CBRNe	Chemical, Biological, Radiological, Nuclear, explotion
CCA	Civil Contingencies Act
CCG	Clinical Commisioning Group
CNWL	Central and North West London NHS Foundation Trust
COBR	Cabinet Office Briefing Room
CRIP	Common Recognised Information Picture
CSM	Clinical Site Manager
DH	Department of Health
DoCC	Department of Critical Care
DSU	Day Surgery Unit
ED	Emergency Department
EAST	East of England Ambulance Servce
EMAS	East Midlands Ambulance Service
EPO	Emergency Planning Officer
EPR	Electronic Patient Records
EPRR	Emergency Preparedness, Resilience and Response
HALCO	Hospital Ambulance Liaison Control Officer
HALO	Hospital Ambulance Liaison Officer
HAMZAT	Hazardous Materials
ICC	Incident Coordination Centre
IRP	Incident Response Plan
IT	Information Technology
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
METHANE	Major Incident, Exact Location, Type of Incident, Hazards, Access, Number of Casualties, Emergency services at scene/needed
MIP	Major Incident Plan
MKCHSC	Milton Keynes Community Health and Social Care
MKUCS	Milton Keynes Urgent Care Service
MKUHFT	Milton Keynes University Hospital NHS Foundation Trust
MTA	Marauding Terrorist Attack
NIC	Nurse in Charge
OPEL	Operational Pressures Escalation Levels Framework
PDU	Patient Discharge Unit
PHE	Public Health England
PPE	Personal Protective Equipment

PRPS	Powered Respirator Protective Suit
SCAS	South Central Ambulance Service
SIRO	Senior Information Risk Owner
SitRep	Situational Report
STAC	Scientific and Technical Advisory Cell
TCG	Tactical Coordinating Group
TVLRF	Thames Valley Local Resilience Forum
TVP	Thames Valley 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

Chief Executive Forward

Milton Keynes University Hospital (MKUH) 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 MKUH can respond 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.

Joe Harrison
Chief Executive Officer

PART 1 – GENERAL INFORMATION

1.1 Strategic Aim

The strategic **aims** of MKUH, 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 MKUH to respond to local incidents, support NHS England (NHSE) 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 considering subsidiary and mutual aid needs
- Provide a local supporting role for NHS England 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 MKUH command structure should be in relation to:
    - A locally managed incident
    - An NHS England managed incident

[1] See Table 6 – Incident Alert Levels

- 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 and supporting resources.

(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

Resources provided are found in appendices covering Battle Rhythm (time period of incident meetings), information recording and Joint Decision Making Model outlined in this plan.

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.

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

Table 1: Types of Incidents

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 MKUH to respond to, and/or support NHSEI 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 TV LRF Community Risk Register can be accessed at the following link:http://www.thamesvalleylrf.org.uk/useful-links/publications/risk-register.ashx

Table 2: MKUH Specific Incident Plans

Plan	Description	Held
Bomb and Malicious Threat (Held within Security of People and Premises Policy)	Sets out the structured response in dealing with a bomb or Malicious threat	**Electronic Copies** All plans are held on the Trust Document Site within Office 365 and Intranet Page for internal access only External access can be via Trust Resilience Direct[2] page for key partners and On-Call staff Only **Hard Copies** Hard Copies held in Incident Response boxes within command centers and Incident response folders held on each ward or specific clinical areas
Business Continuity Plans	Plans that outline how internal incidents e.g. electrical failure, are responded to ensure critical services are maintained within the Trust.	
CBRN & HAZMAT Plan	This outlined the Trusts response to chemical, biological, radiological or nuclear incident whether accidental or provoked.	
Cold Weather Plan	This forms part of the national plan in how vulnerable people are protected during times of severe cold weather and adaptation to climate change.	
Communication in a Crisis Plan	Supports MKUH 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	

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. Access can be given through the Emergency Planning Officer.

	times of severe hot weather and adaptation to climate change.	
Lockdown	Outlines MKUH 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 responding to a Mass Casualty event	
Evacuation and Shelter	Outlines MKUH actions in the event of internal or external evacuation is required against national guidance	
Pandemic Influenza Plan	Outlines the Trust response with Multi-Agency partners in responding to a Pandemic event. This has been superseded by COVID-19 national, regional and local planning arrangements.	

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

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 Thames Valley 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;

http://www.thamesvalleylrf.org.uk/useful-links/publications/are-you-ready.ashx

- MKUH 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 endeavor 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 Officer (EPO) will monitor MKUH level of compliance within the duties and statutory provisions of the CCA, Standard Condition Contract (SC30) and national guidance.

An EPRR Steering Committee chaired by AEO is held quarterly to review EPRR work plan that includes training and exercising. An annual report will be drafted to AEO in presenting update on EPRR work and the annual NHS Core Standard assurance to Executive Directors and Board.

Further information is contained within MKUH EPRR Policy available from Trust Documentation Site or on request from Emergency Planning Officer

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 MKUH

2.2.1 The Chief Executive

The CEO must ensure that MKUH 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 MKUH 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 Officer

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

2.2.4 On Call (24/7)

To ensure the Trust is able to respond on a 24/7 basis the following on call roles are in place:

a) Executive On Call (Gold On Call)

The Executive on-call will typically be a member of the Trusts Executive Management team (although not exclusively). They should only be contacted in the event of an adverse incident occurring, which may immediately effect the reputation of the Trust or to report a Serious Incident. This tier of management will be responsible ultimately for ensuring the Trust implements its major incident response, in the event of one occurring.

b) Manager On Call (Silver On Call)

The Manager on-call will be the person to be contacted by the Clinical Site Manager if there is a dispute that requires arbitration, internal or external to the Trust, or when advice by way of problem solving is required, or when there has been a Serious or Untoward Incident.

Note: The Silver Commander may delegate additional staff to manage the 'Business as Usual' elements of routine hospital activity during a Critical or Major Incident.

c) Clinical Site Manager (Bronze On Call)

This post holder is the first point of contact for queries or problems that occur out of hours. This post holder is expected to be central to respond to requests for action by the Manager on-call or the Executive on-call.

2.2.5 Divisions, CSU, and Support Services

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.

2.2.6 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 (Thames Valley 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 (Buckinghamshire Fire)

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.

Buckinghamshire fire & Rescue Service will send a Bronze level Fire Liaison Officer to the Trust's Gold Command as required/requested. This role is to allow liaise and exchange of information and tactical advice to aid the Gold Commander.

BF&RS Liaison Officer with provide updates to and from the Gold Command and will also liaise with the TVFCS. The Liaison Officer will remain at the hospital subsequent to "stand down" of incident by the ambulance service to maintain continuing liaison in managing the continuing demands on the hospital and ambulance service as required.

2.3.4 Ambulance Services (SCAS/EEAS)

MKUH is predominately supported by South Central Ambulance Service (SCAS), but also receives number of patients through East England Ambulance Service (EEAS). Both ambulance services are responsible for conveying casualties from the scene of the incident to receiving hospitals they are also the NHS reps at the scene. MKUH is not outlined in EEAS casualty dispersal process, but due to close boarder proximity may at times be contacted to support. Ambulance Trusts also have responsibilities for decontamination.

a) Hospital Ambulance Liaison Command Officer (HALCO)

SCAS will send a designated senior officer to act as HALCO to the hospital if designated as a receiving hospital. They will be part of the Silver Command Team and will initially be based in the Silver Command Centre. Their role will be to liaise between the Trusts and provide a link with the SCAS Silver Command at scene and assist in coordinating incoming casualties from the scene matched with hospital capacity.

b) Hospital Ambulance Liaison Officer (HALO)

SCAS will send a nominated HALO to the receiving hospital. They will be based in the ED and their role is to co-ordinate and assist ambulance crews bringing patients in from the scene. They will liaise directly with the ED Bronze team during the incident.

2.3.5 Voluntary Organisations

Voluntary organisations 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 (Milton Keynes Council)

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.

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.

2.3.9 Other Health Services

Oxford Health NHS Foundation Trust (OH) and Central and North West London NHS Foundation Trust (CNWL) as NHS organisations would support MKUH during a major incident covering community services across Milton Keynes and elsewhere through mutual aid. Both Trusts have number of services based at MKUH site that would be contacted in the event of incidents that disrupts their services.

2.3.10 Thames Valley Local Resilience Forum (TVLRF)

The Local Resilience Forum established through the CCA provides the framework and response arrangements covering multi-agency partners for Thames Valley in the event of a major incident. Further details are covered from paragraph 3.8.

PART 3 – NOTIFICATION AND ACTIVATION

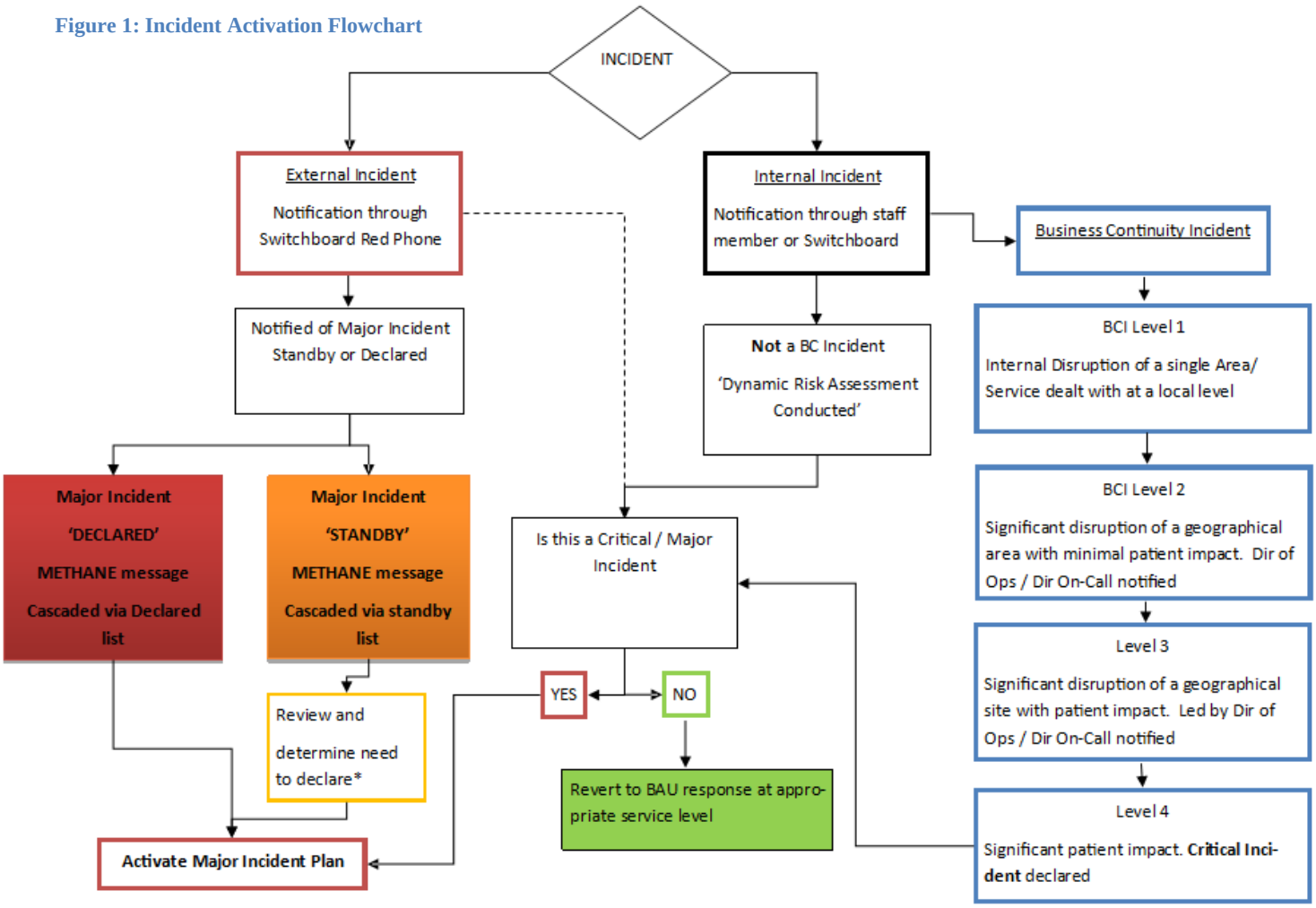
3.1 Notification

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 MKUH 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 illustrated in figure 1.

Figure 1: Incident Activation Flowchart



3.2 Alerting Terminology

Notification of external incident will be predominately from NHS ambulance services contacting hospital switchboard with below alert. This alert will follow national METHANE algorithm covered in 3.3.

Major Incident Standby: alerts the NHS that a major incident may need to be declared and allows organisations to make preparatory arrangements

Major Incident Declared: organisations need to activate their Major Incident Plan and mobilise additional resources

Major Incident Cancelled: cancels either of the above messages

Major Incident Stand Down: relevant to receiving hospitals after all casualties cleared. It is the responsibility of each NHS organisation to assess when it is appropriate for them to stand down.

3.3 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:

Table 3: METHANE

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 2.

For internal incident the Trust or services impacted will utilise SBAR template found in Appendix 3.

3.4 Incident Risk Assessment and Decision Making

The level and organisation of MKUH will be determined using joint situational awareness / risk assessment criteria detailed below. The following is not exhaustive but indicates the form of assessment that will be undertaken by Silver and Gold to determine both the appropriate level of response and any subsequent escalation or de-escalation requirements.

The following are considerations pertaining to the above:

- In the initial stages, the full implications of a potential or actual incident may not be evident. In these situations, it is better to consider 'standby' early and a proportionate response and de-escalating (or escalating) this when the situation becomes clearer.

- An initial dynamic risk assessment and Joint Decision Making Model (figure 2) should inform discussions between senior staff regarding defining an appropriate response level. The JDMM will be used as a framework for decision making throughout the incident, allowing continued reassessment of a situation or incident where previous steps are revisited and updated as required.

- The significance of the impact upon the NHS in terms of resources required to manage the response including events causing surge

- Public perception / concern - issues of public confidence, i.e. an incident with limited risk to the whole NHS might be escalated to a higher level if there is widespread community or media interest

- Media attention - national, international

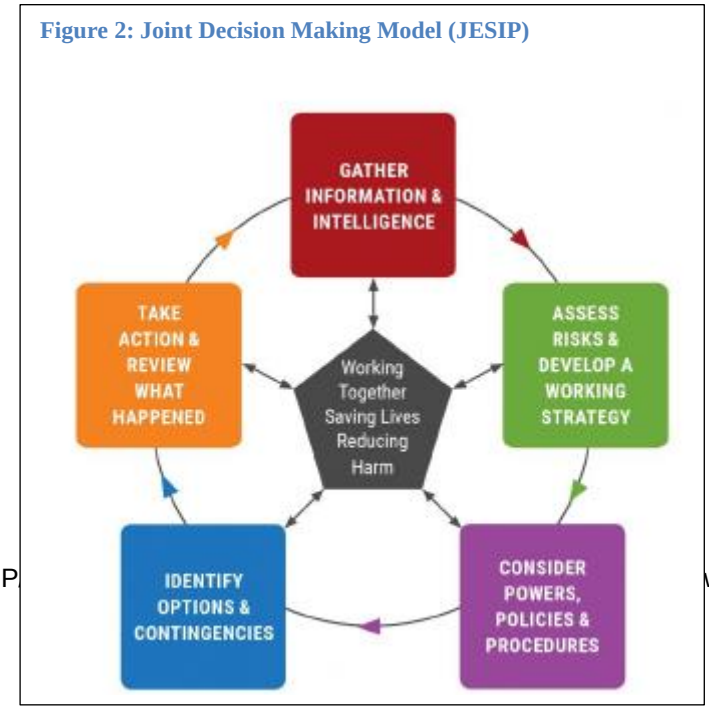
- Implications for NHS partners and partnerships - resources, reputation, reciprocity

- Impact on the NHS reputation and relationships
- Complexity of situation and/or associated competencies for handling
- A belief that an incident may have been caused by a malicious act (Terrorism, deliberate release and hoaxes) can frequently escalate the incident level

- Maintaining a defined state of staff readiness following de-escalation of an incident in case the situation re-escalates, i.e. public rioting or for a very low-level response with a protracted 'tail' to ensure that regional coordination can be provided when required

All decisions and actions must be reasoned, lawful, justifiable and written down.

Figure 2: Joint Decision Making Model (JESIP)



3.5 Trust Response to a Major or Critical Incident

3.5.1 MKUH Command, Control, Co-ordination, and Communication Arrangements (C4)

MKUH Major Incident response must adhere to the Strategic, Tactical and Operational terminology and command model that exists within partner organisations and in line with the Joint Emergency Service Interoperability Principles doctrine used across England.

Strategic – Gold
Tactical – Silver
Operational –Bronze

The command and control (C^2) hierarchy will be implemented from MKUH Execs or on call team in first instance.

ROLE SPECIFIC ACTION CARDS are to be used by all Command and Control levels.

C4 Fundamental principles of Command, Control, Co-ordination, Communication and Information for MKUH

- All staff must respect the chain of command and correct routes for communication – this eliminates duplication and ambiguity.
- There will only be one Strategic and Tactical Commander
- CCG and NHS England will represent the Trust at any required Multi Agency meeting as outlined within the Health command and control structures during the response to incidents (i.e. Strategic Coordination Group (SCG), and NHS England – Regional or Director of Commissioning Operations (DCO)Teams).
- Incident members of the Strategic and Tactical groups involved in the response to an incident must have a specific action card and set of functions to fulfil. This ensures that each member are involved because they have a need to be rather than a desire to be
- Incident members are empowered to take appropriate actions to undertake their roles as described in action cards
- Sharing of information with partner agencies will be vital to increase their and our own

situational awareness and understanding of risk following the JESIP guidelines.

3.5.2 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 Officer. 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.

3.5.3 Silver (Tactical) Commander (Silver on-call out of hours)

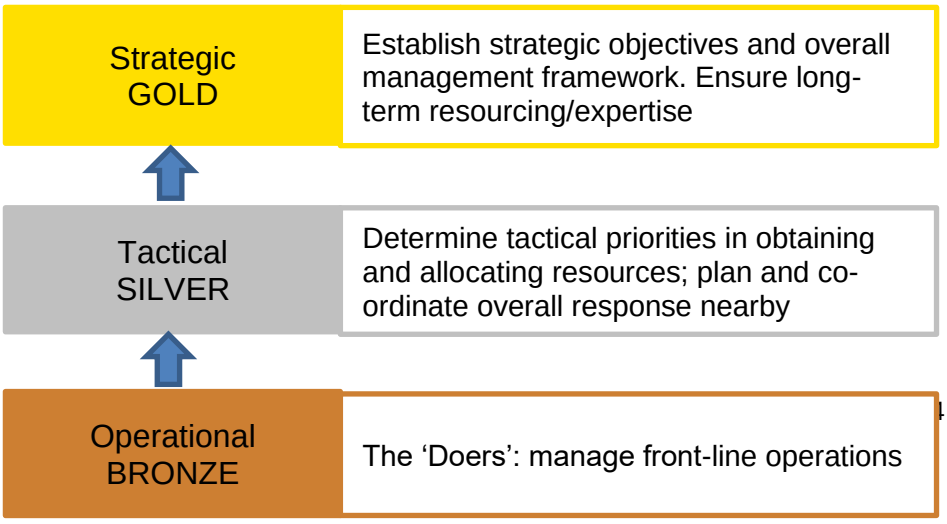
- Assess the initial information received in respect of a potential or actual significant / major incident and escalate to the Gold (Stratregic) on call as indicated.
- Manage the incident as Silver Commander at tactical level when activated.

3.5.4 Gold (Strategic) Commander (Gold on-call out of hours)

- In liaison with the MKUH Silver 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.
- Direct all subsequent actions including stand-down decisions.
- Coordinate the Trust response as appropriate.
- The Gold on call has full authority to respond to the incident on behalf of the Accountable Emergency Officer and CEO.
- Manage the incident as Gold Commander at strategic level when activated.

3.5.5 Framework of Command Management

Figure 3: Framework of Command Management



At the start of any incident for which there has been no warning, these will be introduced, one after the other, as the needs of the emergency require. Implementation of one or more of these management levels will depend on the nature of the incident; however an Operational level of command will always be established for internal incidents. Each level of command is described in greater detail below.

a) Operational Command (BRONZE Team)

The Trust BRONZE Team is an operational control and usually refers to people who are actively involved in responding to the incident, such as a ward or service manager dealing with an incident where it occurred. The command point is always on scene.

The Trust Bronze Team is responsible for the actual hands-on delivery of the service whether in an administrative or clinical role. In a serious event whilst there will only be one Trust Gold and Silver team there may be multiple Bronze Teams. To help ensure clear communication and cascade process is in place between Silver Team and Bronze teams a Bronze Commander will act as the conduit between Silver Command and Bronze Teams.

The Trusts Bronze Commander will be located with Silver command, but will at times be required to liaise with Bronze Teams at scene to support:

- Management of working elements of the response to an incident
- Lead a team carrying out specific tasks within a service area
- Liaise with and provide regular updates to the Silver (Tactical) Commander
- Identify resources needed and communicate this to the Silver Commander
- Implement tactical direction
- Report upwards to the Silver Commander
- Liaise with all the other agencies at the scene
- Manage the safety of responding staff.

Trust Bronze Commander role will fall to the Clinical Site Manager, but in any period of absence will be picked up by a lead Matron. All Bronze Team commanders/leaders will normally be the senior person present or a person nominated by the Trust Silver Commander to take charge of the relevant team.

Members of the Trust Bronze Team may include, but not be limited to the following:

- Clinical Site Manager (Bronze Commander)
- Emergency Department
- Medical Division
- Surgical Division
- Women and Children's
- Security (to support lockdown procedures if required)
- Core Clinical

Further roles will be put into place to support the BRONZE commander if scale of the incident requires cascading staff to attend site. This support will be in the form of a Staff Coordinator whose role will be to liaise and designate staff members that attends to prioritised areas.

The Trust BRONZE Commanders and the BRONZE Command Team will normally be based in the **ED Conference Room**.

b) Tactical Command (SILVER Command Team)

The Tactical or Trust SILVER Commander will be appointed when an incident cannot be managed within normal day to day arrangements.

During a major incident or large-scale disruptive event in hours the Silver Commander is picked up by AEO deputy of the day, with out of hours becoming Manager (Silver) on call.

The Silver Commander will oversee but not be directly involved in providing the operational response to the incident, focusing on determining priorities in allocating resources, obtaining further resources as required, and plan and co-ordinate when tasks will be undertaken. They will also liaise closely with the Trust Gold Commander and provide regular updates as to the status of the response.

The Silver Commander is responsible for the tactical coordination of resources across the Trust. They are required to cooperate/consult with the Trust Gold Commander and any response teams that may be formed, where appropriate.

The Trust Silver Commander will:

- Assume tactical coordination of the Trust response
- Conduct an initial assessment
- Escalate to the Trust Gold Commander, where appropriate
- Request a Major Incident Standby/Declared to the Trust Gold Commander
- Declare a Major Incident Standby/Declared in the absence of the Trust Gold Commander
- Activate incident plans and business continuity plans, as appropriate
- Activate/inform Divisional operational locations, as appropriate
- Identify and activate the Silver Command Team and Incident Coordination Centre (ICC)
- Agree roles and identify initial tasks.

The Trust Silver Commander needs to be aware of what is happening at operational level whilst leaving the responsibility for dealing with operations to the Trust Bronze Teams. Therefore, the appointment of a Bronze Commander should be established to support intelligence and directive between command structures.

The Trust Silver Command Team (SCT) is appointed by the Trust Silver Commander and is responsible for ensuring that the key areas of the organisation operate effectively during the major incident response.

The Trust SCT may consist of:

- Silver Commander
- Clinical Site Manager (managing Business As Usual)
- Bed Manager
- Bed Manager 2
- Divisional Associate Director / General Manager
- EPO (Tactical Advisor)
- Loggist

Note: Out of hours the Bed Manager role will be allocated to a member of the Night Practitioner Team in the first instance. Additional staff can be allocated or called in specifically to cover this role as required.

Different incidents will require different staff and skills to be deployed in the Trust SCT so staff from different disciplines may have to be called in to provide support. Gold Commander may request members of the Silver Team join them in the Gold Incident Co-ordination Centre depending on the nature of the incident.

The Trust SILVER Commanders and the SILVER Command Team will normally be based in the **Site Office**.

c) <u>Strategic Command (GOLD Command Team)</u>

The term Strategic or GOLD refers to the overall Executive command of the Trust response with responsibility for formulating the strategy for responding to the incident. The Trust Gold Commander has overall command of the resources of the Trust delegating tactical decisions to the Silver Commander.

During a major incident or large-scale disruptive event in hours the Gold Commander is picked up by Director of Operations, with out of hours becoming Executive (GOLD) on call.

Gold Command should be seen as standard practice not the exception. It is easy to dismantle if not required and removes the potential for Silver Commanders to be reluctant to ask for a strategic level of command management.

The Gold Commander will:

- Assume strategic control of the Trusts' overall response
- Conduct an initial assessment
- Escalate to NHS England and where appropriate confirm a Major Incident Standby/Declared to NHS England

- Inform the local Clinical Commissioning Group (CCG) or/ and the Specialist Commissioner on call (as appropriate)
- Oversee and co-ordinate the Trust's media response
- Activate any response teams (Crisis/Incident) as appropriate
- Activate/inform the Trust Silver Commander, as appropriate
- Identify and activate the Gold Incident Co-ordination Centre (ICC) or alternative location
- Convene a meeting of the appropriate response team(s), confirming the time of the first meeting
- Agree roles, and identify initial tasks
- The Gold Commander is also responsible for cooperating/consulting with the NHS Strategic Commander and/or Tactical Commander from NHS England, other NHS providers and Responder agencies.

To assist the Trust Gold Command, a team of senior staff will be assigned by the Trust Gold Commander. This Trust Gold Command Team (GCT) will be responsible for the strategic decision making and for liaising with external agencies. It may comprise of the following and anyone the Trust Gold Commander deems necessary to assist them in their function.

- Gold Commander
- Director of Nursing
- Medical Director
- Director of Operations (AEO)
- Communication Lead
- Estates/IT Exec lead (if incident is affecting estate or IT)
- Loggist

The Trust GOLD Commander and the GOLD Command Team will normally be based in the **Elm Room, Oak House**. MKUH Command Chain shown in Figure 4.

Generic meeting agenda is outlined for Silver/Gold Command Team in **Appendix 4**

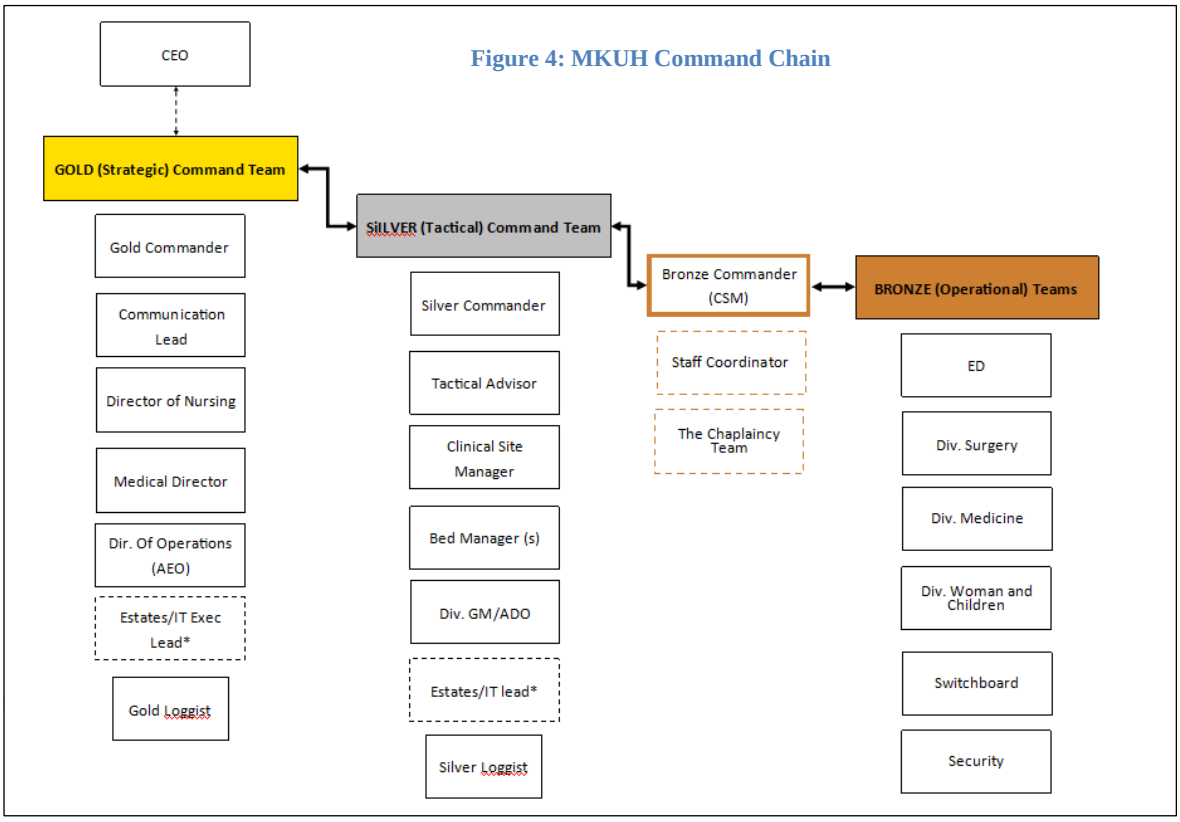


Figure 4: MKUH Command Chain

** Incidents may require Estate or IT led response due to the nature of the impact i.e. Water loss or IT network Failure. This would result in leads being identified from either department to attend GCT or SCT in providing expert advice.*

d) Action Cards for Trust Command and Control Teams

The purpose of an Action Card is to provide, in an accessible form, all the essential information and instruction needed to perform a specific role in the Trust emergency response. All members of the Trust Command and Control Teams must use them to ensure tasks and key functions are delivered within the Trust. It can be tempting during an emergency not to use such aids. However, experience shows that Action Cards help people focus on their role and give useful guidance on key tasks that must be undertaken. They also prevent important tasks being overlooked or delayed. They should remove the need to continually refer to large or complex plans during an incident and should be a simple aide memoir for anyone who might take on the role, especially someone who may not be particularly familiar with it beforehand.

Action Cards are "role" specific and are not designed for designated individuals. Any Trust staff may be asked to perform a key "role" on behalf of the Trust. Action Cards may only be passed to another person once a full briefing has been given.

Hard copies of Action Cards are available in following ways:

Table 4: Hard Copy of Action Cards Held

Action Cards Held	Covering
Elm Room, Oak House	Gold Command Team
Clinical Site Office	Silver Command Team
ED Seminar Room	ED Command Team
Major Incident Cupboard (outside Clinical Site Office)	Bronze Command Team
Incident Response Folders (Held on each Ward/Clinical Service)	Ward level Action Cards

*Electronic copies are held in internet EPRR page Link:

TAKEN OUT FOR PUBLIC PUBLICATION

3.6 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 dictated on

the Trust internal command structure agreed, and staff by appropriate silver or gold command teams. Outline of ICC command structure can be seen in below table:

Table 5: ICC Locations

Command Team	Location	ICC
Bronze Command Team	ED Seminar Room	Bronze ICC
Silver Command Team	Clinical Site Office	Silver ICC
Gold Command Team	Elm Room. Oak House	Gold ICC

3.7 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 of key contacts i.e., on call. 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.

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.

All external notification of incident should come through to the Red Phone held in Switchboard. However, in the event ED red phone is contacted, then ED will call Switchboard to activate the call out.

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

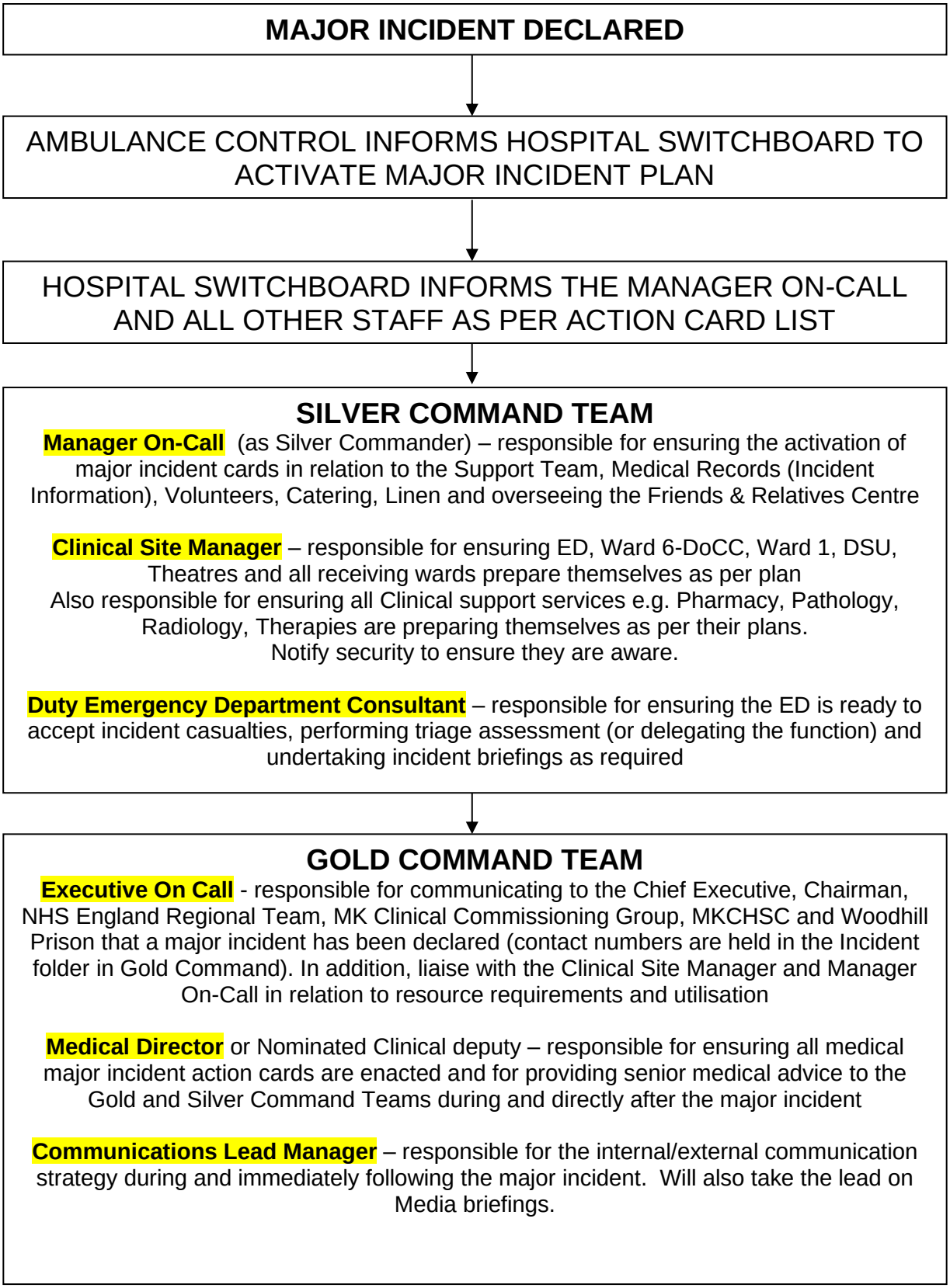
All cascade cards and arrangements are held with Switchboard, with all departments holding individual cascade process for staff.

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.

Example of Major Declared cascade and communication process found on next page

Figure 5: Major Incident Declared cascade process



3.8 Onward Alerting

The Executive (GOLD) on call will be responsible for ensuring key partners like SCAS, CCG and NHSEI Director on-call are alerted in line with the **ACTION CARD**.

3.9 NHS 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 NHSEI Director on-call who will consider whether to assume command and control of the incident. Equally CCG on-call may contact the Trust to mobilise, respond or coordinate the local NHS response. NHSEI and CCG will determine at what point command of the incident passes to the local NHS.

As an incident evolves it may be described, in terms of its level, as one to four as shown in table below.

Table 6: Incident Alert levels (NHS England)

Alert Level	NHS England Incident Levels
1	A health related incident that can be responded to and managed by local health provider organisations and their commissioners within their respective business as usual capabilities.
2	A health related incident that requires the response of a number of health provider organisations across an NHS England local area boundary and will require the South Central team to co-ordinate the NHS local support.
3	A health related incident that requires the response of a number of health provider organisations across the local area and requires NHS England Regional co-ordination to meet the demands of the incident.
4	A health related incident that requires NHS England National co-ordination to support the NHS and NHS England response.

3.10 Multi-Agency Command and Control

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

3.10.1 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.

The **STRATEGIC CO-ORDINATING GROUP** (SCG) is usually chaired by the Police, with the NHS usually represented at SCG by NHSEI SE.

3.10.2 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.

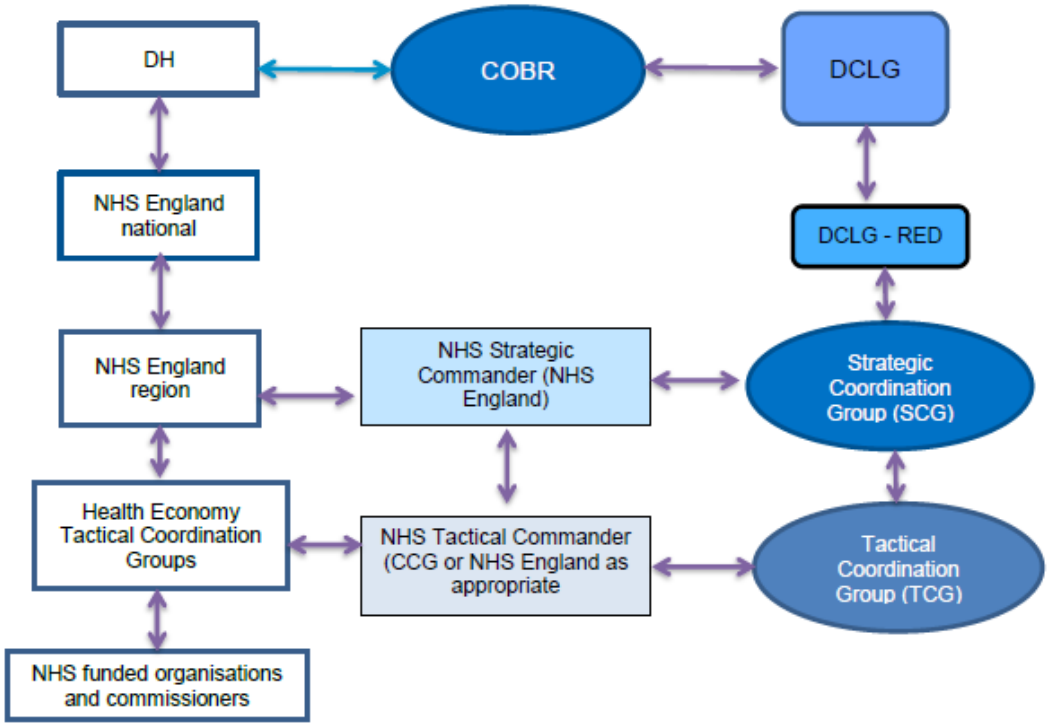
The **TACTICAL CO-ORDINATING GROUP** (TCG) is usually chaired by the Police, with the NHS usually represented at TCG by either NHSEI SE or CCG.

3.10.3 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 6: EPRR response structure for the NHS in England



(EPRR Framework 2015)

Note: DCLG is now Ministry of Housing & Local Government (MHLG)

PART 4: MKUH MAJOR INCIDENT RESPONSE

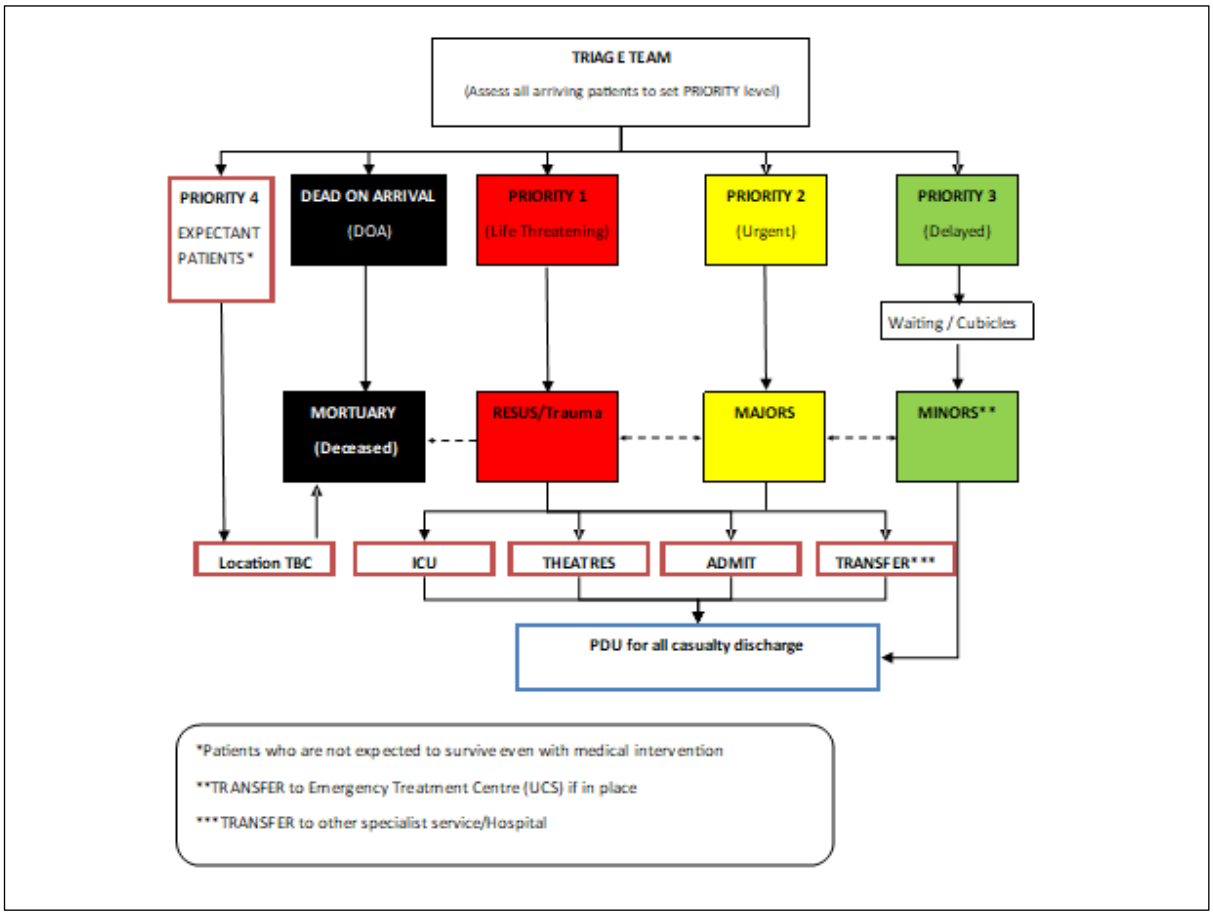
4.1 MKUH Patient Triage

The Trust is outlined as a Trauma Unit under current Casualty Regulation Plan arrangements with South Central Ambulance Service (SCAS). The expectation is that the Trust will receive up to 10x P1, 15x P2 and 30x P3 patients within two hours from a Major incident, as SCAS will assess and triage all patients to designated hospitals from scene. These same arrangements would be in effect for major incident occurring in East England through East England Ambulance Service (EEAS).

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

CATEGORY	DEFINITION	ACTION/DESTINATION
IMMEDIATE P1	casualties with life threatening conditions	Casualties will be taken to Resuscitation/Surgery
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	Process for dealing with P4 will be agreed through executive team (GOLD command)

Figure 7: MKUH Casualty Triage Flowchart



4.2 Emergency Department (ED) Response

4.2.1 Existing Patients in ED

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.

4.2.2 Nurse in Charge of the Emergency Department prepares the Department

The most senior Emergency Department Nurse on duty will clear the department, with the assistance of medical staff, of all patients except urgent cases. Patients undergoing urgent treatment will be transferred out of the department - medical and surgical HO's/SHO's will be responsible for their immediate treatment and admission. All incident casualties will enter the department via the Ambulance Entrance.

Each ward will send one trained nurse to the department (except maternity who have their own plan) the NIC of the Emergency Department will allocate them to additional roles detailed in departmental actions cards as required.

4.2.3 Triage at the Emergency Department Entrance

The Duty Emergency Department Consultant or his/her nominated deputy, together with a Senior Emergency Department Nurse, will begin triage assessment and with the help of Emergency Department Receptionists label patients at the entrance to the department. Triage will follow the Trauma triage protocol as used at scene. Patients will be triaged as P1, P2, P3 or P4.

4.2.4 Cleanliness of incoming patients (due to the incident)

It must be noted that patients arriving by ambulance (and to some extent self-presenting patients) may be extremely 'dirty' to due to the environment they have come from. The level of dirt/dust/ mud etc. will be dependent upon the incident. Consideration must be given to patients covered in dirt/dust etc. as they are moved from the ambulance stretcher to ED trolley. Additional domestic cleaning may be required. It must be taken into account that patients may be contaminated depending on what incident they have left.

4.2.5 Recording of incoming casualties

To ensure that a record of all casualties arriving in the Emergency Department is kept a casualty patient admission record grid summary form will be completed for all casualties from the incident.

The mass casualty patient admission record grid summary form records basic information about the patient including; time of arrival, gender, age, triage category (P1,P2,P3,P4 or dead)). It is not designed to provide in-depth clinical information for individual patients; this will be collected in the standard way. The form is used as an ongoing ready reckoner of total casualties throughout the course of the incident.

Blank copies of the forms are kept with the major incident patient record sheets in the Emergency Department incident store cupboards

The Trust can also expect a number of 'worried well' and provision for these patients, potentially in the patients discharge area or outpatient department should be considered at an early stage.

NOTE: Triage cards that accompany each patient into hospital form part of that patient's medical record. These cards must not be destroyed or shredded after use and must be kept and added to the patient's medical record at the earliest opportunity

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

4.2.6 Unknown Unknown Casualties

ED often care for patients unable or unwilling to give their identity including people who are unconscious or who have a critical illness, people with a mental health condition or delirium, and people affected by drink or drugs. Several unidentified patients may arrive together after an accident, or in mass casualty situations. Giving a unique identity to each unknown patient ensures safe and prompt diagnostic testing and treatment.

On arrival of unknown casualties the department will utilize 'Unknown Unknown' process by;

- For **name**, a randomly generate combinations of first and surname from an edited phonetic alphabet e.g. Foxtrot Whisky is used to ensure duplication doesn't occur.
- **Temporary hospital number** is generated through MRN generator held on ED reception.
- **Date of Birth** is to combine 1 Jan with an estimated year of birth, eg 01Jan1950, 01Jan2015

4.2.7 Forensic Evidence and Management of Fatalities

Major Incidents may be caused by criminal acts and are likely to be subject to subsequent investigation. Everything that could potentially be forensic evidence needs to be carefully preserved and protected, including bodies and body parts, biological specimens, and other material removed from casualties. The Police Liaison Officer on site will provide advice and guidance on this matter.

Patients' personal belongings, clothing etc. will be bagged, tagged and kept with each patient as normal.

4.3 Admission of Incident Patients

4.3.1 Patient flow

- All ambulance casualties will arrive through the ambulance entrance of the ED. Here they will be assessed by a Triage Officer and allocated notes and a designated treatment area;
- All walking wounded will enter the ED via the ambulance entrance, to the ED. Here they will be assessed by a Triage Officer and allocated notes and a designated treatment area;
- Patients requiring admission from ED to a ward or theatres will be moved within the hospital as normal;
- Patients being discharged from ED must go to the designated discharge area PDU
- **All** patients leaving the ED for admission or discharge must be logged out by the Exit Control Point Officer using the nominated exit control point. The Silver Commander in liaison with the ED Consultant decides on the appropriate exit points based on the type and number of casualties.
- Existing patients from receiving wards and Department of Critical Care will be transferred to other units under medical instruction to facilitate admission of incident patients. All ward areas and managers who support this function are aware of their responsibilities.

4.3.2 Urgent Care Service (MKUCS)

The MK Urgent Care Service (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 SCT.

- 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.
- In the event of significant number of casualties MKUCS will be contacted for mutual aid in support P3 casualties

4.3.3 Incident Information Centre (General Office)

The Incident Information Centre will be manned by staff from Medical Records in conjunction with the Police Documentation Team. It is the responsibility of the Police Documentation Team to liaise with the Casualty Bureau which has been established by the Police with details covered in 4.3.6 and 4.3.7.

4.3.4 Management of Relatives/Significant Others

Relatives will be directed to the designated Family and Friends Centre (Academic Centre with rooms TBC from Gold/Silver command) and will initially be looked after by one clerical officer, social work staff, the chaplain and other voluntary staff as necessary.

4.3.5 Use of Two-way Radios

The Two-way radio procedure details how radios are to be used in the event of a major incident.

Stock of Two-way radio handset (dedicated for use in the Silver Command Centre), are permanently on charge in the Silver Command Centre. A copy of the Two-way radio procedure is located in the Silver and Gold Commands Centres.

4.3.6 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 or local 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. This may involve MKUH also publicising this number to patients and relative impacted by the event.

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 SCT will identify a Relatives' Liaison Co-ordinator who will set up a team to help coordinate information.

- 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 Academic Centre when set up.

4.3.7 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 the Trust to collate information or 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 officer in ED or come to cubicles or wards 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.

Police MIDT Room

Room needs to be secure, with external Telephone line and access to internet **Rooms identified – Willow Room, Oak House (alternative venue may be used)**

4.3.8 Casualty Patient Discharged

Patient Discharge Unit (PDU) will be initially used to discharge all casualty patients attending the Trust. This will help ensure a central point to collate all information required of casualties involved. If in the event significant numbers affect the efficiency of PDU, then alternative venue will be sourced.

4.4 Clinical Department Response

4.4.1 Wards

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

4.4.2 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 SCT 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.

4.4.3 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. SCT 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.

4.4.4 Pharmacy

Dependent on time of incident, all on-call staff will be contacted to ensure emergency pharmacy support is actioned, with cascade for staff to come in and support the departments appropriately. Pharmacy will review current pharmaceutical stock in the event major incident requires specific medication for casualties.

4.5 Non-Clinical Departments Response

4.5.1 Outpatient Services

On notification from the SCT or GCT outpatients will be responsible for co-ordinating staff to suspend Outpatients and Waiting List admissions for the duration of the incident or until advised to stand-down. This will be reviewed at executive level if the incident or event require significant redeployment of staff from outpatient services.

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

4.5.2 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 SCT command as required.

In event of specific IT incident, it is the expectation that IT leads will be identified to attend GCT and SCT to provide expert advice aligned to the departments IT Disaster Recovery plan.

4.5.3 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.

4.5.4 Portering

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

They will assist in moving patients to wards and departments to enable ED to have required space for receiving casualties. The porters will also check with the SCT to provide additional beds from the bed store should these be needed.

4.5.5 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 if a Major Incident render one of Trusts buildings/premises unavailable and allow for flexible use of premises during an incident. Further support may be provided by putting up temporary signage to direct relative to the academic centre when Friends & Relatives rooms are established.

In event of specific Estates incident, it is the expectation that estate leads will be identified to attend GCT and SCT to provide expert advice aligned to the department Business Continuity plan.

4.5.6 Procurement & Stores

The procurement team will liaise closely with SCT to understand stock replenishment requirements for consumables and ‘ad hoc’ matters. The receipts and distribution part of procurement will

regularly report back to SCT for procurement with regard to the availability of suitable equipment and vehicle (s) to deliver stores to critical areas designated e.g. ED.

4.5.7 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.

4.5.8 Internal & External Lockdown

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

4.5.9 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.

4.5.10 Media or VIP

The Gold Commander in liaison with the Gold Communications Lead will be responsible for the arrangements for VIP visits, including liaison with the police about necessary security support. Silver Commander and Senior clinical staff should be informed of any such potential visits and the VIP and Trust media policies invoked;

Staff should be mindful that within a very short period of time following a report of a Major Incident, the press will focus in large numbers on the scene, reception centres, receiving hospitals and the mortuary. All members of the press not in their delegated area must be escorted to agreed area by security or available appropriate staff;

There is provision for media to set up within the Post Graduate Centre, and this area will be managed by the allocated press liaison officer. This is likely to be a member of the communications team or a senior manager. All press enquiries must be put through to here;

Any press releases or statements MUST be approved and organised through Gold Command in conjunction with the Gold Communications Lead and TVP/TVP SCG/TVP TCG (if convened).

Statements or briefings should be given at regular intervals. Gold Command will liaise with the Whole Systems Press Team as any statements must be coordinated and managed as a whole

Note regarding the term VIP to include new groups of individuals; A VIP can now include an injured terrorist/gang member, where there is a heightened need for security and confidentiality that is over and above normal patient's requirements (including Category 'A' HMP patients).

During a Major Incident the SCT in conjunction with Gold Commander will review the response required to handle media enquires activating MKUH 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.

4.5.11 Psychosocial Support and Staff Welfare

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.

MKUH holds a number of Psychosocial leaflet in helping give patients, relatives and staff advice following a Major Incident that can lead to traumatic experiences.
Two national leaflets will be made available found in appendix 9, with printed leaflets held within the Capacity Lounge.

4.6 MKUH Major Incident Internal Structure

Function/Facility	Locality	Telephone	Hospital Officer(s) in Charge
Gold Command Team	TAKEN OUT FOR PUBLIC PUBLICATION		
Silver Command Team			
Hospital Ambulance Liaison Officer			
Receiving Ward for non-incident emergencies			
Incident Information Centre			

Police Documentation Team	
Media Centre	
Volunteer's Reception Centre	
Hotel Services (Support Team, Catering, Linen)	
Friends & Relatives Centre	
Discharge area	

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 SCT / GCT for a number of days or weeks. In particular, in the early phase of an incident, the ICT / GCT 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 Silver and Gold Commander 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 MKUH 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 MKUH 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). All training records are held centrally with the EPO, with all training records reports to the AEO and Board as part of the annual Core Standards assurance process.

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).

7 Governance

7.1 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Emma Livesley	AEO	12.08.21	02.09.21		Yes
ADO	Divisions	12.08.21	02.09.21		Yes
Head of Nursing	Divisions	12.08.21	02.09.21		Yes
Operational Managers	Divisions	12.08.21	02.09.21		Yes
Head of estates	Estates	12.08.21	02.09.21	Confirmed Estates details	Yes
Local Security Management Specialist	Security	12.08.21	02.09.21		Yes
Head of clinical Services	Corporate	12.08.21	02.09.21		Yes
Domestic Services Waste Manager	Domestics	12.08.21	02.09.21		Yes
Head of Hotel Services	Core Clinical	12.08.21	02.09.21		Yes
Head of Pharmacy	Pharmacy	12.08.21	02.09.21		Yes
Information Governance Manager	Information Governance	12.08.21	02.09.21	Confirmed IRP process for police bureau	Yes
Silver On Call	Tactical	12.08.21	02.09.21		Yes
Consultant Leads	Divisions	12.08.21	02.09.21		Yes
BLMK CCG	CCG	12.08.21	02.09.21		Yes
UCS	UCS	12.08.21	02.09.21	Details amended to ETC	Yes
SCAS	Ambulance	12.08.21	02.09.21	Confirmed terminology	Yes

NHSE	NHSE	12.08.21	02.09.21		Yes
MK Council	Council	12.08.21	02.09.21		Yes
IT Service	IT	12.08.21	02.09.21		Yes

7.2 Audit and monitoring

This Guideline outlines the process for document development will be monitored on an
ongoing basis. The centralisation of the process for development of documents will enable the Trust to audit more effectively. The centralisation in recording documents onto a Quality Management database will ensure the process is robust.

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Plan to be reviewed every two years	Civil Contingencies Act 2004 – Plan / Preparedness maintenance requirements Annual agenda item for the EPRR Board NHS England annual EPRR Core Standards Assurance Programme	EPO	Every two years (Watching brief annually by the EPRR Board)	EPRR Board (NHS England annual EPPR Core Standards Assurance programme - Reviewed and checked by MKCCG then signed off by NHS England local regional office)
The plan will be updated with identified lessons learnt following planned Internal Emergency Incident / Mass Casualty / Major Incident response exercises	Civil Contingencies Act 2004 – Training and Exercising requirements TVLRF Training & Exercise Programme NHS England annual Core Standards Assurance Programme	EPO	As planned exercises take place	EPRR Board (Report to TVLRF Training and Exercise Group and the Human Health Sub-group as required)
The plan will be updated with identified lessons	Civil Contingencies Act 2004 –	EPO	Following a live	EPRR Board

learnt following an Internal Emergency Incident / Mass Casualty or Major Incident	Post event / review of planning and preparedness requirements		incident / event	
The plan will be updated following the publication of new / updated guidance	Department of Health, Public Health England, NHS England publications / guidance	EPO	As new guidance is published	EPRR Board

7.3 Equality Impact Assessment

As part of its development, this policy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified.

Equality Impact Assessment			
Division	**Corporate**	**Department**	**Emergency Planning**
Person completing the EqIA		**Contact No.**	**Ext.**
Others involved:	**N/A**	**Date of assessment:**	**September 2021**
Existing policy/service	Revision of previous IRP EIA	**New policy/service**	**N/A**

Will patients, carers, the public or staff be affected by the policy/service?	Staff
If staff, how many/which groups will be effected?	All staff as IRP outlines how the Trust will response to a major incident event

Protected characteristic	**Any impact?**	**Comments**
Age	NO	IRP outlines MKUH response to a Major Incident Event to maintain patient care and safety
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?	*Forwarded to all Divisions and key leads for comments*
How are the changes/amendments to the policies/services communicated?	**Email**

What future actions need to be taken to overcome any barriers or discrimination? N/A

Who will lead this?	Who will lead this?	Who will lead this?	Who will lead this?
N/A	**N/A**	**N/A**	**N/A**

Review date of EqIA	**September 2024**

Data Sharing During Emergency	
Responsible for: Information is shared between Category 1 and 2 responders as they work together to perform their duties under the Civil Contingencies Act. Information sharing is a crucial element of civil protection work, underpinning all forms of co-operation. However there are 8 key principles of data sharing when planning and responding to an emergency.	
Number	**The 8 Key Principles of Data Sharing when planning for and responding to Emergencies**
1.	Data Protection legislation does not prohibit the collection and sharing of personal data – it provides a framework where personal data can be used with confidence that individuals' privacy rights are respected.
2.	Emergency responders' starting point should be to consider the risks and the potential harm that may arise if they do not share information.
3.	Emergency responders should balance the potential damage to the individual (and where appropriate the public interest of keeping the information confidential) against the public interest in sharing the information.
4.	In emergencies, the public interest consideration will generally be more significant than during day-to-day business.
5.	Always check whether the objective can still be achieved by passing less personal data.
6.	Category 1 and 2 responders should be robust in asserting their power to share personal data lawfully in emergency planning, response and recovery situations.
7.	The consent of the data subject is not always a necessary pre-condition to lawful data sharing.
8.	You should seek advice where you are in doubt – though prepare on the basis that you will need to make a decision without formal advice during an emergency.

APPENDIX 1: DATA SHARING DURING EMERGENCY

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 MKUH 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)	

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: SILVER/GOLD COMMAND TEAM GENERIC AGENDA

Silver/Gold Command Team
0930hrs/Daily
Via Microsoft Teams (chaired from ICC)

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.		
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			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	

APPENDIX 9: Psychosocial support and staff welfare

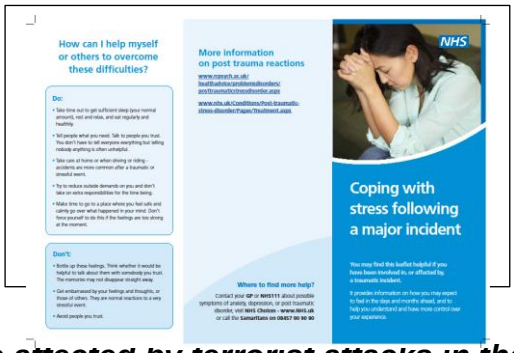
Victims of major incidents or terrorism will often have been through highly stressful or traumatic experiences, and the depth of mental health support victims need in the immediate, medium and long-term can be easily underestimated.

Victims may not only be the casualties and families involved, but the staff members dealing with the incident at the time within a stressful environment. Victims initially experience a post-trauma reaction, requiring help and guidance to understand and manage their reaction. Post-traumatic Stress Disorder (PTSD) can develop immediately, but also weeks, months or even years after a traumatic incident. Someone with PTSD may relive the traumatic event through nightmares and flashbacks, and may experience feelings of isolation, irritability and guilt. Symptoms may also include sleeping problems and difficulties concentrating.

In support there are two national leaflets in support to give further advice and essential contact numbers being:

- ***Coping with stress following a major incident (NHS)***

(Double Click Picture to Enlarge)



- ***Support for people affected by terrorist attacks in the UK (Home Office)***

(Double Click Picture to Enlarge)

- **Third Party Support covering Mental Wellbeing**

Double click on the image below to open the matrix in full outlining third part support

	CRUSE BEREAVEMENT CARE	SAMARITANS	VICTIM SUPPORT	BRITISH RED CROSS	PEACE FOUNDATION
Who can we support?	Specialises in those bereaved, but also provides psychological response to witnesses (may have injuries).	Bereaved, seriously injured & witnesses (may have injuries).	Bereaved, seriously injured & witnesses (may have injuries) in England and Wales.	Bereaved, seriously injured & witnesses (may have injuries).	Bereaved, seriously injured & witnesses (may have injuries), wider community including extended family, friends and professionals, survivors from historic incidents
How can we be contacted?	•Permanent Free helpline: 0808 808 1677 (open Mondays and Fridays 9:30-9pm, Tuesdays, Wednesdays and Thursdays 9:30am-8pm) •Bespoke email depending upon incident •Hope Again website www.hopeagain.org.uk •Humanitarian/Community Assistance Centre •Local office (depending upon location of incident) •Incident-specific outreach •Accepts referrals from statutory/non-statutory agencies, including Victim Support.	•Permanent Free helpline: 116 123 (24/7) •Permanent Email jo@samaritans.org (24/7) •Permanent Text number: 07725 90 90 90 (24/7) •Humanitarian/Community Assistance Centre •Incident-specific outreach.	•Permanent Free helpline: 0808 168 9111 (24/7) •Webpage with form that generates an email to the Supportline (24/7) •LiveChat with trained staff and volunteers (24/7) •Social media •Humanitarian/Community Assistance Centre •Local office (where available); •Incident-specific outreach (including hospital trauma wards) •Routine referrals from the police and Family Liaison Officers (FLO) (those bereaved are referred through FLOs with consent to the Homicide Service) and non-statutory agencies.	•Emergency Rest Centre(s): 0113 965 8338 •Free helpline (set up within four hours) •Social media •Humanitarian/Community Assistance Centre/Survivors Reception Centre •Incident-specific outreach •Local offices UK wide.	•Permanent phone number: 01925 581 240 •Permanent Email: SANI@FoundationPeace.org •Webpage with form that generates an email •The Peace Centre, Cheshire •Social Media •YAMMER private social network •Referrals from Victim Support.
Physical health			•Liaise with health bodies on service users' behalf •Aid application for Local Authority Disabled Facilities Grant.	•First aid •Assisted discharge, Home from Hospital and Support at Home services •Mobility aids •Ambulance support.	•Liaise with health bodies on service users' behalf.
Emotional support	•Immediate emotional support •Further bereavement support provided face-to-face or via telephone (up to 6 sessions) •Support for children and young people via the Hope Again web based peer support •Produce resources.	•Immediate emotional support; •Ongoing emotional support available via phone, email or text.	•Immediate emotional support; •Referral to trauma first aid if needed; •Further emotional support provided face to face or via phone as part of support plan; •Support available at events likely to generate high levels of distress; •Assistance with developing coping strategies as part of support plan; •Produce resources; •Commissioning of or referral to psychosocial therapies & peer support.	•Immediate emotional support; •Potential further emotional support face to face or via phone; •Support available at events likely to generate high levels of distress; •Assistance with developing coping strategies •Produce resources; •Briefing and debriefing responders.	•Further emotional support face to face or via phone •Help accessing appropriate psychological support •Peer support & online network •Events covering trauma awareness, commemoration and sharing experiences •Support available at events likely to generate high levels of distress •Assistance to develop coping strategies.
Practical health and safety	•Information and signposting to other organisations.	•Information and signposting to other organisations.	•Information and signposting to other organisations; •Arranging & funding accommodation & travel immediately or for inquest and coroners court; •Food vouchers; •Safety planning including travel buddy; •Liaising with housing provider on service users' behalf & access to qualified housing advice; •Language support & liaising with embassies; •Commissioning of cleaning & removals; •Liaising with police & FLO on service users' behalf; •Guidance on attending coroners court & inquest, referral to Witness Service if attending criminal court •Guidance on handling media attention.	•Immediate practical support e.g. rest centre(s); •Information and signposting to other organisations; •Safety messages; •Facilitating access to donated accommodation, travel and food; •Safe spaces for vulnerable groups; •Support to reunite families including international family tracing; •Liaising and working alongside other agencies e.g. NHS and Police to provide holistic care.	•Information and signposting to other organisations; •Liaising with housing provider on service users' behalf •Advocacy & alumni work including help with establishing trusts & memorials •Guidance on handling media attention •Liaison with police & FLO on service users' behalf •Advice on personal safety planning when travelling/ attending music events etc.
Financial, work and education assistance	•Training and debriefing of major incident response staff and volunteers.	•Training for emergency services, local authorities and others in dealing with suicidal contacts, trauma support and emotional resilience in the workplace.	•Aid applications to welfare benefits, emergency appeal funds & Criminal Injuries Compensation including liaising with agency on service users' behalf •Liaising with employer on service users' behalf •Guidance and liaising with schools for service user	•Support with application and distribution of emergency appeal funding (if set up) •Guidance and materials for schools •Trauma education and a range of psychosocial courses and workshops.	•Liaising with schools and employer on service users' behalf •Aid applications to CICA •Trauma education •Advocacy relating to terrorism/ political violence and war.

APPENDIX 10: List of Action Cards

This annex contains the Action Cards relating to the Major Incident Plan. **Always refer to the current version of the action cards on the Trust Intranet**

Note: With the exception of Switchboard, ED and Gold and Silver commanders **all** action cards are held in the Major Incident Action Card Cupboard outside the Clinical Site Office. It is the responsibility of the Manager On-Call to ensure that all cards have been collected by the designated personnel and follow up on those cards not collected.

The roles formulated into numbered and titled Action Cards are:

- 1 Switchboard

Strategic Management Team – Gold Command

- 2 Gold Commander (Executive On-Call)
- 3 Medical Director (NB only when available on site)
- 4 Communications Team lead (NB only when available on site)
- 5 Loggist (Gold)
- 5A Gold Command Administrator
- 5B Gold Command Runner
- 5C Gold Command Centre Access officer

Incident Management Team – Silver Command

- 7 Silver Commander (Manager On-Call)
- 8 Clinical Site Manager
- 9 Bed Managers
- 10 General Managers
- 11 Loggist (Silver)
- 11A Silver Command Administrator
- 11B Silver Command Runner
- 12 EPRR Tactical Advisor

Incident Information Team

- 12 Incident Information Officer
- 13 Information Room Clerks
- 14 Thames Valley Police Hospital Liaison Officer: Police Documentation Team

Emergency Department

- 15 Duty ED Consultant

- 16 ED Nurse in Charge
- 99 ED Bronze Commander
- 99 ED Bronze Command Medic
- 99 ED Bronze Loggist (when available)
- 99 ED Bronze Administration (When available)
- 17 ED Registrar / Middle Grade
- 18 ED SHO
- 19 ED NURSE – Triage
- 20 ED Nurse – Resus (3)
- 21 ED Nurse – Majors (4)
- 22 ED Nurse - Minors (2)
- 23 ED Nurse - Paediatrics (2)
- 24 ED Nurse – Waiting Room (2)
- 25 Non-ED Nurse – Majors
- 26 Non-ED Nurse – Minors / Paediatrics
- 27 ED Receptionists - On Duty
- 28 ED Receptionists – Called In

Medical Staff

- 29 Duty Anaesthetic Consultant
- 30 Duty Anaesthetic Registrar
- 31 Duty Anaesthetic SHO
- 32 Off Duty Anaesthetic Consultant
- 33 Duty ENT Consultant
- 34 Duty ENT SHO
- 35 Duty Gynaecology Consultant
- 36 Duty Gynaecology Registrar
- 37 Duty Gynaecology SHO
- 38 Duty Medical Consultant
- 39 Duty Medical Registrar and SHO
- 40 Duty Medical HO
- 41 Off Duty Medical Consultant(s)
- 42 Duty Consultant Microbiologist
- 43 Duty Orthopaedic Consultant
- 44 Duty Orthopaedic SHO
- 45 Off Duty Orthopaedic Consultant(s)
- 46 Off Duty Orthopaedic SHO(s)
- 47 Duty Paediatric Consultant
- 48 Duty Paediatric Registrar
- 49 Duty Surgical Consultant
- 50 Duty Surgical Registrar/SHO
- 51 Duty Surgical HO
- 52 Off Duty Surgical Consultant
- 53 Off Duty Surgical Registrars/SHO(s)

Nursing Staff

- 54 Matrons / Divisional Bleep holders/Night Practitioners
- 55 Nurse in Charge – ACU/DSU
- 56 Nurse in Charge – Ward 1/
- 57 Nurse in Charge – Ward 6- DoCC
- 58 Nurse in Charge – Other wards / Departments
- 59 Nurse in Charge – Outpatients
- 60 Nurse in Charge - Patient Discharge Unit
- 61 Theatres – Emergency Coordinator /Phase I Bleep holder
- 62 Theatres – Phase II Bleep holder
- 63 Theatres – Operating Department Practitioner

Family and Friends Centre – The Academic Centre

- 64 Family and Friends Centre Manager
- 65 Family and Friends Centre Clerk
- 66 Social Worker Lead

HR

- 67 Medical Staffing
- 68 Temporary Staffing/Communications Staff

Hotel Services

- 69 Catering Manager/Supervisor
- 70 Domestic Manager/Supervisor
- 71 Linen Supervisor
- 72 Support Team, Car Park and Security – CBRNe

Estates and IT

- 73 On Call Engineer – CBRNe
- 74 On Call Electrician and Fitter – CBRNe
- 75 IT On Call

Corporate Divisions, Core Clinical and Support Services

- 76 Chaplain
- 77 HSDU Manager
- 78 Imaging – Duty Radiographer
- 79 Imaging – Imaging Services Lead
- 80 Pathology – Duty Haematology BMS
- 81 Pharmacy – CBRNe
- 82 Therapy Manager

- 83 Purchasing Manager

Emergency Services – On-Site at the hospital

- 99 Thames Valley Police Casualty Bureau staff
- 99 Hospital Ambulance Liaison Officer (HALO)
- 85 Hospital Ambulance Liaison Control Officer (HALCO)
- 99 BF&RS Liaison Officer

APPENDIX 11: Planning References

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