Gloucestershire Hospitals NHS
NHS Foundation Trust

GLOUCESTERSHIRE

HOSPITALS NHS

FOUNDATION TRUST

MAJOR INCIDENT

RESPONSE PLAN

WARNING

IF AN INCIDENT HAS OCCURRED AND YOU HAVE NOT READ THIS PLAN, ***DON'T READ IT NOW***

GO STRAIGHT TO RELEVANT 'ACTION CARD' & FOLLOW THE PROCEDURES

Foreword

This Major Incident Response Plan outlines the operational arrangements to be undertaken by Gloucestershire Hospitals NHS Foundation Trust, at the time of a Major Incident, civil emergency or in response to a disruption to service provision requiring Business Continuity Management plans to be implemented. This Response Plan is supported by a Major Incident and Business Continuity Management Strategy.

The document follows guidance from the NHS Commissioning Board Emergency Preparedness Framework 2015, the Department of Health (DH) and requirements of the Civil Contingencies Act 2004. It has formal links with Gloucestershire Care Services, South West Ambulance Service, ^{2}gether Trust, Local Health Resilience Partnership, Local Clinical Commissioning Group and Gloucestershire Local Resilience Forum.

The Trust has designated Gloucestershire Royal Hospital (GRH) as the default site for receiving casualties from a major incident. Cheltenham General Hospital (CGH) will continue to plan and maintain arrangements to be able to respond to a major incident. This will be particularly important in the event of a Level 2 or 3 incident, or when the nature of an incident compromises the ability of GRH ED to respond or if the incident directly effects CGH or in the immediate locality.

Wards/clinical areas and departmental managers must familiarise themselves with the contents of this plan and appropriate action cards. The trust has a legal responsibility to ensure departments train and exercise to maintain their emergency preparedness and resilience plans. Lessons learned from incidents and exercises should be reviewed, any changes to be agreed with the EPM and action cards and plans updated as required.

As the Nominated Accountable Emergency planning officer, I acknowledge that responsibility for emergency response planning rests with me. However, it is responsibility of the divisional leads to ensure their departments maintain emergency preparedness and resilience plans, supported by the EPM.
I am satisfied this plan ensures the Trust has effective arrangements in place to respond to a critical or major incident, that we meet the needs of vulnerable groups and are able to provide culturally appropriate services. The EPM will conduct an annual, or more frequent if required, review of this plan and associated Action Cards.

Name: Caroline Landon **Signature:**_____

Title Chief Operating Officer

Date Oct 2017

Version Control and Administration

The document is managed by the EPM, Gloucestershire Hospitals NHS Foundation Trust. (GHNHSFT)

Document Management and Consultation

Internal and external stakeholders were consulted during compilation and where appropriate, will be included during further reviews. Evidence of consultation is retained by the EPM.

Issuing Authority and Distribution

This plan is issued on the authority of the Director of Clinical Strategy after the consultation process outlined above, with the final draft being agreed by the Emergency Planning and Resilience group, Trust Management Team and approved by the Board. The document will be accessible to staff in Acrobat Portable Document Format (PDF) on the Intranet.

Permission is granted to copy/print the PDF. The EPM will manage both the internal and external distribution.

Record of Amendments

A record of amendments will be retained by the EPM and issue dates identified on the table below.

Amendment Number	Date Incorporated	Amendment	Incorporated By
1	September 2015	Full Plan	EPM
2	November 2015	Up dated to reflect the changes in the NHS England Preparedness Resilience and Response Frame work November 2015	EPM
3	December 2016	Updated to reflect OPEL	EPM
4	January 2017	Addition of Section 5 Vulnerable People inc. Peads	EPM
5	January 2017	Change of Nominated Accountable Officer to Chief Operating officer	EMP
6	June 2017	Amendment to Appendix 1 SWAST alerting	EPM
7	August 2018	Amendment to ED SWAST internet. Amendment Appendix 3	EPM
9	January 2021	Links all updated and contacts	JO/JR
10			
11			
12			

Training

LRHP/GHT Emergency preparedness Training matrix can be found in the Appendix 2

Training Exercises can be found in Appendix 3

Governance

Please refer to Emergency Preparedness, Resilience and Response Policy on the Trust Policy Website.

Freedom of Information

This plan is subject to the freedom of information act.

Bibliography

The following documents were consulted or are directly linked to this plan:

- Civil Contingencies Act 2004 – Cabinet office
- NHS Commissioning Board Emergency Preparedness Frame work 2015
- https://www.england.nhs.uk/wp-content/uploads/2015/11/eprr-framework.pdf
- Emergency Planning Requirements – Care Quality Commission
- Joint Major Incident Procedures Manual - Gloucestershire LRF
- Major Incident Plan - 2gether NHS Foundation Trust
- Major Incident Plan – Gloucestershire Clinical Commissioning Group Major Incident Plan – South Western Ambulance Service Trust
- LRHP Local Health Community Response Plan
- Planning for Major Incidents – DH Health Emergency Preparedness Division
- LRF and LRHP mass casualty plan
- LRF Vulnerable persons plan
- GHT Patient flow policy (escalation) 2016
- http://glnt313/sites/ghnhsft_policy_library/NonClinPolices/B0713.pdf
- GHT CBRN/Hazmat plan
- NHS Operational Pressures Escalation Levels Framework Nov 1016

Acronyms

Without a common understanding of what specific terms and phrases mean, multi-agency working will always carry the risk of potentially serious misunderstandings, the consequences of which could be extremely severe. Since 2007 the Cabinet Office has been working with a wide range of partners to build and maintain a single point of reference for civil protection terminology as one of the underpinning elements of interoperable communications and coherent multi-agency working.
The latest version of this lexicon can be found here:

https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon

Table of Contents

Glossary of Abbreviations

The following is a list of abbreviations and acronyms used in this document:

2gether	- 2gether NHS Foundation Trust
ED	- Emergency Department- A&E term still used in line with road signposting – also referred to as A&E
ACU	- Acute Care Unit. Followed by 'A' for GRH or 'C' for CGH
ADoSD	- Associate Director of Service Delivery
BASICS	- British Association for Intermediate Care Schemes
BCM	- Business Continuity Management
CBRN	- Chemical, Biological, Radiological, Nuclear
CCG	- Clinical Commissioning Board
CGH	- Cheltenham General Hospital
CEO	- Chief Executive Officer
DH	- Department of Health
DSU	- Day Surgery Unit
EDOc	- Executive Director On-call
EPM	- Emergency Planning Manager
EPRR	- Emergency Planning Resilience and Response
GCS	- Gloucestershire Care Services
GRH	- Gloucestershire Royal Hospital
HALO	- Hospital Ambulance Liaison Officer
HIC	- Health Incident Control (CCG)
HPA	- Health Protection Agency
HSE	- Health and Safety Executive
LHRP	- Local Health Resilience Partnership
LRF	- Local Resilience Forum
MLP	- Media Liaison Point
NSC	- NHS South Central Area Team (Changed from NSC)
OCC	- Operational Control Centre
OCM	- On-call Manager
OPEL	- Operational Pressures Escalation Levels Framework
PAS	- Patient Administration System
PTSD	- Post Traumatic Stress Disorder
STAC	- Scientific and Technical Advice Cell
SWAST	- South Western Ambulance Service
SWSHA	- South West Area Team

Other Plans to be used in conjunction with this plan as indicated

Plan	What plan covers	link
Emergency Preparedness, Strategy	Provides the overarching framework for Emergency Planning Resilience and response	Link
Local Health Response Plan	Local health joint response, Command and control Key partner contact details, SITREP and conference call templates.	Link
LRF mass casualty plan	Multi agency response	Via LRF / LHRP
LRF communication plan	Wider health /multi agency communication strategy and arrangement	Via LRF Link
GHT Escalation policy for Patient Flow	Operational policy for Maintaining Safety and Quality through Effective Patient Flow Divisional and departmental actions. Health community capacity conference call	Link
GHT Mass prophylaxis plan	Management and flow arrangements for rapid dispensing of countermeasures/mass prophylaxis (excluding flu pandemic)	Link
Pandemic Flu plan LRF		Via LRF/ LHRP Link
GHT CBRN/Hazmat plan		Not available on the intranet
Loss of essential work force plan	Critical services to be maintained during situation of loss of staff e.g. due to: adverse weather, strike, pandemic.	BCM / MI plan Link
Business Continuity Management plan		Link
Operation link	Operation Link is a police facilitated telephone cascade protocol which provides a quick time communication capability for multi-agency partner members of the Gloucestershire Local Resilience Forum (LRF). It provides for the set-up of a multi-agency teleconference within a minimum of forty five minutes of an agency requirement for activation being made to the Police Control Room Inspector, Force Incident Manager (FIM). The facility can be used; urgent information sharing purposes to inform a commonly recognised information picture (CRIP), to initiate a Tactical Coordination Group (TCG) teleconference or, to identify the requirement to set up a formal Strategic Coordination Group	Link
NHS England Preparedness Resilience and Response Framework November 2015		https://www.england.nhs.uk/wp-content/uploads/2015/11/eprr-framework.pdf

Section 1 - Major Incident Plan Overview

The Trust will respond to a Major Incident using established patient pathways. **The Trust has designated Gloucestershire Royal as the default site for receiving casualties from a major incident**. Cheltenham General Hospital (CGH) will continue to plan and maintain arrangements to be able to respond to a major incident. This will be particularly important in the event of a Level 2 or 3 incident, or when the nature of an incident compromises the ability of GRH ED to respond or if the incident directly effects CGH or in the immediate locality.

1. This Major Incident Response Plan is compiled to provide staff with an operational brief and actions to take in response to an external major incident or internal incident or escalating situation.

2. Where appropriate, wards, departments, teams and some individuals will have agreed Action Cards that outline procedures to be followed. Under the guidance of the EPM, these cards will be owned and maintained by those areas or individuals who will use them in response to an incident. See Section 2 for further information.

Definitions

Emergency Preparedness [1]

The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies

Resilience

Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges

Response

Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders

Emergency definition

Under Section 1 of the CCA 2004 an "emergency" means

"(a) *an event or situation which threatens serious damage to human welfare in a place in the United Kingdom;*

(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom;

(c) war, or terrorism, which threatens serious damage to the security of the United Kingdom".

Incident terminology

For the NHS, incidents are classed as either:

- Business Continuity Incident
- Critical Incident
- Major Incident

Each will impact upon service delivery within the NHS, may undermine public confidence and require contingency plans to be implemented. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration, particularly where this may be due to internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.

Business Continuity Incident

A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)

[1] Section 6 NHS England Preparedness Resilience and Response Framework November 2015 revisions

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.

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

The words 'special arrangements' means that management and staff may be called upon to respond, outside of their normal routine service arrangements, to a major incident involving casualties, standby to receive casualties and or implement Business Continuity Management (BCM) procedures to restore service delivery after a disruption e.g. loss of electricity or staff.

Types of incident [2]

The following list provides commonly used classifications of types of incident. This list is not exhaustive and other classifications may be used as appropriate. The nature and scale of an incident will determine the appropriate Incident Level.

- 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
- Pre-planned major events that require planning - demonstrations, sports fixtures, air shows.

[2] Section 7.1 NHS England Preparedness Resilience and Response Framework November 2015 revisions

NHS Acute Trust Defined Roles and Responsibilities

The Trust hospitals are responsible for providing:

a. Reception and triage of casualties in ED if designated as a receiving hospital;
b. Back-up facilities in the rest of the hospital;
c. Support to any designated receiving hospital including planning to offer effective support to any neighbouring service that is substantially affected (in return relying on such mutual support if needed locally);
d. Identification of patients requiring transfer to specialist centres e.g. burns and plastics unit as appropriate and liaison with those units;
e. Communication with relatives and friends of existing patients and those from the incident, the local community, the media and VIPs;
f. Counselling, advice and support in partnership with other agencies;
g. Ensure that the hospital continues all of its essential functions and the maintenance, as far as possible, of normal acute health services;

Areas of Responsibility

In the event of an external major incident, the relevant NHS Tactical Commander on call will inform the Trust senior managers on call, who will alert relevant managers and service heads to mobilise clinical and other staff to support the response to the incident. This may be for one or more localities depending on the size and nature of the incident. We may be the receiving hospital or one of the receiving hospitals.

Other senior managers will be brought in to support the incident, or maintain business continuity. They will identify and call in other staff as required and direct staff to their individual duties to support health services across the relevant area of the Trust.

Each line manager must hold the contact details (office and home/mobile numbers) for all staff in the teams under their management. All staff have responsibility for ensuring that their departments and human resources have their up to date contact details.

Managers and staff will be directed to areas of work as appropriate to maintain a sustained response to manage the incident or maintain business continuity.

It must be noted that any staff may be required to undertake duties that would not normally be part of their daily work (eg, working in different areas, supporting the key areas involved, control room support or execution of allocated tasks)

Responsibility for Ward/Department Emergency Planning Leads

1. Each ward, department will have an emergency response lead who is responsible for:

a. Ownership and maintenance of local plans and action cards including revision as procedures or protocols change ;
b. EPM agreement of local plans and actions cards;
c. Ensure staff familiar with and trained on local plans and action cards;
d. Receiving, maintaining and ensuring that this plan is available to staff;
e. Ensuring that staff are aware of the location of and are able to implement the Action Cards.

Staff Responsibilities

1. All managers are to ensure that staff, regardless of their role, is aware of the Trust's response to a Major Incident, the function of their ward/department and the individuals responsibilities. The six main areas of staff must know:

    a. **Their Roles & Responsibilities** - and the function of their ward, department or team;
    b. **How the Alerting Cascade works** - Staff must ensure that they always have access (including at home) to telephone numbers of colleagues if they are part of a callout cascade system;
    c. **Their Business Continuity Plans (BCM) – how to maintain their critical functions.**
    d. **Where to Report to** - Some staff will report to work and others may be briefed to remain on standby;
    e. **What 'Action Card' they may have to implement** - If they have a specific 'Action Card' to implement response to either a Major Incident 'Standby' or 'Declared';
    f. **Who their Emergency Planning Lead is and where they find emergency planning response information**;

2. Directors and general operational managers / on call also act as members of the Trust Operational (silver) Control Team and ADO, ADoSD, Matrons and DOc require a working knowledge of this entire document. They should also be familiar, through training and testing of the plan, with the principles of 'Command and Control' roles and responsibilities in the Trust control room and the Health Community Response Plan.

NHS Incident levels[3]

There are 4 national levels of response as detailed in the following table. Updated November 2015

Alert	Activity	Action		NHS CB Incident levels	Lead
Alert	**Dynamic Risk Assessment**	**Declaration of Incident level**	**1**	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.	CCG / Provider (Area Team for Primary Care)
			2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.	CCG/ NHS Health England local office
			3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.	NHS Health England coordinates response in collaboration with local commissioners at the tactical level.
			4	An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.	Area Team / Region / National

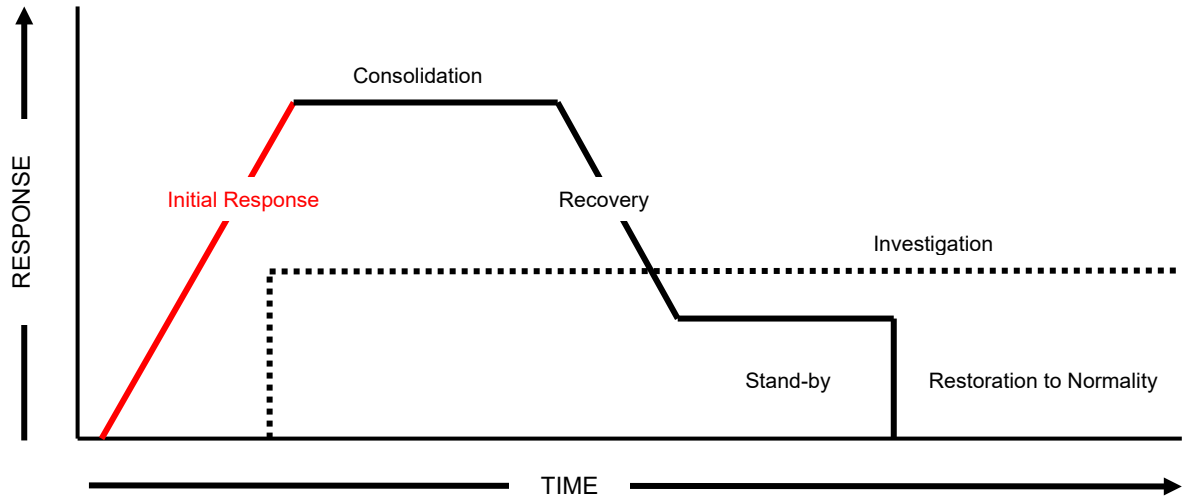
NB. You must inform CCG, GCS and Area team if declaring, see Health Community Response Plan for key contacts.

[3] Section 7 NHS England Preparedness Resilience and Response Framework November 2015 revisions

Phases of a Major Incident

1. Most major incidents can be considered to have four phases - Initial Response, Consolidation, Recovery, and Return to Normality.

Phases of a Major Incident



a. **The Initial Response** - The initial response to the report of a major incident will correspond with the time when action is being taken by the emergency services. The initial responses may occur very rapidly. Once a major incident has been declared, it is essential that liaison occurs quickly with other agencies involved. This is particularly important for SWAST who will be the NHS lead at the scene;

b. **Consolidation** - The consolidation phase involves on-going action by the emergency services supported by Local Authority and other agencies as required. During this phase, the CCG Health Incident Control (HIC) Co-ordinator may need to call a Strategic Incident Control Team meeting to discuss an appropriate management approach to what may become a prolonged incident. The formation of this group will be dependent on the type of incident and may require attendees from the NHS and other agencies;

c. **Recovery** - The recovery phase will usually commence when lifesaving is complete. The caring for those involved or affected less seriously can then begin. In terms of the Trust response, this phase will encompass the instigation of further investigations, on-going communication with the other agencies, health professionals, press and the general public;

d. **Return to Normality** - This involves action by the Trusts to restore service delivery, investigate the causes/circumstances of the incident, evaluate the costs incurred, recommend ways to reduce risk and improve response in the future.

e. **CCG** has procedures in place to support the Gloucester Health Community during both the recovery and return to normality phases. The health implications surrounding an incident may take a long time to resolve and may require medical intervention for some years after the event. The HIC Co-ordinator may need to identify appropriate staff to support organisations e.g. local authority management of a return to normality.

Internal Escalation Procedures

In incidents with high bed pressures, escalation /Critical internal / major incident, the Escalation Policy - Operational policy for Maintaining Safety and Quality through Effective Patient Flow is followed for OPEL level 3 and 4 escalation. Especially sections 7.8 to 8.4 for communication and capacity arrangements across our health community, timings and frequency may vary during incidents.

Operational Pressures Escalation Levels	
OPEL One	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL Two	The local health and social care system is starting to show signs of pressure. The local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at local regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL Three	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL Two have not succeeded in returning the system to OPEL One. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/local regional teams through internal reporting mechanisms.
OPEL Four	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL Four for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.
Business Continuity Incident	An incident where the Business continuity Plan is implemented. [4]Business continuity is defined as the "capability of the organisation to continue delivery of products or services at acceptable predefined levels following a disruptive incident." (ISO 22300)

[5] It is **not** normally expected that escalation would be the cause of a major incident as **escalation is a result of general capacity and demand pressure rather than pressure** caused by a specific event. However, there may well be actions that are common to escalation OPEL levels 3 and 4 and major incident plans and this should be considered within local economy action cards.

[4] NHS England Business Continuity Policy dated December 2014
http://www.england.nhs.uk/wp-content/uploads/2014/12/business-continuity-policy.pdf
[5] NHS Operational Pressures Escalation Levels Framework

An Escalation Alert is an internal alert to an incident that may affect the smooth running of the Trust or present a risk to the provision of service delivery but does not require full implementation of this plan. There may be circumstances which cause areas to become overwhelmed e.g. fire, snow/icy conditions, bed pressures, heatwave or a small number of contaminated self-presenters (not linked to a deliberate release scenario) but would not necessarily merit a full response from the Trust.

In these circumstances, a Director or Chief Operating Officer may decide to call a 'Escalation Alert/ Internal 'Critical Incident' in order to ensure that there are sufficient personnel to respond locally to the incident and to create a management response appropriate to the incident but without the disruption that declaring a Major Incident would cause. However, in extreme situations an 'Escalation Alert' may lead to an internal Critical or Major Incident being declared by the CEO or Deputy CEO. See Flow Chart 4 for internal escalating incidents alerting procedures.

Internal Critical incident - In the event of an internal Critical incident escalating to an Internal Major Incident

In the first instance NHS organisations must consider declaring a Critical incident before escalating to a major incident. A significant incident is when their own facilities and/or resources, or those of its neighbours, are over whelmed. The specific triggers for escalation and the process for managing this must be identified in the respective incident plan which must also describe the process for escalation to a major incident.[6]

Critical incident [7]
Declaring a critical incident should adopt the following format;

"Critical Incident declared by (organisation)"

	SBAR report
Situation	describe situation/incident that has occurred
Background	explain history and impact of incident on services / patient safety
Assessment	confirm your understanding of the issues involved
Recommendation	explain what you need, clarify expectations and what you would like to happen
	Ask receiver to repeat information to ensure understanding

"SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety" (*NHS Institute for Innovation and Improvement)*

Please note: A Critical Incident is principally an internal escalation response to increased system pressures/ disruption to services that are or will have a detrimental impact on the organisation's ability to deliver safe patient care.

Appendix 4 of the Operational Pressures Escalation Levels Framework outlines Serious Incident Guidance NHS Operational Pressures Escalation Levels Framework

[7] 12.4 NHS England Preparedness Resilience and Response Framework November 2015 revisions

Standard Major Incident alert level messages used by NHS organisations[8]
Taken from NHS EPRR Framework
The following message will be given as part of the Major Incident alert by switchboard:

Standby	use time wisely to prepare
Declared	activation of plans and action cards
Cancelled	deactivation of plans –
Stand down	plan to return to normal- some areas may be stood down before others.

To avoid confusion about when to implement plans, it is essential to use these standard messages in relation to either significant or major incidents:[9]

See appendix 16: NHS Escalation and de-escalation

Standard Major Incident alert level messages used by NHS organisations[10]
Taken from NHS EPRR Framework
The following message will be given as part of the Major Incident alert by switchboard:

1. Major incident – standby

This alerts the NHS that a major incident may need to be declared. Major incident standby is likely to involve the participating NHS organisations in making preparatory arrangements appropriate to the incident, whether it is a 'big bang' ,a 'rising tide' or a pre-planned event.

2. Major incident declared – activate plan
This alerts NHS organisations that they need to activate their plan and mobilise additional resources

3. Major incident -Cancelled

This message cancels either of the first two messages at any time

4. Major incident stand down

- All receiving hospitals are alerted as soon as all live casualties have been removed from the site. Where possible, the Ambulance Incident Commander will make it clear whether any casualties are still enroute
- While ambulance services will notify the receiving hospitals(s) that the scene is clear of live casualties, it is the responsibility of each NHS organisation to assess when it is appropriate for them to stand down their own response

[9] 12.2 NHS England Preparedness Resilience and Response Framework November 2015 revisions

If the Trust itself declares a Major Incident then it will inform CCG, GCS, SWAST and if required, the Police and Fire and Rescue Service. These organisations will cascade the alert as appropriate.
This may evoke the Local Health Community response plan.

CCG has the strategic lead of the NHS in the County and will establish a Health Incident Control (HIC) to provide 'Tactical' management of an incident for the health community and respond/support the CCG Chief Executive as the Health Gold in the Strategic Co-ordinating Group (Gold Command) at the Police Headquarters in Quedgeley. Gloucestershire Care Services provides clinical care across the county through the Community Hospitals and Community Nursing etc. In the event of an incident, Care Services will establish an Operational Control Centre (OCC) to provide 'Operational' management of their clinical services and work in close liaison with GHT.

Major Incident 'Standby'

1. Major Incident 'Standby' alerts relevant personnel/departments that information has been received or there is an escalating situation, which may develop into a major incident and **to prepare**.
2. 'Standby' is only used by the NHS and staff should gain as much information about the incident and casualty type and numbers expected and use the time to prepare.
3. Operation Link activated by the Police may be used to advise partner agencies of a particular risk or, the declaration or likely declaration of a 'major Incident', emergency or any other significant incident which may require enhanced multi-agency co-ordination involving one or more LRF responder agency. (See Operation Link Appendix A)

The operational lead should consider the risk and the impact – early contingency plans may be required e.g. effects from a plume of smoke to our sites / population.

Major Incident 'Declared'

A whole local health system approach will be required in declaration of a Major Incident, although it may not be a Major Incident to other organisations. The health community response plan will be activated.

Major Incident 'Cancelled'

Major Incident 'Cancelled' - this message cancels either of the first two messages.

Major Incident 'Stand Down'

A stand by GHT will be declared as soon as able as directed by the Trust Incident Control room but this may be some time after the other blue light services.

Section 2 – Major Incident Activation

Major Incident Notification

Notification of an event requiring major incident response can come from a number of different agencies.

These include:

a. **SWAST** – for incidents involving immediate casualties.

b. **CCGs and Area teams** - Relating to information being disseminated from the Department of Health (DH) or in support of neighbouring CCGs This will usually be via local CCG;

c. **DH** - In the case of a major incident requiring a co-ordinated national response. Again via CCG, from the area team;

d. **Public Health England** - The Director of Public Health with CCG will co-ordinate alerting relating to incidents affecting public health e.g. outbreaks of infectious disease, drug/medical device problems, water contamination. The information is likely to originate locally from the Health Protection Agency (HPA) or Local Authority Environmental Health Officers, nationally from the DH or HPA or internationally from the World Health Organisation;

e. **Gloucestershire Constabulary** - In the case of public health issues stemming from chemical or biological terrorism or accident, however this will normally be relayed via SWAST Control.

f. **Internal Escalation** – This can trigger a major incident if multiple organisations are involved and in accordance to the Operational Pressures Escalation levels Framework NHS England South Central . However, there is a separate process for managing internal escalations, see below.

NHS Operational Pressures Escalation levels Framework

Declaring a Major Incident

External Incident – Can be declared by any of the organisation in the list about but most likely it will be The South Western Ambulance Service Trust (SWAST). They will alert the ED Departments to a major incident via a METHANE report.

The Joint Emergency Services Interoperability Principles (JESIP) identifies METHANE as the preferred model to share information to promote a shared situational awareness

The standard mnemonic used by NHS and other Emergency Services is **METHANE**

- **M**ajor incident declared?
- **E**xact location
- **T**ype of incident
- **H**azards present or suspected
- **A**ccess – routes that are safe to use
- **N**umber, type of casualties
- **E**mergency services present and those required

(source JESIP, 2015)

SWAST alerting to ED

On receipt of a Major incident Standby/Declared Alert from SWAST

- On answering the RED ED phones always say ED emergency phone, NB the automated Everbridge system will assume an answer phone if it does not hear a voice.
- Gain as much information as possible about the incident, casualty type and numbers expected. (METHANE)
- Inform switchboard to on 2222 to activate Major Incident cascade.
- Inform /brief Silver
- Brief Doctors, nursing and reception staff on Duty GRH and CGH.
- Access SWAST briefing via **https://www.swast.nhs.uk/p/major-incident**
- GHT password glos
- CGH password chelt
- Receipt of the **METHANE** briefing by pressing 1- SWAST then can see we have received the message.
- Information Updated every 15 mins

Acute capacity notification to SWAST the Acute Emergency Department Capacity page to submit your Emergency Department capacity.

Plan activation

- **ED staff** will activate local plans and action cards appropriate to Major Incident being declared and alert Associate Director of Service Delevery /Director of operations and On call Director and instruct the Switchboard to cascade the alert.
- **In-hours,** the ADO must be informed.
- **Out-of-hours** firstly the ADoSD then the EDOc, who will brief the Chief Executive.

- Upon receiving notification of the major incident switchboard will commence a call-out of senior managers and required staff. This initiates departmental staff cascades.
- The ADoSD or EDOc may identify an incident manager for one or both CGH and GRH

- **Only the Chief Executive Officer (CEO) or Deputy CEO can formally declare an internal Major Incident.**
- The ADoSD, EDoSD or OCM is responsible for briefing on call director who will brief the CEO or Deputy CEO to gain approval for an Internal Major Incident to be declared
- The ADoSD or OCM is responsible for initiating an appropriate management response to the Major Incident.
- CCG, GCS, and area team must also be notified. Key contacts are in the Health Community Response Plan.
- Upon receiving notification of the major incident switchboard will commence a call-out of senior managers and required staff. This initiates departmental staff cascades.
- The ADoSD or EDOc may identify an incident manager for one or both CGH and GRH

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On-call Arrangements

The Trust has the following arrangements in place to provide on-call senior management cover for both in and out of hours:

In-hours

Associate Director of Service Delivery (ADoSD) or nominated will be the first point of contact for the Switchboard. If required the ASoSD will alert the On-Call Manager (OCM)/Executive Director On-call (EDOc) for support and other key persons relevant to the incident .

Out-of-Hours

Cover is provided by the OCM who if required will alert the Executive Director On-call (EDOc) for support.

Regardless of the time of day, the Switchboard will alert both the EDOc and ADoSD about a Major Incident alert.

Notification to the health community will by the On-Call Director or nominated following the:

The local Health Resilience Partnership Health Community response plan used in conjunction with this Major Incident plan and contains the key contacts and templates, e.g. conference calls, SITREPs, risk assessments.
Electronic plan and templates available on the Trust control room log on and restricted on call managers info.

Major Incident Cascade

a) The cascade system employed by both ED and or the Hospital switchboard will ensure that the required clinical, nursing and management teams are established quickly. A Major Incident bleep group has been established at both CGH and GRH to alert key on duty staff. The switchboard will only give a single automatic message e.g. 'Gloucestershire Hospitals: Major Incident Declared at GRH or CGH'. It is therefore important that individuals are aware of where they need to report to and where they will be based **in advance** of a Major Incident being declared.
b) Switchboard cascade initially contacts the key staff, on receipt off the alert staff follow their action cards and initiate their team / department cascades.
c) Consideration must be given to not calling staff who are also required for the next two shifts, calling in only who you need and consideration for ongoing staffing depending on the incident type.

d) There are different cascade list for different types of incidents, eg BCM, bed pressure escalation and Major Incident. These will become more refined as our technology advances.

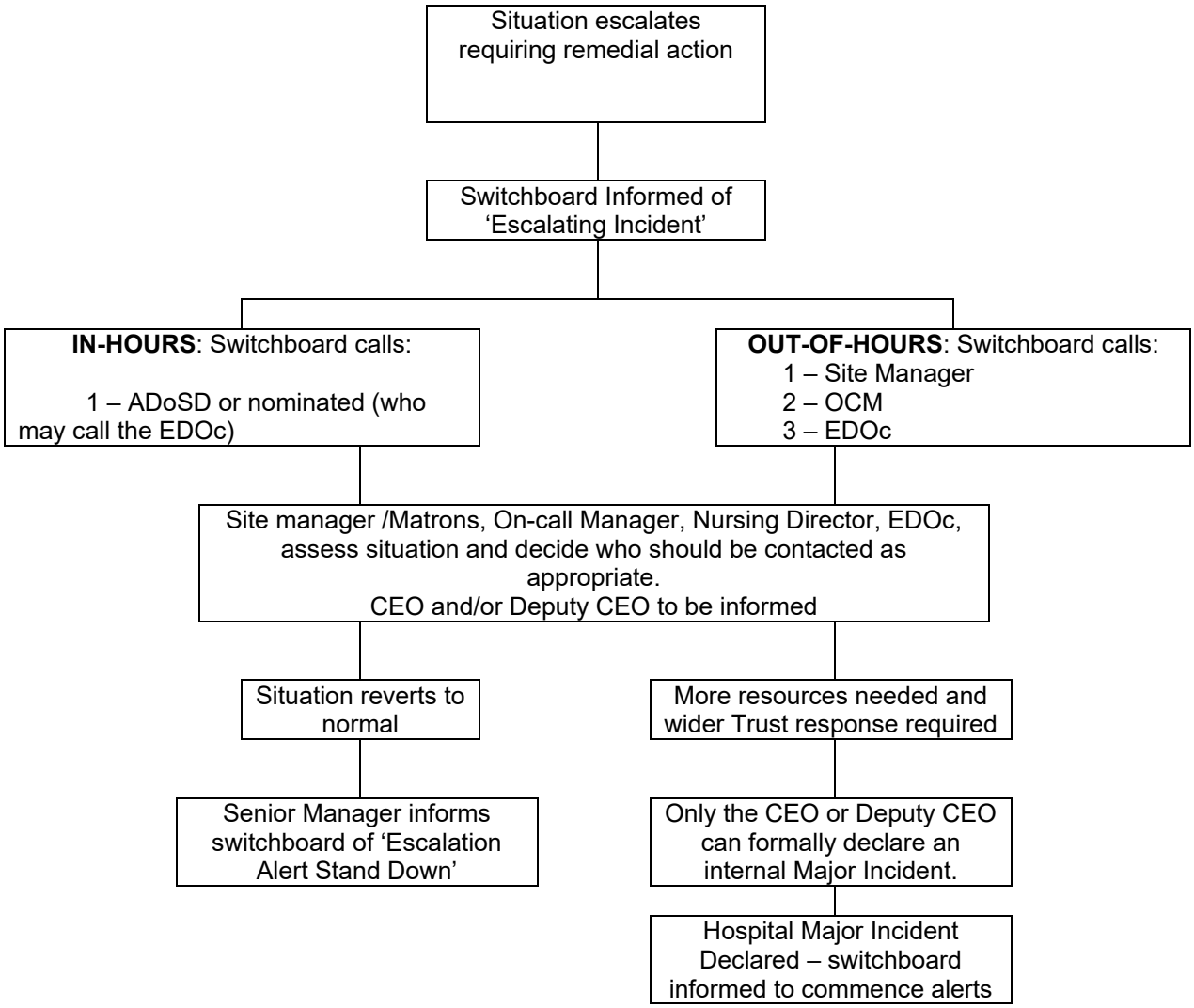
Individuals, Wards and Departments on receiving the Major Incident alert message should

Instigate their own departmental plans and/or follow the relevant action card for their role. For some staff, this will involve deploying to other areas of the hospital – as detailed on the relevant action cards.

Staff without a pre-defined role will still be required to support the major incident response by:

- Wards: identifying patients that can be discharged and expediting discharge.
- All areas:
    - Reviewing planned activity/ work/ meetings/ training, Study – cancelling
    - Identifying staff, especially clinical staff with back room functions and inform Trust Control room.
- Reducing the demand on:
    - Site managers,
    - Porters
    - Support services
    - Switchboard

Flow Chart 1 – Internal Escalation Alerting Actions

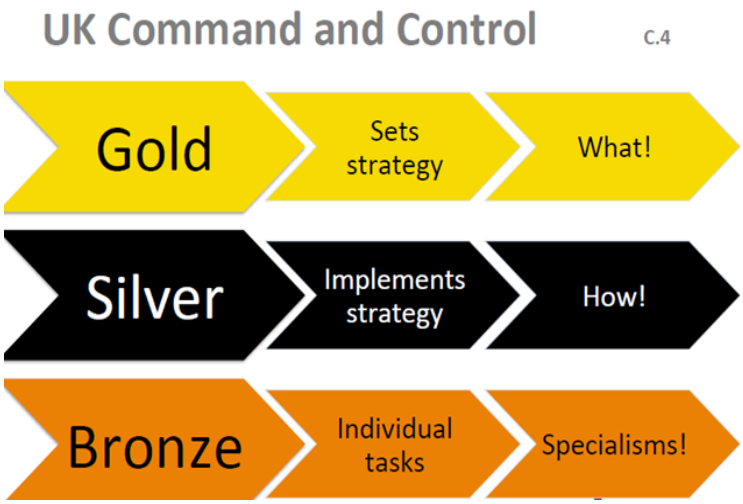

Situation escalates requiring remedial action
Switchboard Informed of 'Escalating Incident'
IN-HOURS: Switchboard calls:
1 – ADoSD or nominated (who may call the EDOc)
OUT-OF-HOURS: Switchboard calls:
1 – Site Manager
2 – OCM
3 – EDOc
Site manager /Matrons, On-call Manager, Nursing Director, EDOc, assess situation and decide who should be contacted as appropriate.
CEO and/or Deputy CEO to be informed
Situation reverts to normal
More resources needed and wider Trust response required
Senior Manager informs switchboard of 'Escalation Alert Stand Down'
Only the CEO or Deputy CEO can formally declare an internal Major Incident.
Hospital Major Incident Declared – switchboard informed to commence alerts

Command and Control

UK Standard Command and Control for Major Incidents

There is a national standard for controlling and managing Major incidents

It is divided into operational (Bronze), tactical (Silver) and strategic (Gold) levels. The nature of the incident will determine whether one or more of these levels will be implemented. The Hospitals' Trust Command and Control structure will mirror the countywide structure.



Multi-Agency Command and Control Organisation – See Appendix 4

Acute Trust – Command and Control

Gold Strategic: Executive Director Level /CEO located adjacent to or collocated in Trust Control room

- Role to set the strategy
- Communicate with wider health
- Communicate with Silver

Silver Tactical (Trust Control room): Nominated Control room lead, Director of Operations/Associated Director of Operations, or nominated in hrs On-call manager out of hrs.

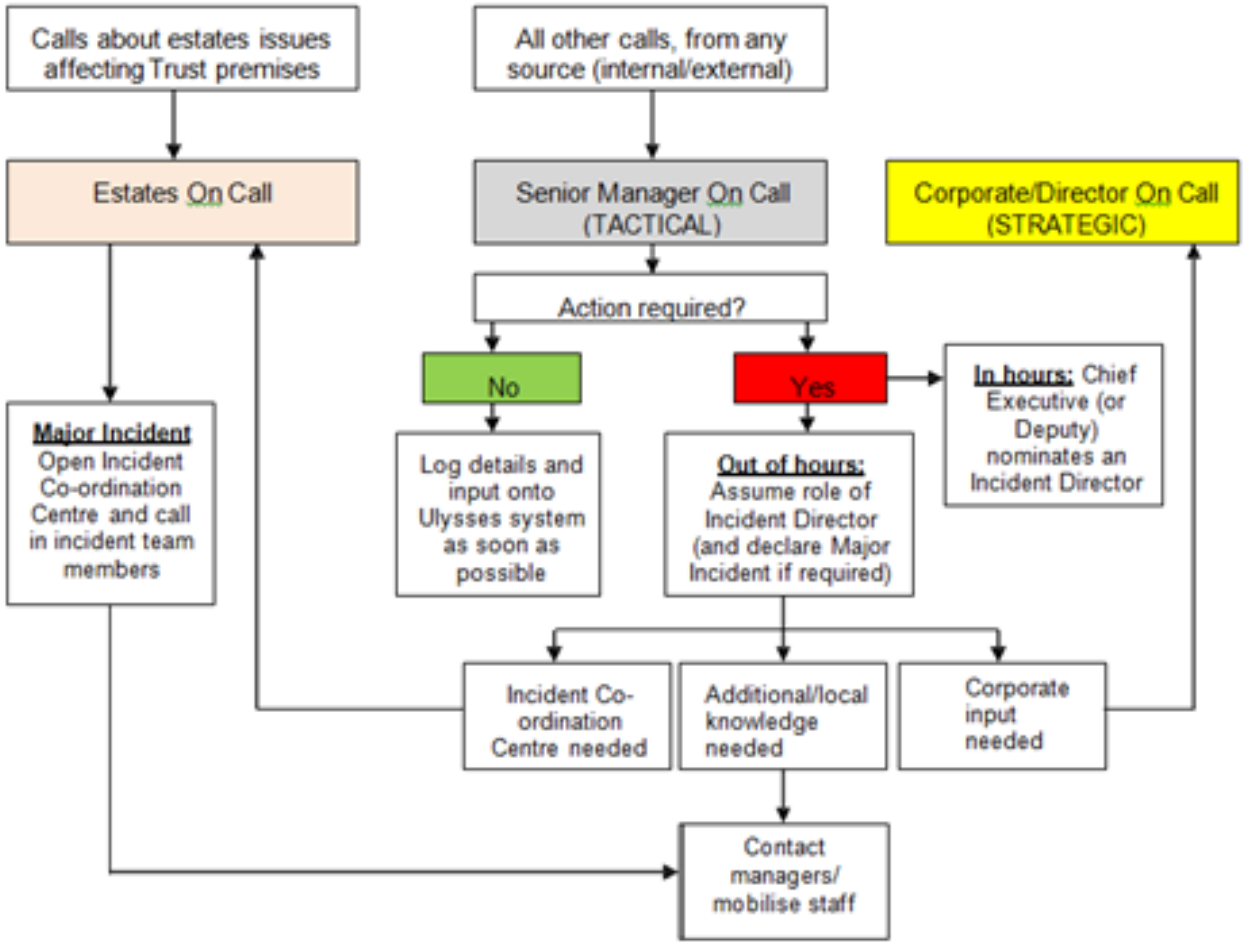
- Role turning strategy into plans/ actions and getting them done.
- Communicate with internal Bronze and Gold

Bronze Operational: ED control room or maybe multiple bronze: these are the staff responding to the incident e.g. ED

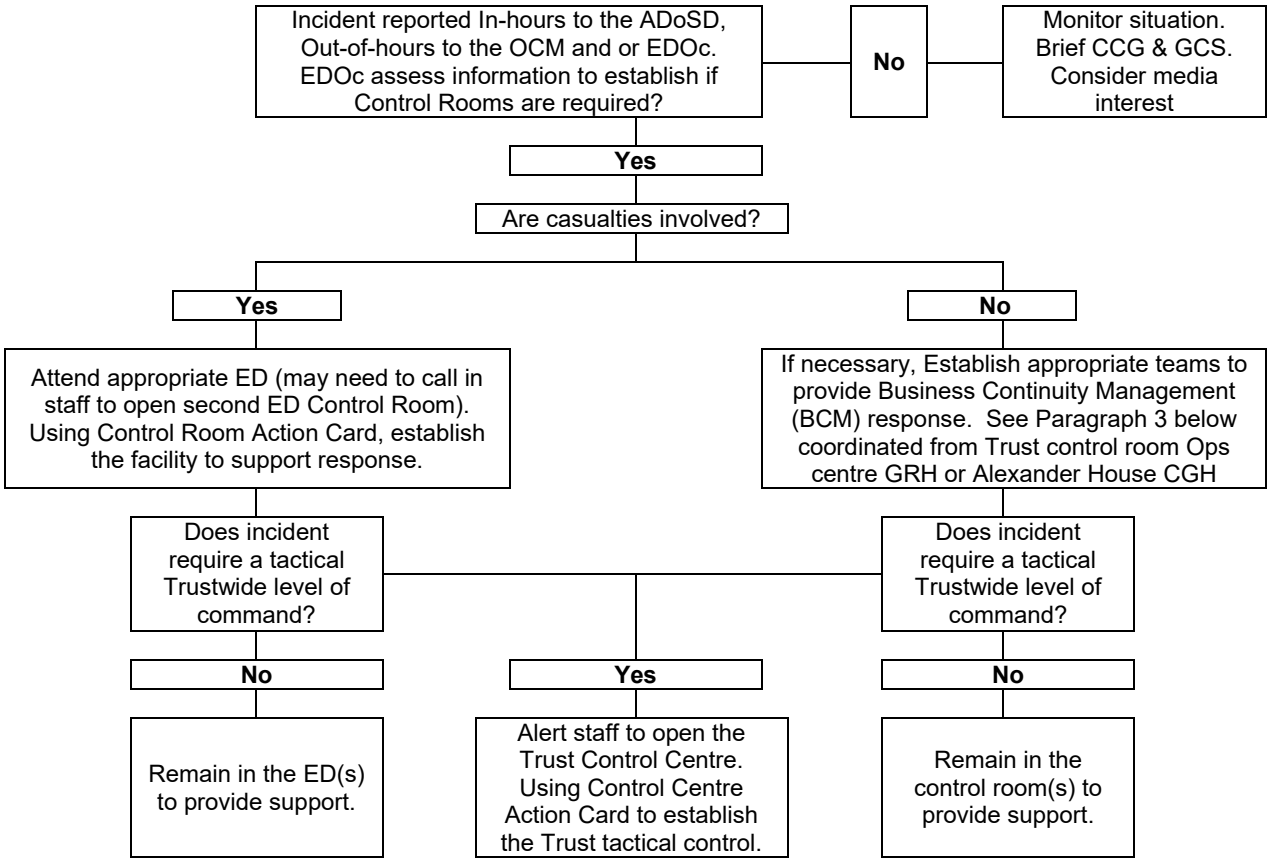
- Role to carry out actions set by Silver
- Liaise/communicate with Silver

Mobilasition of Trust staff

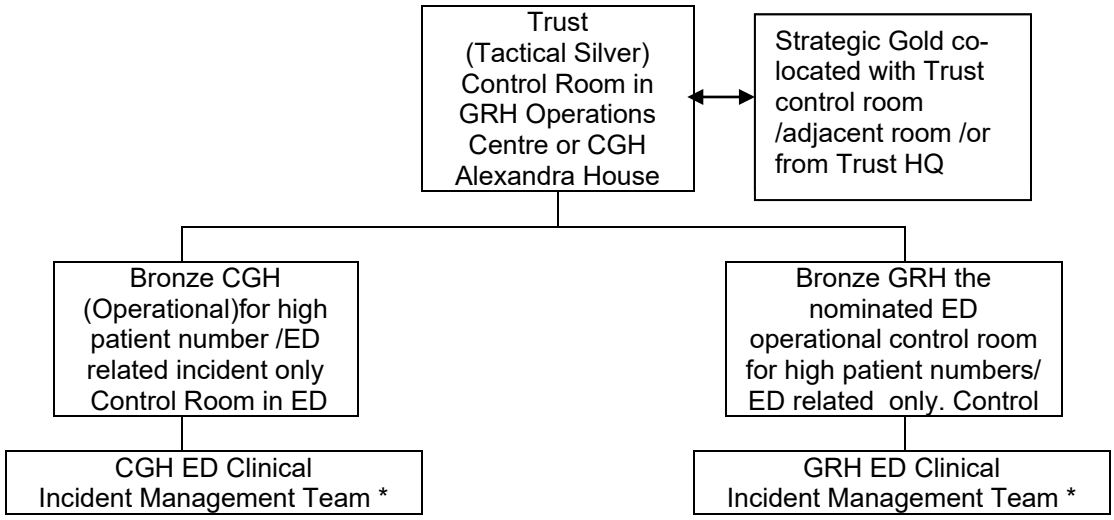
It is important during a Major Incident or Emergency that staff are mobilised in a co-ordinated way to assist in the response. The information and requests for help should be cascaded in the following way (more details are included in the on call packs):



Flow Chart 2 – Executive Director (EDOc) Command and Control Escalation Process



Flow Chart 3 - Internal Command and Control Organisation



Will remain under of the Command and Control of the Trust Incident Control Room until informed differently..

Incidents not involving casualties e.g. BCM incident (inclement weather etc) will be managed from designated Trust Control Room.

The internal command and control structure may be supported by CCG representation at the (Gold Control) at Police Headquarters.

Appendix 5 identifies the NHS lines of communication and links with the multi-agency elements of command and control in response to a major incident.

Section 3 - Major Incident Management

Incident Coordination Centre (ICC)[11]

The ICC supports the Incident Management Team (IMT) to provide an enhanced level of operational support. It is widely recognised that the efficiency and effectiveness of an ICC is greatly improved through the utilisation of a formal structure. Benefits of this include:

- Unity of effort – all team members operate under a common list of objectives
- Accountability – each individual has a specific role for which they are responsible
- Eliminates redundancy – clearly established division of labour eliminates duplication of effort

All organisations need to have in place suitable and sufficient arrangements to effectively manage the response to an incident. Arrangements for the ICC need to be flexible and scalable to cope with a range of incident scales and hours of operation required.

ICC functions = Oversees and leads on Command, Control, Coordination, Cooperation and Communication

While the specific activities undertaken by the ICC will be dictated by the unique demands of the situation, there are five broad tasks typical of ICCs:

- **Coordination** – matching capabilities to demands
- **Policy making** – decisions pertaining to the response
- **Operations** – managing as required to directly meet the demands of the incident
- **Information gathering** – determining the nature and extent of the incident ensuring shared situational awareness
- **Dispersing staff and public information** – informing the community, news media and partner organisations

The ICC will provide a focal point for coordination of the response and the gathering, processing, archiving and dissemination of information across the organisation to health partners externally as required.

Trust Control room (Silver control) activation

Once a Major Incident has been declared, the Trust Control room will be activated. However, the Control room can also be activated in response to an Escalating Incident with the aim to reduce the escalation level and/or prepare for a worsening situation i.e. an Internal Critical Incident.

Early activation of the Trust control room is strongly recommended. Delay in declaring a Major Incident may result in procedures being activated late, with a reduction in ability to properly respond. It is better to prepare and declare early and give time if an Escalating Incident would benefit from activating the Trust Control room.

Triggers for activating the Trust Control room before a MI is declared include but are not limited to:

- Multiple wards closed due to infectious outbreak
- Adverse weather forecast
- Unpresented bed pressures
- Industrial Action
- Loss is significant service, staff, department or infrastructure.

[11] 14.5 NHS England Preparedness Resilience and Response Framework November 2015 revisions

Trust Control room (Silver Control) setup.
There are step by step instructions for control room set up and roles and responsibilities in each control room.

The Trust Control room Coordination team leads will be called via the MI cascade to set up and activate the Control room located at:

GRH control room 2nd Floor Gallery Wing
or
CGH management office top floor Alex House

Consisting of:

Control room lead :
○ In hours - Associate Director of Service Delivery / Director of operations (or nominated)
○ Out of hours - On call operational general manager
Task managers
○ To undertake actions for the control room lead General manager and assistant general managers with the required skills and knowledge
Matron
○ To support site management and coordinate staffing requirements with the bank office
Nursing director or nominated Senior Nurse
○ To support impacted clinical areas ward designated by site management.
Loggists
○ X 2 initially for control room logging and information management.
Medical coordinator/medical director or nominated (could be an allocated general manager)
○ This person may be in ED with a direct link from ED bronze control room to the Trust control room or go between. ○
Communications
○ Essential monitoring of media/social media and for regular staff / patient /media updates
Other key people as identified dependent on incident type e.g. transport, estates rep
Obtain Contact names and phone numbers to support the incident:
○ Divisional leads
○ Estates and facilities
○ IT
○ On call GCS and GCC staff – See health community response plan.
○ Any leads of directly affected departments.
○ Other areas as needed

Bronze Control Rooms - ED

ED has dedicated Bronze Control rooms and local processes for setup. ED Bronze control rooms are only used for incidents where casualties are involved i.e. not for BCM incidents.
The Bronze control room are for liaison hubs between key service leads such as SWAST HALO, Police, CCD and a direct link to Trust Silver Control room.

ED local plan is in Annex 1 of this plan.

Incident Information Management /Records and Log Keeping

1. Trust Control Rooms maintain an incident electronic log as a record of situations, options, actions taken decisions made. This include for conference phone meetings which a Loggist should also attend.
2. Electronic logging templates can be found via the control room log on and on the intranet under Emergency Planning hard copies and bound log books are available as a contingency.
3. Loggists are not on the Major Incident switchboard cascade and therefore need contacting as soon as possible. Lists of trained 'Loggists', are kept with the control room set up instructions:

   Loggist:
   - Maintains emergency log of all events and decisions
   - Informs Hospital Co-ordination Team of outstanding issues
   - Collates and secures all documentation used within the Major Incident Control Centre

The log accuracy is very important as they may be required as evidence in any of the following post incident proceedings, Coroner's inquest;

a. Public inquiry;
b. Criminal proceedings;
c. Internal inquiry or disciplinary procedure;
d. Civil litigation;
e. As guidance for post incident de-briefs.

All records appertaining to an incident must be retained.
Depending on the type of incident, records may be kept for many years or indefinitely. Records may include very rough contemporaneous written notes, a computer generated log, video footage, photographs or any other item that acts as a diary of events, e.g. cassette tape from a hand held tape recorder. The following must be considered:

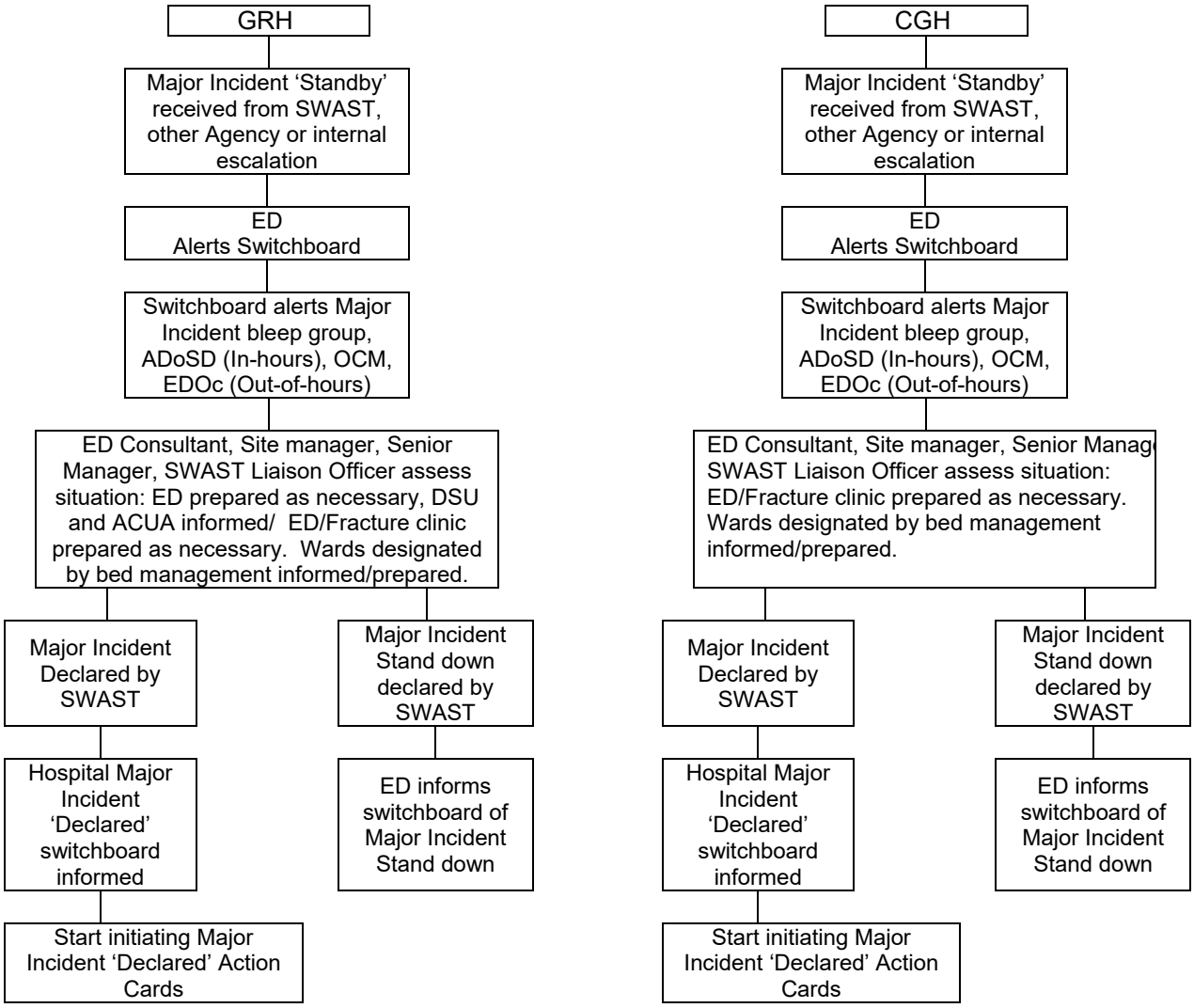
Record keeping during an Incident:

a. Suspend any procedures for destroying both archived files and current documents. Only lift suspension when procedures are in place to ensure incident records are not accidentally destroyed;
b. Keep an accurate log of information received, decisions made (within reason), and actions taken;
c. Ensure that records are maintained of media management issues.

Record keeping after the Incident:

a. Collect and collate all documents relating to the incident for the EPM;
b. Ensure records are secure and access is restricted;
c. Some staff may require professional advice with regard to making written statements;
d. Consider witness training;
e. Consider legal representation.

Flow Chart 4 - Major Incident 'Standby', Alerting and Action

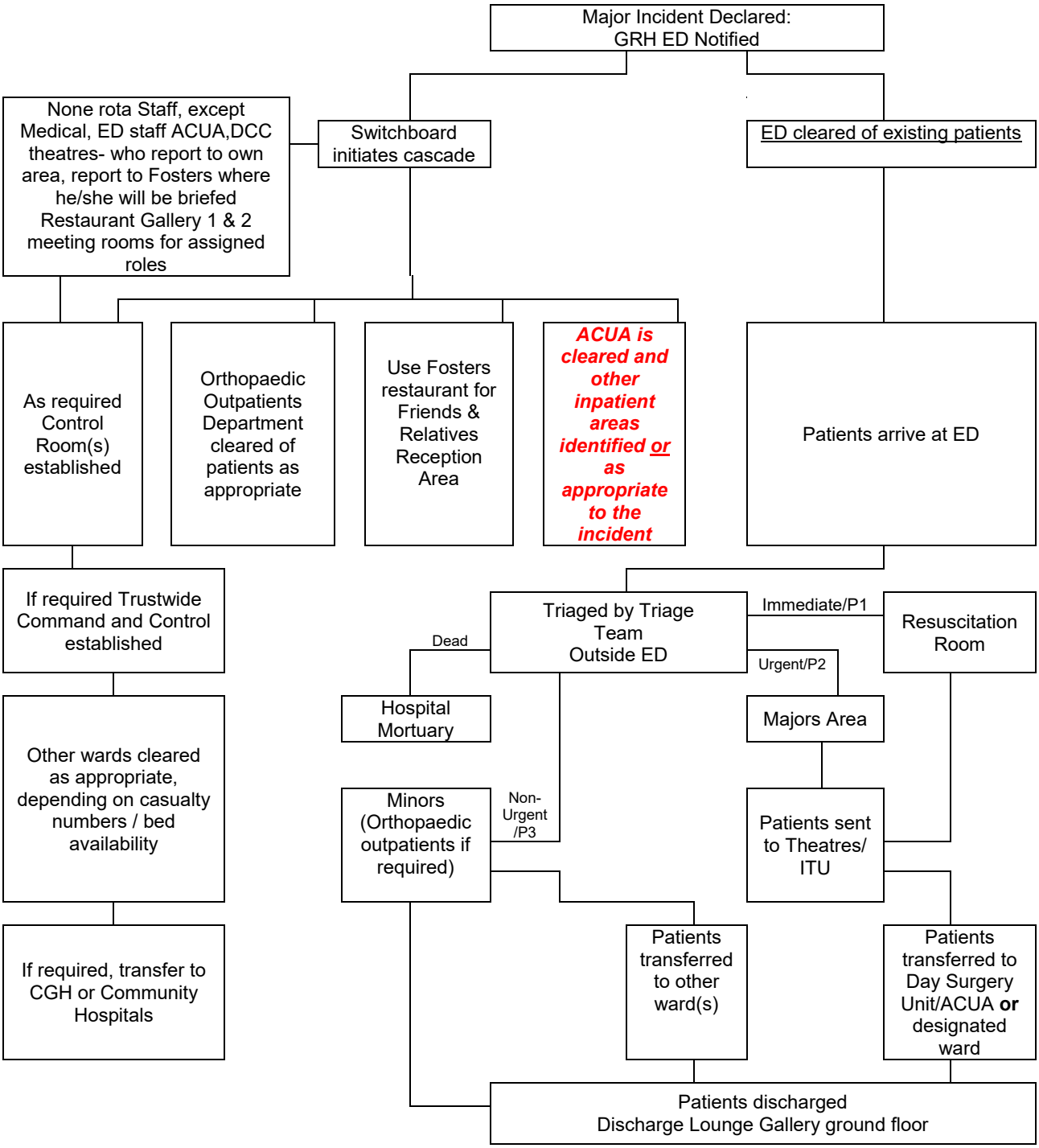


Key actions

a) Brief staff
b) Staff cascades
c) Allocation of action cards,
d) Identify teams /leads where applicable
e) Preparation of departments where applicable.
f) Identify required resources
g) Monitor global emails, phones
h) Decide how and who you are going to communicate with.
i) Make sure both sites are aware

Flow Chart 5 - GRH Major Incident 'Declared', Alerting and Patient Pathways

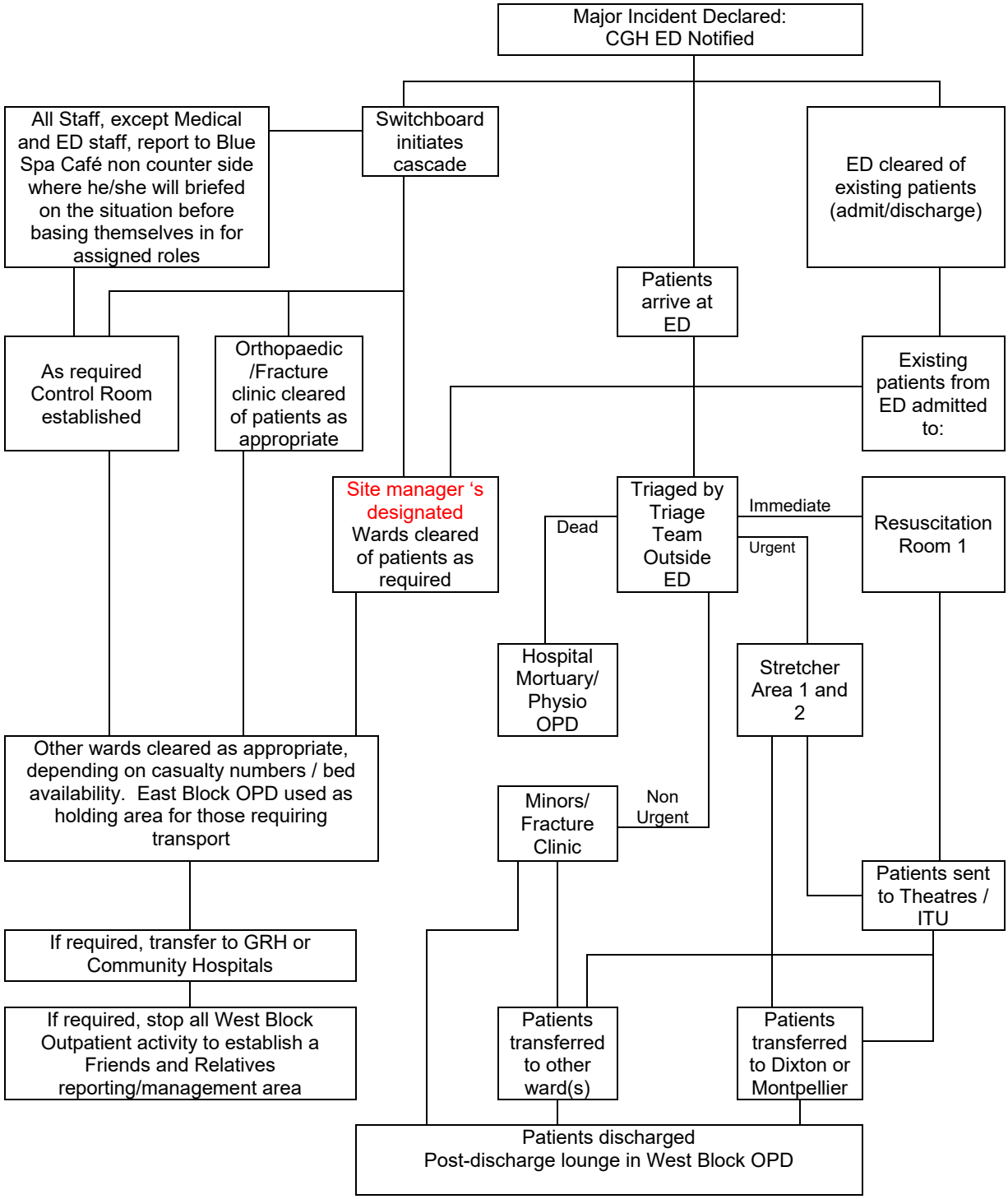
The patient pathway may need to differ depending on the incident, ward closures due to infection etc and will be decided with ADO/ site management



Key actions:

a) Brief staff
b) Staff cascades
c) Allocation of action cards,
d) Assemble teams/leads where applicable
e) Preparation of departments where applicable.
f) Identify required resources
g) Monitor global emails, phones
h) Decide how and who you are going to communicate with.
i) Inform CGH to support GRH

Flow Chart 6 - CGH Major Incident 'Declared', Alerting and Patient Pathways



Key actions:

a) Brief staff
b) Staff cascades
c) Allocation of action cards,
d) Assemble teams/leads where applicable
e) Preparation of departments where applicable.
f) Identify required resources
g) Monitor global emails, phones
h) Decide how and who you are going to communicate with.
i) Inform GRH to support CGH

Action cards

Action cards are in place for all areas that may be involved in a Major Incident. They should be comprehensive and easy to follow and are essential to initiating and managing incidents consistently. They are Working Documents that can be amended and reissued as required, liaising with the EPM. It is the responsibility area holding the action card to maintain them.

It is imperative that each Area and/or individual is familiar with their action card(s) and knows where to find them in the event of a Major incident being declared.

Action Card List – See Appendix 1

Key Major Incident plan responders and summary of roles

A comprehensive list of teams areas that may be involved in incidents. Some of which will be from other organisations

Area, staff group or service	Key function	Action card no / appendix info if applicable
ED	Front door for receiving patients from the incident	Annex 1 ED local plan Action cards G92 G0, G01a,G04, Appendix 12 Mass casualty Plan
Hospital Ambulance Liaison officer (HALO)	Communication: Between incident scene, SWAST control and ED - via mobile phone capability and a terrestrial trunked radio (Tetra)	Appendix 11
Police Casualty documentation teams	Deploy documentation teams to acute hospitals. The teams work with clinical staff to document any known information about casualties received, providing this information to the Police Casualty Bureau	Appendix 6
Police Casualty Bureau	The Police Casualty Bureau serves three main purposes: • To gather as much information as possible about the people involved, or potentially involved • To process the information • To provide accurate information to relatives and friends as well as the police officer in charge of the enquiry. In addition: • The Casualty Bureau is designed to receive details from friends and relatives about people who have not returned from the scene of an incident. • Details of anyone who has either been evacuated or has survived will also be received from the scene of the incident. • Although the Casualty Bureau is	Appendix 6

Area, staff group or service	Key function	Action card no / appendix info if applicable
	receiving information from the scene, it may not be in a position to immediately answer any specific concerns about a particular person. • Details of any casualties will be forwarded to the Casualty Bureau by the hospital so that any next of kin are informed quickly. • Witnesses to the incident may also be requested to contact the Casualty Bureau to pass on any information they may have.	
ACUA	Initial receiving ward	Action card 31
Site Management	• Nominate a direct link with ED to empty ED and ACUA • Identify and designated receiving wards to cohort incident patients as far as possible – keep a track of incident patients	Action card 06 senior site manager Action card 07 junior site manager
Designated receiving wards	• Supported by a nominated matron and site management will manage cohorted incident patents where possible.	
Matron (DLN old role) staffing	To support site management and oversee/monitor staffing requirement with bank nurse office	Action card 17
Integrated IDT discharge team	Key to patient flow - Follow action card	Action card 09
Associate Director of Service Delivery / director of Operations or nominated / General manager	In hours leads the operational response.	Action card 11
On call /available Consultants	Support their teams and ED	
On call Junior Medical Staff	Report to normal work area or s directed by their leads	
Matrons	To support their departments for the operational response required for the incident	
Theatres	Follow local plans – cancel none urgent surgery	
DCC	Follow local plans and actin cards directly link with ED and theatres	Action cards13,14,15
OPD	Activity reduced proportionate to the response requirement, as directed by the control room Main OPD for mass casualties P3 may be used under ED lead.	Action card 22
Porters	Key to patient flow	Action card G16 Portering lead
Estates	Provide staff to support pottering and for access, egress	Action card 09 estates lead
Fosters restaurant	Provide basic refreshments out of normal operational hrs for incident relatives, friends, staff.	Accessible out of hrs via on call estates lead
OPD GRH for mass prophylaxis	GRH designated plan for distribution of mass countermeasures. (not for Flu)	
ED bronze control room	Coordination incident hub between ED ambulance, police and internal GHT (Silver) Trust control room	
Director lead	Act as Trust Gold command to: Role to set the	Action card T1

Area, staff group or service	Key function	Action card no / appendix info if applicable
	Strategy • Communicate with wider health • Communicate with Gold • Communicate with Silver Decide what we will stop doing	
Trust control room lead	Logs incident situation, options and actions Over sees the implantation of actions required to manage the incident by: • Turning strategy into plans/ actions and getting them done. • Communicate with internal Bronze and Gold • Responsible for incident log • Follows action card for control rooms roles and responsibilities. Over all control room management, pulling of staff to the control room. • Allocation of control room roles/action cards and relatives/friends and staff reporting point action cards.	See roles and responsibilities sheet in Control Rooms.
None designated receiving wards	Support areas affected by incident. Follow black escalation and expedite discharges. Reduce the demand on: Porters, switchboard, matrons, estates and facilities. Consider what activity will need to be cancel or changed (e.g. training, meetings, patient activity in liaison with the control room)	Action card 21 ward generic action card
HAZMAT/ CBRN team	Decontamination of patients contaminated with harmful substances prior to admission	Action card10, management actions
Support services Estates and Facilities /	Provide Trust Control room with person details for direct link for any estates and facilities requirements	Action card 30
Path labs	Review requirements depending on type of incident	Action card G18 C23
IT	Provide Trust Control room with person details for direct link for any IT requirements	Action card 05
Education centres lead	Liaise with bank office and control room for staffing requirements and cancel Sandford and Redwood actively as required. Education centre staff support control room for e.g. logging, staff reporting area.	Contact Education centre leads for cancelling REC/SED activity
All other areas	Reduce the demand on: Porters, switchboard, matrons, estates and facilities. Consider how they can support the incident with: services, equipment or staff and inform Trust control room. E.g. runners, admin, nurses, support for porters,	
Volunteers	Cary out usual roles in their normal work areas	Action card 35 Volunteers manger
Pharmacy	Follow action as for black escalation	Action card 32

Area, staff group or service	Key function	Action card no / appendix info if applicable
	Close liaison with key /critical services	on call pharmacy
Chaplaincy	Follow action card - provide multi faith support Provide advice on religious practices.	Action card 03
CCG - HIC	The HIC Co-ordinator takes a strategic overview of the incident and monitors the overall response capability and required resources Directly links with area team	
GCS	Work closely with DAT team Trust Silver control.	
Voluntary agencies See LRF doc	GHT volunteers do what they would normally do – unless special arrangements are made with their manager	
VIP visits	The Police will co-ordinate any VIP visits to the hospitals or control rooms. VIPs will require comprehensive briefings before any visit and meeting the media. A Trust Director will be nominated to plan VIP visits and present a briefing, which will be written by the Communications Department.	Restricted document available in control room and to operational on call staff
Dealing With Vulnerable People And Patients With Special Needs	As for all vulnerable people and patients with special need follow usual polices/ safeguarding.	
Non-English Speaking Communities	The Trust has arrangements for translation services, but in exceptional circumstances the policy may need to be relaxed in order to utilise services of those who can speak the language under the guidance of a member of staff	
Bereavement office	The Senior Bereavement Officer maintains a Bereavement Policy and Procedures protocol which includes major incident involving a large number of casualties and possible deaths. If required, BCM plans have been put in place to provide additional trained staff to support the Bereavement Office Team, which includes issues like out-of-hours procedures and additional property storage space	
Mortuary	GHT has contingency plans in place for extra mortuary capacity the LFR county wide mortuary plan will be activated for mass fatalities. The overall responsibility for all matters concerning the dead lies with HM's Coroner. If required, the Police, acting for HM's Coroner, will make arrangements for the temporary storage of bodies.	Action card 28

Key areas used in a Major Incident
Appendix 7 for GRH
Appendix 8 for CGH

Patient flow

Outlined in flow charts 1, 2 and 3 above

Staff/department incident response

Emergency Department

ED local plan is in Annex 1 of this plan

a) Follow local plans; **Casualties from the incident enter ED via the ambulance doors** triaged at the scene by SWAST using CRUCIROM triage cards, these cards will also be used by ED for any patients who have not already been triaged and for subsequent triage until admitted surgery/warded or discharged the cards become part of the patients documentation. Triage follows the National patient categorisation.

National patient categorisation for Triage

Triage Definitions
Priority 1 patients (life-threatening injuries requiring prioritised access to definitive care)
Priority 2 patients (serious but non-life threatening injuries)
Priority 3 patients (walking wounded)

a) Patients are recorded on Patient first/ PAS /SMARTCARE when available and flagged as Major Incident patient for tracking purposes.
b) Clinical management of major incident patients will follow the Clinical Guidelines for use in Major Incidents 2011 NHS
c) Early consideration must be given for paediatric input i.e. Paediatrics are to be notified, if no paediatric patients there may be children needing safeguarding in the paediatric OPD or from play specialist support in Fosters.

Mass casualties see Appendix 12

Management of Contaminated Patients

Deliberate Release of Chemical, Biological, Radiological or Nuclear Material (CBRN) Accidental release of Hazardous Materials (HAZMAT)

If patients have or suspected to have been exposed to Chemical, Biological, Radiological or Nuclear Material, the following processes need to be followed:

CBRN / HAZMAT are referred to and treated the same

a) CBRN/ HAZMAT plans are available in the Trust control rooms and in each ED
b) ED staff will follow IOR steps 1,2,3+ for self-presenters
c) The CBRN Teams are alerted by **ED who hold the call out lists in the ED CBRN plan and initiate the CBRN team call in. Site management should deploy someone to assist them in the early essential actions**. The ADoSD, OCM, and Switch board must also be informed. Procedures for deploying the CBRN Team are outlined in the Trust CBRN Response Plan
d) Contaminated patients if not decontaminated via IOR steps 1,2,3, will be decontaminated via the decontamination team in the designated areas and then enter via an designated route, GRH via the bin cupboard, CGH via ambulance doors with ambulance patients via Glass house cafe.
e) The Trust has the capability of deploying a CBRN Team outside the ED to decontaminate arriving people. As per other Major Incidents, GRH is the default site. The Trust will however maintain its' ability to deploy at either site. The hospital chosen will depend on the type and incident location.

f) It is imperative the initial ED CBRN/HAZMAT management action card X1 is followed – ED may need support from senior management / Control room.

See **Appendix 10** for Trust wide CBRN/HAZMAT action card.

Patient Flow from ED

This is managed by the Site management team.

They will initially work from information and resources available to empty ED and ACUA until other support is available. The Site Manager will manage incident patient flow for both Medical and Surgical. When able, they will support ED with a nominated person, work in close liaison with DCC, theatres and designate the receiving wards.

Site Management principles are as follows:

a. Patients from the Major Incident will be kept together on a ward as far as possible;

b. Full use will be made of available resources before outside assistance is requested;

c. Elective surgery will be cancelled if required to free up theatres, space and staff;

d. Outpatient appointments will be cancelled if required to free up space/staff to go to GRH Fosters restaurant, CGH Blue Spa Cafe to establish Friends and Relatives reporting/management areas and, if required, other support functions i.e. Mass P3s managed through outpatients;

e. It will be the responsibility of all wards across the county to free up as much space as possible, based on sound clinical assessments;

f. Sound clinical decisions on patient stability and suitability for internal transfer or discharge will be paramount, but in exceptional circumstances a lower threshold for suitability for internal transfer may need to be made where the dictum '*doing the greatest good for the greatest number'* may need to be applied;

g. Patient flow with in the health community will be vis the normal operational arrangements in close liaison with GCS patient flow coordinator and via the ALAMAC calls

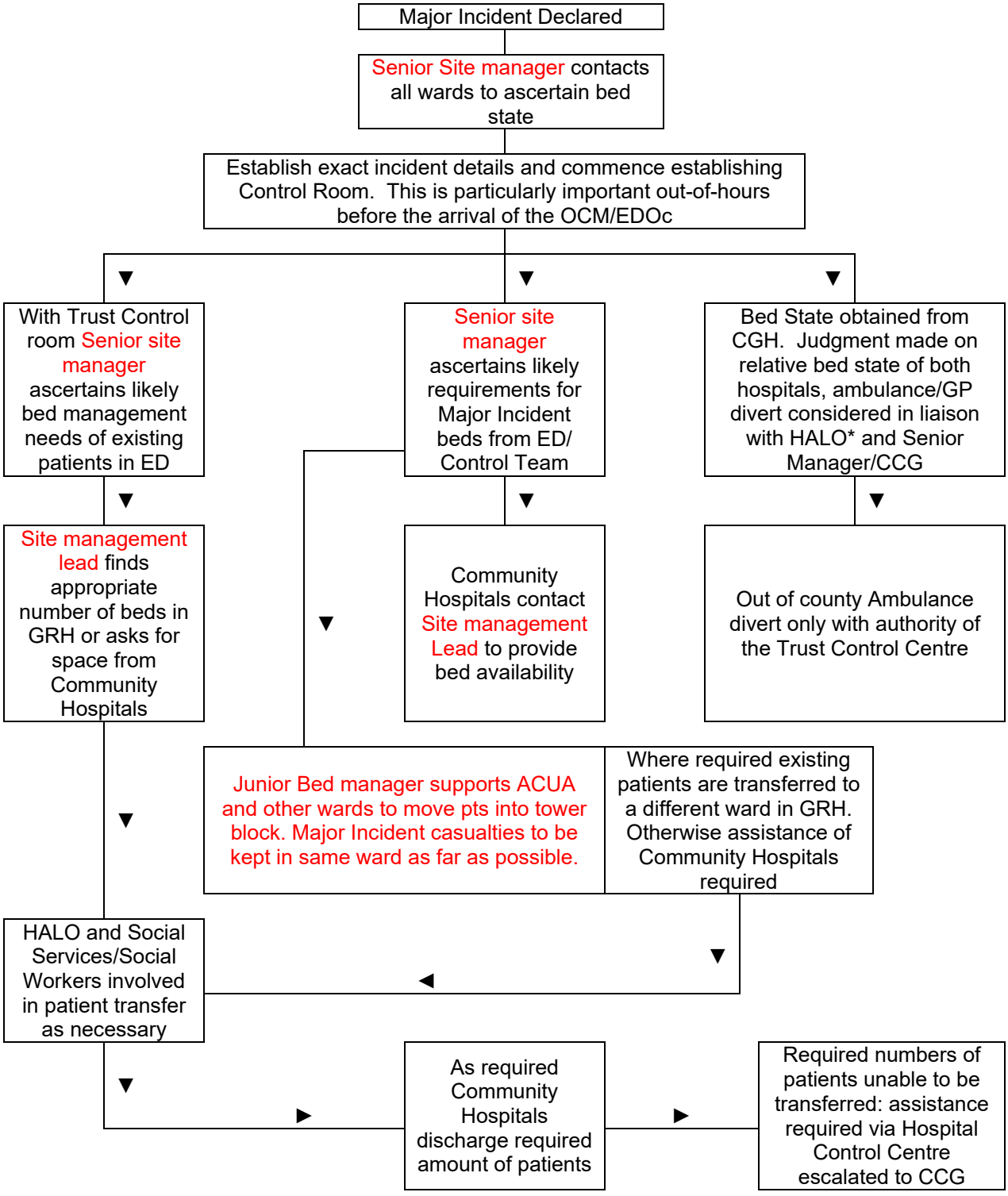
h. When patients are decanted they will be transferred with the necessary specialist equipment, dressings and drugs if these are not available at the receiving hospital;

i. Transport for patients to be decanted to other hospitals will be co-ordinated by the transport team;

j. Any requirement to seek assistance from other hospitals outside of Gloucestershire, under mutual aid arrangements, will be co-ordinated by the Trust Control Rooms to CCG and if established, on wards to Health Gold at Gold Command;

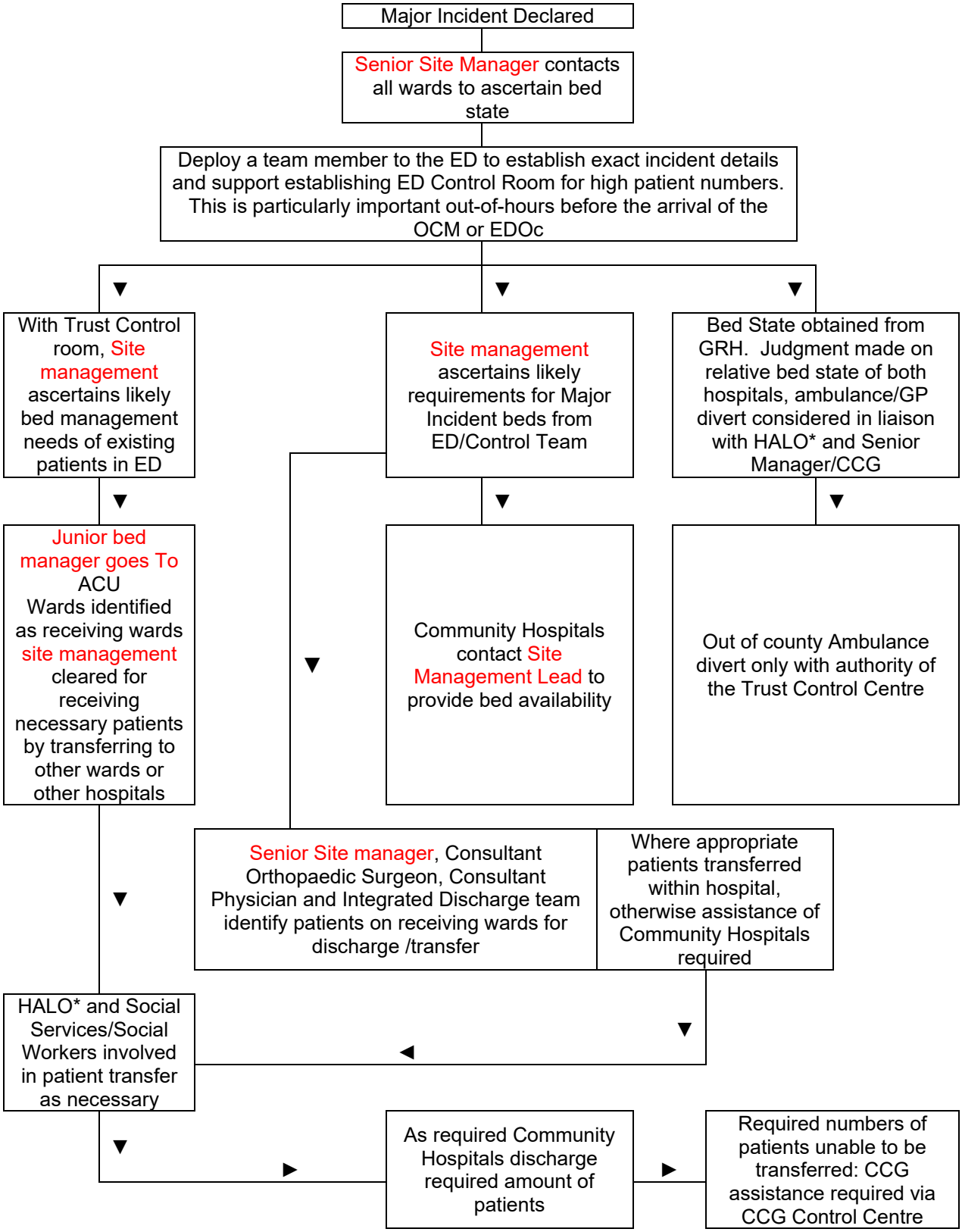
k. At the conclusion of a Major Incident, the Integrated Discharge teams will liaise with those hospitals that have received some of our in-patients, and will advise the Site Management Teams of any problematic placements.

Flow Chart 7 - GRH Site Management



* Hospital Ambulance Liaison Officer (HALO) may be deployed by SWAST to support response. See section 3.

Flow Chart 8 - CGH Site Management



* Hospital Ambulance Liaison Officer (HALO) may be deployed by SWAST to support response. See section 3.

Discharge and transport arrangements

a) ALL inpatients awaiting collection or transport should be discharged/ expedited to the discharge waiting lounge or Fosters restaurant excluding paediatrics. Family and friends are to be encouraged to assist. The transport team must be kept informed.

b) The decision to discharge a patient will remain with the medical staff in charge of the patient's care. This decision will be made in consultation with the multi-disciplinary team on duty, with consideration given to lowering discharge thresholds, as necessary.

c) The nursing staff on the ward will remain responsible for the safe and complete discharge of any patient, whether the patient was involved in the incident or not.

d) The transport team will utilize ant transport available including taxis.

Areas not directly involved have a role to support the incident:

- Wards, identifying patients that can be discharged, expediting discharge.
- Reviewing planned activity/ work/ meetings/ training, Study – cancelling
- Identifying staff esp. clinical staff with back room function and inform Trust control room
- Identifying resources available to the Trust control room.
- Reducing the demand on;
    - Site managers,
    - Porters
    - Support services
    - Switchboard

Friends and Relatives Reporting Areas

GRH Fosters Restaurant

CGH West Block Outpatient Departments

The Trust Control Room (Silver control) is responsible for allocation of the Relatives and friends Action Card to establish Reporting Areas to record details of anyone involved in the incident. Management of these areas may be closely linked with the Police Casualty Documentation Team.

NB. An incident reception centre is likely to be set up near the scene and some relatives and friends may be displaced there.

Other wards in both hospitals may be required to receive or decant patients as required by the incident. The cascade system to disseminate this information will be through either the Site manager and or the Matron for each speciality.

Out-of-hours wards may only initially be contacted on a priority basis according to clinical need to inform them of a Major Incident occurring. The Site Management team will start the cascade and are limited by those available initially to do until further support arrives .

In-hours wards are likely to be aware of a Major Incident more quickly through the Matrons, cascade system and Media.

In consultation with the clinical teams it will be the responsibility of Site Manager, Matrons and Ward Sisters or team leads to call in additional people as required by the nature of the incident.

Management and Support Staff

As required, management and support staff will be called in as part of the switchboard cascade system or individual ward/department/team staff cascade alerting system. Staff should report to predetermined location or as detailed on their Action Cards. Other staff should go to Fosters Restaurant Gallery meeting rooms 1&2 for GRH and the Blue Spa Café none food counter side for CGH where they will be directed to where needed.

Monitoring and provision of staffing requirements

During the early stages of an incident, Directors and Managers at all levels must be aware of staffing levels and seek information regarding the length of time an incident is expected to last. This may be difficult to assess and the worst case scenario should be planned for. This could include staff, who may have been called into work, being stood down, with instructions to return at a later time.

Prolonged Incident

During a prolonged incident, managers will establish a team to manage staffing levels and organise rostering.

Staff welfare must be taken into account e.g.;

a. Breaks
b. Catering
c. Shift length and number of consecutive shifts
d. Stress during and post incident
e. Emotional impact during and post incident

Section 4 - Media Management and Communications

Introduction

1. This section on communications is designed to set out the procedures that should be adopted in response to a major incident occurring either at Gloucestershire Hospitals NHS Foundation Trust or as part of a multi-agency response. In specific it relates to the management of two key areas: internal communications (staff comms, intranet, globals etc) and external communications (media management, social media, website etc). In responding to a major incident it is accepted that each incident will present its own unique circumstances. The communications/messaging issued by the Trust should reflect this. Therefore this section sets out what a good communications process should look like and should be used as guidance by both communications professionals and senior management. It is not a substitute for judgement which will need to be applied to each incident as the scenario unfolds/develops.

2. While this section sets out the procedures and guidance for the hospitals trust's communications function in response to a major incident it is important to consider the implications of any incident on partners. If the incident requires a multi-agency response it is likely that the police will take the lead on public safety messaging (depending on the incident) and the gold, silver and bronze command structure will be established. In this scenario communications professionals and senior managers should consult the Local Resilience Forum Gloucestershire plans:

   - A communications plan for a major incident; and,
   - A warning and informing communications plan.

   As part of a multi-agency response the communications team at GHNHSFT will work closely in a co-ordinated way with its partners across health and social care as well as more broadly across the public sector. Relationships with communications professionals/managers in the appropriate organisations will be established as necessary and a constant dialogue established/maintained throughout the incident. Where possible messaging will be shared and agreed jointly. Contact information of communications departments is available in LRF warning and informing plan and the control rooms.

Principles: external & internal comms

3. The principles on which external & internal comms are based on are set out below:

   - All information issued must be accurate, timely and co-ordinated.
   - Written or verbal briefings must be factual and should not include any speculation. Inaccurate reporting must be quickly countered/challenged and altered.
   - Clear public safety information reduces panic. If appropriate the media should be used to inform and advise the public. External comms channels should adhere to the same principles.
   - Communications specialists must be at the centre of the control room and should be kept up to date and informed on developments.
   - Communications specialists should be consulted over best approach to managing the message.
   - Use the relevant # in all social media.

General principles

4. A major incident is likely to provoke widespread public concern. There is a natural thirst for information. Therefore the communications lead will play an important role in shaping the overall communications response to such an incident. The hospitals trust will work constructively to communicate quickly and accurately details of what has happened, what the implications are and what action people should take. The communications lead will utilise the hospitals trust external communications channels with the aim of:

- Distributing public information and safety advice.
- Providing public reassurance.
- Protecting and preserving the reputation of the Trust.

Early considerations

Quick guide: This will apply to the lead agency initially dealing with the incident. In this case the assumption is that GHNHSFT is leading the incident. In addition the comms specialist should always consider partnership comms and how we should work jointly in responding to an incident.

- As soon as a major incident takes place an initial holding statement should be prepared by the Trust in preparation for distribution to the media, the Trust's website and via the Trust's social media. This holding statement should be shared and agreed with the executive or most senior manager leading the Trust's response at that stage. Judgement should be applied as to the timing and need to distribute this statement. Consideration should be given to the ability of the Trust to manage the situation without unduly alarming the public. This should be balanced against the need/considerations to warn and inform the public.

- The holding statement need only confirm that an incident is taking place, the nature of the incident and where it is happening, brief details of who is responding and any initial safety advice including how the public should access services if affected.

- The communications lead should consider how the Trust would resource/manage the press and media interest. Considerations should include:

  - How long is the incident likely to last?
  - Is additional help needed either from in-house (via the Trust's communications team) or externally (via NHS England and other partners)?
  - If the incident is GHNHSFT lead you should consider whether you need a comms specialist on the GHT scene – at least initially to manage the situation? If the incident is multi-agency this decision will be made through Gold Command.
  - Do you need to set up facilities (toilet, access to refreshments etc) for the press and media?
  - Where can you contain the press and media to give them pictures while keeping the location safe and free from interference?
  - Who will monitor digital channels such as social media and blogs and respond if appropriate?

External communications: media management

5. Initially the press and media focus will be the same as that of the Trust's i.e. the scene of the incident. The comms lead managing the situation will take the lead on the comms approach and management of the media. The comms lead will have responsibility for:

- If the incident is GHNHSFT led and if appropriate you should consider establishing a media briefing point at the scene. The briefing point should be safe in terms of reporters not being exposed to dangers and considerate in terms of its impact on the Trust's staff and patients.
- Identifying a suitable vantage point for cameras/journalists to view the scene.
- If the incident is GHNHSFT led and if appropriate you should consider escorted visits to the incident site (having checked the reporter's accreditation and provided the appropriate health and safety equipment, for example, hi-vis jackets).
- Where there is no specific scene it may be possible to establish a focal point for media attention.
- Issuing a holding statement.

  As the incident develops the comms lead will need to consider the nature of the incident, its severity and possible longevity. Judgement will have to be applied as to the seriousness of these factors. The comms lead will be responsible for:

- The overall approach in terms of the comms response to the incident.
- How best to manage the situation based on the emerging circumstances.
- If appropriate agreeing who should front the press & media.
- Preparing spokespeople (key messaging/killer questions) to address the press and media.
- Considering whether or not a press conference should be called.
- Forward thinking and implementation of the exit strategy when the situation is presented.

Media guidance is available for senior managers preparing for a broadcast interview in **appendix 13**

External communications: Social media & website

6. Throughout the incident the comms lead should utilise the range of corporate digital comms channels available: mainly Twitter, Facebook and the website. Messaging should be consistent across all channels. Social media will be one of the main sources of information for the public in an emergency. It should be used to warn and inform the public as well as staff. It is important to ensure that the information shared is accurate and timely.

Internal communications

7. Throughout the incident the comms lead should utilise the range of corporate internal comms channels available: mainly the intranet, global emails, targeted emails, PAS and notice boards. Staff messaging may take on a particular theme depending on the situation, for example, if there are specific operational points that need to be communicated. If appropriate the comms lead may also shape/cascade operational comms. A word of caution: often internal comms are shared by members of staff to the press and media. Therefore the comms lead should treat internal comms with the same caution as external comms.

Telephone enquiries

8. The Switchboard and staff must be aware of the procedures to follow when dealing with media enquiries e.g. do not respond to enquiries but direct the caller to the Communications Team. Initially this will be the ADoSD/OCM or the EDOc. Communications is initiated by the senior incident lead/ on call manager with liaison with Communications via Switchboard.

   Contact can be made via telephone or email: Telephone: 0300 422 3563, 0300 422 3120 or Communications Mobile. For Trust Control room use: Sarah Townsend's (number): 0300 422 4735. Email: comms@glos.nhs.uk

   Regular situation reports/up-dates will be submitted to the Major Incident Control Centre by:

- Emergency Dept. Bronze Control Room.
- SAUs Theatres.
- Critical Care.
- Paediatrics– if involved in incident.

Plans and procedures

9. The following procedures will be included in the Gloucestershire Health Major Incident Media Plan for dealing with the media:

    - Press procedures will be linked into local multi-agency press briefing plans.
    - Agreements are in place for CCG to call for support from other agencies.
    - Agreement exists with other NHS agencies for co-ordinating regular provision of accurate information.
    - Where possible, the same main spokesperson should be retained throughout the incident. This procedure builds trust and credibility.

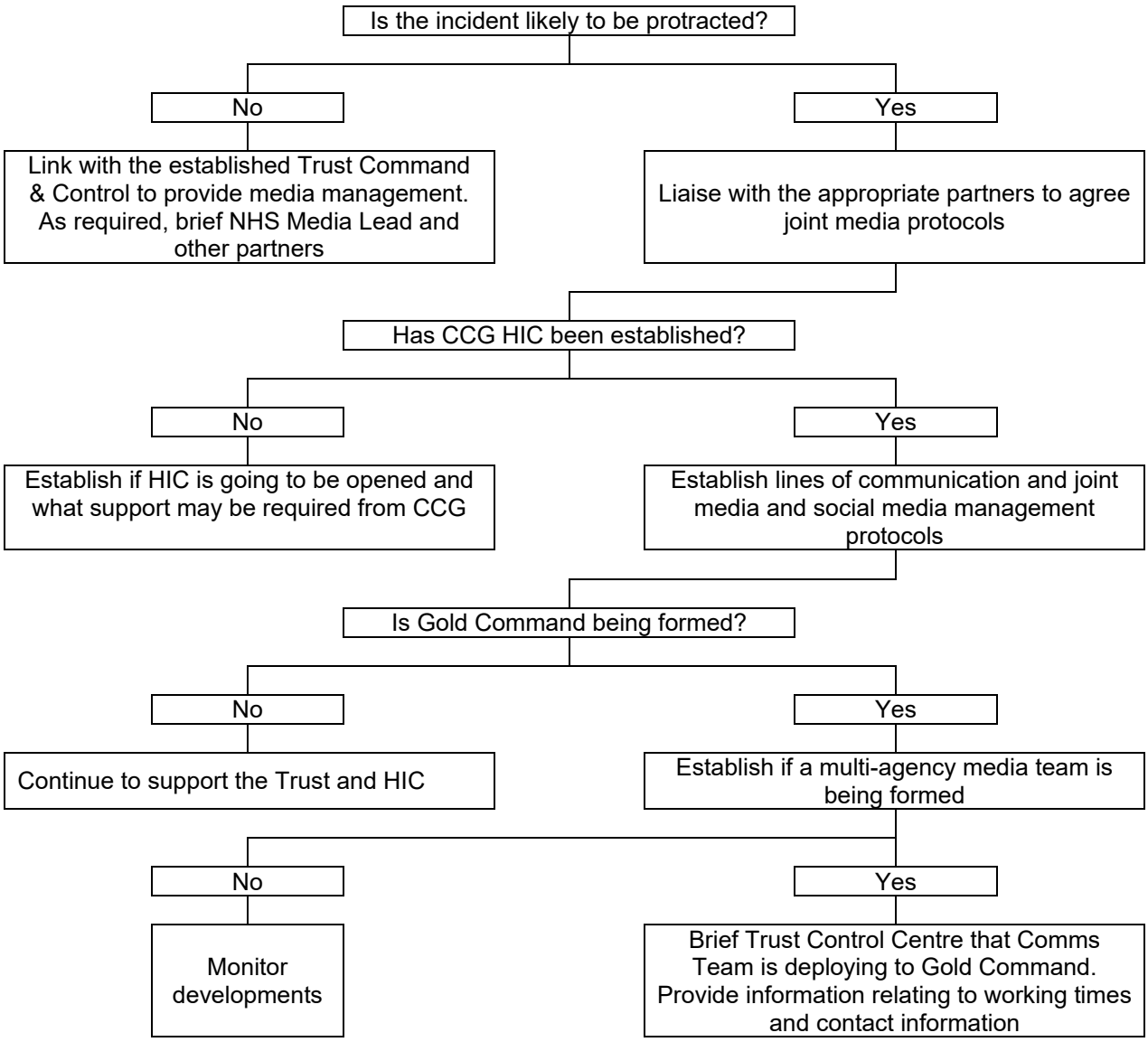
Out of hours

10. Communications support is available OOHs. Contact details are available via the switchboard.

Communications colleagues

11. A comprehensive list of contacts (communications colleagues) is available in the Health Community Response Plan.
12. This plan should be used in conjunction with the LRF communications plan.

Media Management Considerations



Section 5 – Dealing With Vulnerable People And Patients With Special Needs

Introduction

1. The purpose of this section is to highlight the special needs and considerations required when dealing with vulnerable people. This section deals with the following vulnerable people:

   a. Children;
   b. Elderly and infirm;
   c. Mentally ill and people with learning difficulties;
   d. Non English speaking communities and religious groups;
   e. Those with special needs, e.g. people with physical disabilities (mobility problems).

2. Vulnerable populations often have greater need during a major incident. They need to have additional planning to ensure their vulnerabilities are recognised and supported.

3. The Trust has polices, guidance and training for vulnerable people in place as part of normal operational practice which will continue to be adhered to for the protection and management of vulnerable people taking into consideration the greater vulnerability during incidents.

Children

4. Children have special needs in any major incident. They are different from adults in terms of their size, physiology and psychological needs, all of which have an impact on their care and staff should take their needs into account. The following paragraphs provide guidance for dealing with children.

SWAST Paediatric Management Considerations

5. SWAST has emergency plans in place for designating specific Trusts able to receive paediatric casualties. These plans include hospitals capable of taking (possibly large numbers of) children, and those units with special equipment/specialist staff. Their plans also include out of county hospitals. There are three types of situation to be considered:

   a. Those involving children only;
   b. Those resulting in adult and child casualties;
   c. Those only involving adult casualties but, also, children requiring care.

6. The following key issues will need to be considered:

   a. GRH is designated to receive children
   b. The paediatric unit, emergency dept and department of critical care stock paediatric equipment and consumables – depending on the nature of the incident equipment such as specialist monitoring or therapy may have to be loaned urgently from suppliers or decisions made re prioritisation of specific equipment by consultant anaesthetists or paediatricians as required. Additional orders will be made to restock consumables used during incident urgently.
   c. Paediatric trained medical and nursing staff will be required to oversee any areas where children are being cared for outside of ED and DCC. If insufficient paediatric trained staff cannot be identified – the usual ratio of paediatric/ non paediatric staff may need to be changed with priority for paediatric skills being given to high risk areas such as Paediatric HDU.
   d. During a major incident where high numbers of paediatric admissions are likely other hospitals in the area who accept paediatric admissions – such as Worcester, Hereford, Swindon and Bristol should be contacted to see if they can accept admission either from the incident, or other emergency paediatric admissions being referred via GP. Diverting children to hospitals such as CGH with no paediatric presence/limited facilities should only

be considered if there is an ability to move specialist staff from GRH to CGH to support their care.

e. Supplying the Police with information to enable them to respond to enquiries.

7. Some incidents may require children to be taken to a hospital for immediate treatment and transfer. This type of arrangement will require additional transport and may necessitate an ambulance to remain at the initial receiving hospital to implement patient transfer.

8. Following a major incident, children will need comfort from familiar adults and, wherever possible, the family should be kept together. However, the medical needs of both adults and children are the overwhelming consideration when planning where to take casualties. The following table provides guidance when considering transporting adults and children from the same family at the scene of an incident:

Table 4 – Child Transport Considerations

If adults and children are seriously injured.	They may need to be taken to separate facilities, but a balance needs to be struck between the benefits to children of being kept close to their parents and their distress at seeing severely injured parents/other adults.
If the adults are seriously injured, but the children have only minor injuries or are uninjured.	The family should be taken to the hospital for treatment of the adults where arrangements for the (non-medical) care or the children should be made - this could include the use of the Hospital Play Specialist Team if available.
If the children are seriously injured and the adults are uninjured or have only minor injuries.	The family should be taken to the children's hospital, or a hospital with a sufficiently large paediatric department, where arrangements for the minor treatment of adults can be made.

Paediatric Services Response

9. On activation of the major incident plan, the Ward Co-ordinator on a Paediatric Ward will implement the 'Action Card' retained in the Major Incident Folder and use the cascade alerting list to call staff in. The on-call Paediatricians will report to work and the following will be considered:
   a. When it becomes apparent that children are involved, the on-call Paediatric Team (Consultant, Registrar and Senior Nurse on duty) will attend ED at GRH.
   b. In liaison with the Paediatric Clinical Team, A&E consultant, and the Trust Control Team, the on-call Paediatric Team will establish the numbers of extra staff required to deal with the incident and call them in using the agreed cascade.
   c. The patient flow will be the same as that for any incident; consideration must be given as to whether additional regional hospitals need to be contacted re their ability to accept paediatric patients
   d. Depending on safe staffing levels additional beds can be opened within the paediatric dept as identified in the Paediatric Escalation Policy- this will potentially increase the bed base to 52 if day unit beds are utilised. This is dependent upon elective activity being cancelled including out patients to enable PAU to move into COPD.
   e. Consultants will ensure paediatric input to patient care wherever children are involved;
   f. Where possible family units will be kept together.

Discharge Protocols

10. The Trust's discharge planning policy will be implemented but it is very important that the information given to the GPs/Health Visitors includes the nature of the major incident and whether parents/guardians are also injured. In the event of there being no parents or other responsible adult available to receive the child on discharge, then social care will be informed to arrange suitable care. Full details of the discharge plan and the name and address of the responsible receiving adult must be recorded in the medical/nursing notices.

Elderly and Infirm

11. The type of support will be dependent upon the individual needs and location, type and size of incident. Social Care being heavily involved as per our normal interoperability liaison. Existing arrangements will need reviewing as part of the operational response.

Mentally Ill and People with Learning Difficulties

12. Mentally ill and those with learning disabilities may require specialist support during a major incident. Most can usually be treated by the Trust with, when required, support may be able to be provided by the ^{2}gether Trust.

Non-English Speaking Communities and Religious Groups

13. Most key responding organisations and faith groups have arrangements in place to call upon interpreters to support response to an incident. Where it is practicably possible the policy for use of interpreters should be followed. However the urgency and speed at which an interpreters may be required/necessitate in incidents staff or other persons able to translate may need to be utilised with the guidance and supervision of senior clinical staff.

People with Mobility Difficulties

14. Both Social Care and the NHSE may need to be called to assist a number of people with special needs who have been involved in a major incident or evacuated from a home. The Police or GWAST may contact the Local Authority/Social Care for support.

Section 6 - Restoration to Normality

Introduction

A successful and expedient recovery should restore normal service delivery at the earliest opportunity. A professional restoration to normality will also mitigate a possible loss of public confidence in the Trust.

Aim

During an incident, the aim will be to maintain critical and essential services and as far as possible, as much normal clinical service delivery. The Command and Control teams will judge the degree to which this is possible based incident type and scale.

Initiating Recovery

Recovery planning should begin as soon as possible, preferable in parallel to the incident management and should be overseen by a nominated person leading a team with divisional representation or as a minimum with leads from key areas affected.
Depending on the nature and duration of the incident there may need to be agreement with the local Clinical Commissioning Group for relaxing targets.

Planning Recovery

The following principals should be considered by the Trust and Hospitals Control Rooms and incident recovery planning team:

a. Consider the effects each decision taken during the incident management phase may have upon recovery time;

b. If required, add the issues or services suspended to the attached Incident Restoration to Normality Plan. A copy of the document should be available on each Control Room PC;

c. Allocate a 'Lead' person to manage restoring the issue to normality;

d. Identify a recovery date, which may be a number of days after the incident has been terminated e.g. '4 days after incident terminated';

e. If necessary, use existing Business Continuity Management contingency plans to restore services e.g. loss of utilities;

f. Co-ordinate actions with the other Control Rooms to ensure duplication of actions are avoided.

Managing Recovery

The following will need to be considered to ensure a successful recovery management process:

a. Initiate recovery procedures as soon as possible;

b. If the incident is protracted e.g. lasting days or even weeks, consider establishing a Recovery Team, comprising of speciality staff, to restore normal service delivery;

c. If necessary, co-ordinate recovery plans are likely to involve CCG and GCS.

Section 7 - Incident Debriefing Process

Introduction

1. Information gathered from post incident debriefings forms part of the emergency planning cycle outlined in Section 1. Information gathered from debriefing sessions can be used to identify areas for improvement, plans to be amended or updated and training requirements. No matter how small or large an incident may have been there will always be areas for improvement and lessons to be learnt.
2. Debrief forms are available on the Intranet under emergency planning or from the Emergency Planning Manager

Immediate Post Incident Debriefing

Structured debrief definition

A disciplined but flexible technique for learning through reflection by sharing experiences, gathering information and developing ideas for the future.

- To get each participant to reflect on the operational responses,
- To identify personal experiences and learning
- These views to be shared and discussed to establish how that learning can be applied positively in the future.
- These views to be shared and discussed to establish how that learning can be applied positively in the future on:
    - What went well
    - What did not go so well
    - What would I recommend for the future
    - The most significant thing I have learned ……
      For the Trust, this could be used for the future…..
      What 3 suggestions would you give someone in your role in a similar situation in the future….

Informal 'hot' debriefs, immediately following a major incident, are also an essential part of the debriefing process. For disseminating useful information quickly, while fresh in the minds of the participants and to be able to quickly respond to urgent required actions.

Copies of all 'hot' debriefs are to be sent to the EPM, or nominated deputy, for collation.

Incident Debriefing Process

There are two types of debriefing process:

a. A structured facilitated debrief meeting, usually inviting key participants.
And or

b. An electronic version

In both cases, points are recorded and an action plan produced.

Debriefs should be undertaken as soon possible after an incident to capture points whilst still fresh in the mind and enabling important issues to be improved as quickly as possible. It should be remembered that notes taken during debriefing processes can be subject to legal rules on disclosure and may form the basis of evidence before an inquiry.

Debriefing Co-ordination and Documentation Custodian

The EPM, or nominated deputy, will co-ordinate the debriefing process, produce a post incident report, amend plans as required and identify additional training needs. If required, the EPM will also become the custodian of original documents appertaining to the incident, which will not be destroyed until after agreement with senior management.

Incident Debriefing form appendix 9

HR Staff Support Critical Incidents and Events Policy

All managers and senior staff tasked with chairing or arranging any debriefing process must be aware of the requirements detailed in the HR Staff Support Critical Incidents and Events Policy, which sets out a framework for supporting staff, including volunteers and students on placement, during and after critical incidents or events.

Section 8 - Training and exercises

Under the Civil contingency Act, as category one responders and for compliance with the Emergency Preparedness Resilience and Response we have a duty to train and exercise.

See **Appendix 2** **and** **Appendix 3** for training and matrix.

The training schedule is subject to change and availability.

Please contact the EPRR Team for details dates and availability. ghn-tr.eprr@nhs.net

Annex 1 - Major Incident Emergency Department - Local Plan

GRH is designated as the default site for receiving casualties as long as this is practicable i.e. Mass Casualty P3 cases/walking wounded may still attend CGH.

Incident response follows CSCATTT appendix ED 1

On receipt of a Major incident Standby/Declared Alert from SWAST

- On answering the RED ED phones always say ED emergency phone, NB the automated Everbridge system will assume no answer phone if it does not hear a voice.
- The Everbridge SWAST alert information will also simultaneously be sent to any mobile phones that you have submitted the numbers to EPRR.gloucestershire@swast.nhs.uk
- Gain as much information as possible about the incident, casualty type and numbers expected. (METHANE)
- Inform switchboard to on 2222 to activate Major Incident cascade.
- Inform /brief Silver
- Brief Doctors, nursing and reception staff on Duty GRH and CGH.
- Access SWAST briefing via **https://www.swast.nhs.uk/p/major-incident**
- GHT password glos
- CGH password chelt
- Receipt of the **METHANE** briefing by pressing 1- SWAST then can see we have received the message.
- Information Updated every 15 mins

  - **M**ajor incident declared
  - **E**xact location
  - **T**ype of incident
  - **H**azards present
  - **A**ccess & egress
  - **N**umber of casualties
  - **E**mergency services on scene and required
  -

  Acute capacity notification to SWAST **Acute Emergency Department Capacity** page to submit your Emergency Department capacity.
  Pass word GRH is glos / Pass word CGH is chelt

More information on triage and patient prioritisation used by SWASFT can be found at: http://naru.org.uk/naru-input-to-new-triage-sieve/

To support information sharing across the Trust and our stakeholders, this Major Incident webpage has been made available to provide all of the briefings issued, and also act as a portal for hospitals to provide SWASFT with their current capacity.

Shared Situational Awareness

In the initial stages, pass information between emergency responders and Control Rooms using the METHANE mnemonic:

SWASFT will triage and categorise patients into four main categories:

DEAD

P1 – Life threatening (Resus)

P2 – Urgent, non life threatening (Majors)

P3 – Delayed (Minors)

- **GRH** Obtain the Major incident Plan Action Cards from Major Incident box in seminar room/office by the ambulance doors . Lead action cards G01, G01a, G02.
- **CGH** obtain plan and action cards from Consultant office and Sisters office.
- **Allocate ED staff Designated Roles** according to their skills and Experience

CBRN/HAZMAT (contamination incidents) See CBRN plan and PHE CBRN guidance PHE CBRN guidance

- If any indication CBRN is involved Alert CBRN Team via call out list in ED CBRN Plan. Identify 2 staff to do this.(out of hours resources may be need to be requested via site Management)
- Be prepared for self- presenters and be ready for Follow the NARU **IOR** principles = disrobing and dry decontamination *for training video* contact EPRR Team ghn-tr.eprr@nhs.net
- Obtain CBRN plan and action cards.
- If know contaminate follow guidance for management Toxbase/ CBRN matrix
- Use appropriate PPE (can utilize VHF/Ebola PPE)
- Decide on isolation areas.
- Make sure CBRN action card **X 1** –ED lead key actions are carried out.

Only incidents with a patient flow

- Start a log of events as they happen.
- Liaise with Site Manager to plan/start clearing patients already in ED identifying a clearing Nurse. (Action card G0) to elsewhere in the hospital or home.
- Assess Medical and Nurse Staffing numbers
    - Allocate member of staff to ring staff at home to put them on standby. + or – available (sheets available in Major Incident Box)
- Liaise with Orthopaedic Outpatients , ACUA and Day case
- Prepare Dept. to take casualties, Trolleys, Triage Cards, Linen, and PPE.
- Set up ED Bronze control room GRH inform admin office and make sure it's resourced.
- Assess Medical and Nurse Staffing numbers
    - Allocate member of staff to ring staff at home to put them on standby. + or – available
- Announcement to ED waiting room using the planned statement in Major Incident Folder.
    - Triage those that need to be seen and advise others on other Health Care services they can use.
- Liaise with Orthopaedic Outpatients and ACUA
- Delegate staff Member to call in additional Staff as required.
    - All staff need to Bring their ID, consider that parking may be challenging and report to ED. (Other Staff should report to Fosters Restaurant)

ED Preparation, consider:

- Prepare resus **P1**,
- Majors **P2**
- Minors / fracture clinic **P3**
- Consider need to “upgrade” appropriate majors spaces to resus capability
- Paediatric considerations
- Organise teams – (work well = ED doctor, surgeon, anaesthetist, nurse, scribe)
- Have tabards available to identify leads.
- Get out triage cards and triage logging sheets. (In Major Incident Box)
- **Patient tracking:** Make sure reception know how to mark incident patients on PAS + make sure MI folders are available as a contingency.
- Liaise with Fracture clinic for use of their resources.
- Be prepared for On-call teams to report to ED and will need briefing /direction
- Agree communications to be used: designated phone lines, use of radios between bronze control room and Trust control room.
- Radio channel used is estates for direct link between key departments; Extra radios can be obtained through the Trust control room from estates.

Use this time wisely to prepare!

ED Bronze Command and Control

Role of ED Bronze management team is to locally coordinate and manage the ED response in liaison with SWAST HALO, Police Documentation Teams, and directly communicate allocated site manager and with Trust Control room (Silver) to:

- Maintain an incident log and collation of incident information which must all be kept.
- EDs have electronic logs and hard copies as back up and via intranet Emergency Planning: http://intranet.glos.nhs.uk/en/Your-Division/Corporate-Services/Emergency-Planning/
- Keep Trust (SILVER) control room informed
- Request additional resources via Trust control room
- Monitor global emails
- Make sure there is close liaison with Estates and Facilities for:
    - Required supplies
    - Waste removal, support porters/ marshalling / directing patient flow etc
- Inform Trust control room of media interest.
- Make sure staff are regularly briefed.
- Make sure staff rotas are in place for medical and nursing for the anticipated incident duration.
- Make sure the staff welfare is looked after: during and post esp. for support and post-traumatic stress.
- Liaise with designated site management and make sure incident patient tracing is kept up to date.
- Keep a list of all staff involved in the incident.
- Start a recovery plan.
- Ensure patients discharge later is available "Major Incident Letter. Accessible from ED control room log on, Trust control room log on under comms, hard copy in ED Magor incident box. Contains info on patients' involvement in incident. (Agreed with comms and booking office).

Areas used:

- **GRH** Admin office esp. for calling in staff.
- **GRH** ED bronze Seminar room (office by ambulance doors)
    - The ED seminar room is also the liaison point for HALO and police documentation – who will be allocated room in fracture clinic.
- **CGH** consultants office
- Fracture clinic becomes a resource for ED. Fracture clinic staff become under the direction and leadership from a nominated ED Senior lead
- **For mass casualties ED extends to fracture clinic and OPD as required.**
    - OPD becomes the main P3 route and is managed under a designated ED senior nurse lead utilizing the OPD staff and calling on Trust control room for required staff resources. There is a mass casualty plan for this to be used in conjunction with the major incident plan.
    -

Mass casualties see ED appendix 2

Communications

- Senior Doctor, nurse in charge and designated site manager to communicate regularly as required.
- All communications to go through this team and up to Trust control room.
- Aim for return to Normal working at the earliest possible time.
- Ensure Major Incident Stand Down message communicated

Triage on arrival at ED – use mobile PCs (COWS) identified for MI use

- Done at ambulance bay doors and recorded on smart cards and triage log:
- Create a triage team to include an ED doctor (middle grade or Consultant) and an ED nurse (senior) (Action Card G21 + appendix 3)
- All patients, whether from the major incident, arriving by ambulance, self-presenters or walking wounded will be Triaged using Triage Sieve (appendix) Method at Ambulance bay doors and all P3's directed to ED reception or # Clinic (Depending on Number of Patients). P1 + P2 patients enter the department through the ambulance bay doors.
- Can use prehospital documentation initially
- Patients will be booked in on Patient First/ MI folders are a contingency for no IT available
- P1 and P2 booked in resus/majors
- P3 directed to reception or # clinic to book themselves in.
- Don't remove any identifiers from patients.
- Police presence will be as soon as possible.
- Hospital ambulance liaison officer (HALO) will be sent as soon as possible.
    - Based at receiving hospitals and working closely with the hospital designated ED site management team.
    - HALO will liaise between ED and Ambulance Incident Commander for the requirement to find alternative hospitals. They will also facilitate swift handover and turnaround of ambulance resources.

Triage Sieve appendix ED 3

This is a very rapid assessment of casualties. This will be undertaken at the scene of the incident by SWAST using the slap Bands.
NB not all patients will have been triaged at scene if self-evacuated.

Triage sieve is repeated on admission to ED and as required on patients change in condition.

Whilst the triage Sieve includes Capillary Refill Time as an indicator, this should only be used in the absence of pulse or AVPU as it can be less accurate.

Clinicians are required to verify the absence of signs of life where they encounter victims who have already been covered by other agencies / individuals and triage accordingly.

Casualty Labelling & Patient Records

There are three stages of casualty labelling and documentation, namely;
Triage Slap Bands SMART Triage Cards Patient Care Record Forms

Triage Slap Bands
To be used by SWAST for the process of Triage Sieve. These bands are single use and do not allow for any patient information to be recorded. They are an initial prioritisation only.

Patient Care Record Form used by SWAST prior to patient arrival.

All patients will have a Patient Care Record (PCR) completed during a major incident, even if details have been captured within the SMART triage card.
The PCR should be completed at the Casualty Clearing Station and during onward transport.
A record of those leaving the scene will be kept by the Ambulance Loading Officer.
Lists of those transported may be viewed and / or copied by the Police documentation teams, but the original should be held by the Ambulance Loading Officer.

Post incident – Restoration to normal working

Make sure a hot debrief is carried out by a senior staff member and caption:

What went well?

What did not go well?

Lessons for the future

Keep a list of all staff involved.

Make sure the staff welfare is looked after: during and post esp. for support and post-traumatic stress.

Appendix ED 1 CSCATTT (HMIMMS)

Incident response - CSCATTT

Staff must use the 'CSCATTT' mnemonic to remind them of the structured approach to major incident management.

C – Command and Control

Appoint the Silver team (Hospital Co-ordination Team) including the immediate roles including: the Hospital Silver (Hospital co-ordinator), Silver ED (ED Consultant) Bronze Triage (Triage officer at ED), Bronze P3 (P3 patients co-ordinator) and Silver Resources (the staff resource officer) as quickly as possible. Declared major incidents should also include the instigation of the Gold Team.

S – Safety A, B, C

a. Ensure the safety of yourself (don Personal Protection Equipment) especially in the case of a chemical or biological incident AND immediately refer to the Decontamination Protocol in CBRN action cards/ plan.
b. safety of the hospital (using cordons/cordon tape/security) and consider Lockdown procedures; and
c. the survivors (keeping them safe).

C – Communications

Instigate communications including the initial call out cascade, the hospital control room becoming the Incident Co-ordination Centre –ICC, also known as Trust control room, the distribution of radios, use of dedicated phone lines and the use of logging materials. Ensure that the media liaison is commenced.

A – Assessment

Carry out an NHS Hospital assessment – mobilisation of the specialist team to ED, identifying the additional staffing required, the clinical supplies needed, whether specialised equipment is required, mobilisation of the decontamination unit.

T – Triage

Appoint a triage officer (s) and instigate the triage system as soon as possible by using the Adult Triage Sieve and the use of the Major Incident Triage cards. Ensure that P1/P2 patients are triaged and enter at the Ambulance entrance. Ensure that P3 patients then are directed and triaged via ED reception/# clinic for Mass P3 at GRH OPD may be the preferred option for P3 registration and management.

T – Treatment

Ensure that the NHS Clinical Guidelines for use in Major Incidents are being used by clinicians in ED. Commence extended treatment at the point of theatres and ICU as soon as the triage and life-saving intervention is complete. Ensure that the flow of patient treatment is maintained to ensure that ED, theatres, P3 treatment area, ICU and radiology department are not being overloaded. Ensure that emergency escalation is instigated.

T – Transportation

Ensuring that arriving ambulances routes and parking are kept clear, that recalled off duty staff parking is available, that hospital discharge or transfer transport is arranged.

Appendix ED 2 - Mass Casualty Incidents (Including Bomb and Blast)

To be read in conjunction with Major Incident Action Cards
Also refer to: LRF Mass Casualties Plan
(LRHP Mass Casualties plan due to be published Spring 2016)

Background

A mass casualty incident is defined as:

> *"a disastrous single or simultaneous event(s) or other circumstances where the normal major incident response of several NHS organisations must be augmented by extraordinary measures in order to maintain an effective, suitable and sustainable response"*
>
> (Department of Health (2007) Mass Casualties Incidents: A Framework for Planning)

In a Mass Casualty Incident the RD&E may be a receiving hospital for:

- Casualties from an incident
- Patients transferred from receiving hospitals nearer the incident to increase their capacity

Notification

- If the number of casualties exceeds local major incident response capabilities, the Ambulance Service, NHS England Area Team and Region should declare a mass casualty incident and agree the ongoing co-ordination of the NHS response.

- If the Trust becomes overwhelmed due to the number and type of casualties being received and patient safety is at significant risk, notify the Ambulance Service regarding the need for a wider area response. If necessary prompt the Ambulance Service to issue a mass casualty alert to the wider NHS.

Co-ordination

- The NHS England Area Team or Region will convene an audio-conference with all NHS organisations in the area likely to be directly affected or acting in support to establish a situation report, clarify response arrangements, anticipated demand and capacity and dispersal of casualties.

- NHS England will arrange for representation at the multi-agency Strategic Co-ordinating Group (Gold).

Pre-Hospital Care (See diagram at end of this section)

Special arrangements to manage large numbers of casualties may be initiated including the establishment of the following

- Triage - Revised triage arrangements including the introduction of the P4 'expectant' category may be used

- Casualty Collection Point(s) - Established to ensure casualties are removed to safe shelter from the incident where they may receive basic life-saving treatment before transfer to a Casualty Clearing Station. Casualty Collection Points may be designated by first responders or may be self-designated by casualties congregating at certain locations prior to the arrival of responders.

- Casualty Clearing Station(s) – Set up to provide patients with pre-hospital care before transfer to an acute hospital. Patients may receive treatment in this environment for up to eight hours

- Emergency Treatment Centre(s) - Emergency Treatment Centres may have to be set up to receive and treat large numbers of P3 casualties transferred from the incident or from other hospitals in the locality, region or further afield

- Use of Military and other air assets for transfer of casualties - The GTH Helipad is limited to H1 Class helicopters of less than 15m in length and less than 7 tones weight.

Incident Control Team

- If the incident is outside GHT catchment area, establish at the earliest opportunity with the organisation co-ordinating the NHS response any plans to disperse casualties from the incident to other hospitals, which hospitals will receive dispersed casualties, numbers and types of injuries

- If the incident is within the GHT catchment area, a holding area for large numbers of self presenting P3's will be established by SWAST to be cared for until Emergency Treatment Centres are established.

- NB if the mass casulty incident is on the doorstep of GRH or CGH with P3 self presentors naturaly comming to the acute trust our OPDs are designated areas to recive therse. As far as possible Mass P3 will be managed elsewhere.

- Review and implement options for expanding Critical Care facilities (balanced against use flexability of HDU and of theatre and recovery areas)

- Ensure Clinical Directors and Consultants are engaged in decisions regarding:
    - Clinical priorities and pathways
    - Decisions and implementation of changes to triage, admission, treatment and discharge criteria and thresholds – See below
    - The need to request (through the NHS England Area Team or Region) specialist military support under Military Aid to Civil Authorities (MACA) for incidents involving large numbers of trauma, blast and ballistic injuries

- Site access and security
    - ED will initiate Lock Down of the department
    - Determine the need for partial or total lock-down and implement plan
    - Communicate with staff, public and service providers (e.g. patient transport) regarding changes to access

Emergency Department

- Treatment teams may have to be reduced in number and skill mix from normal trauma team levels in order to accommodate higher volumes of casualties
- Extend Resusitation into Majors (with caveats regarding staffing as above)
- Consider implementing Clinical Guidelines for Major Incidents
- Priorities would be to control bleeding and neurovascular deficit and wound cleaning to prevent infection. Definitive care may require intermediate returns to theatre.

Critical Care admission guidelines if demand exceeds availability

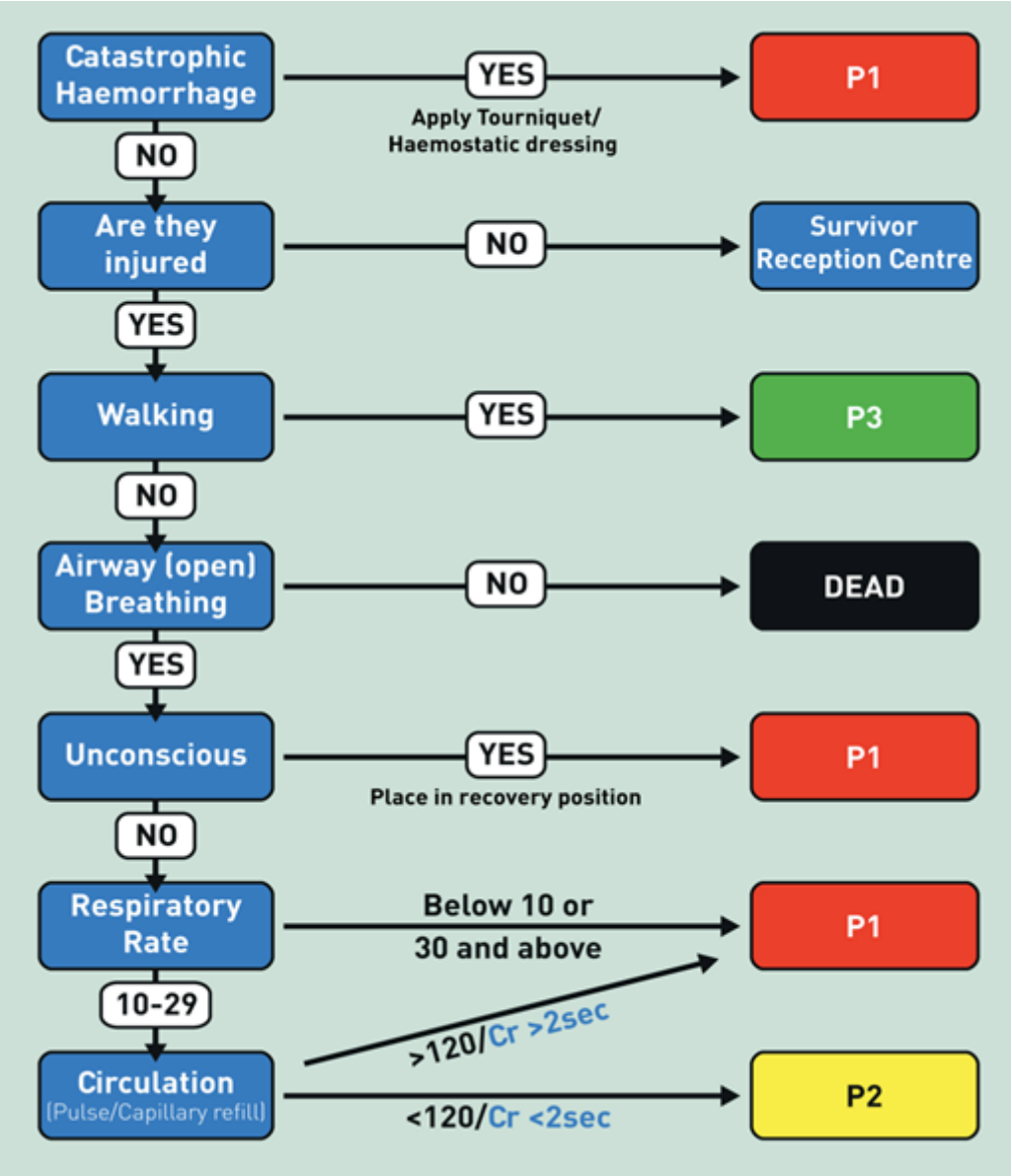
<u>Decision Making</u>

- Onus for decision making will rest upon the senior clinicians on site, using experience and common sense, with assistance, where available, from tertiary specialists. It is not certain that any form of triage tool will help in the acute phase.
- Use a “3 wise men” approach to decision making including senior clinicians and Critical Care nurses
- Sharing of the onus for decision making is essential to ease the psychological load on clinicians and to assist difficult discussions with relatives
- Appropriate documentation is essential

Considerations

- Cease normal elective Critical Care activity
- Triage all patients including those already receiving Critical Care
- Triage should be dynamic, ensuring that those patients with a realistic chance of a good outcome are prioritised
- Triage should be undertaken for all admissions by experienced Critical Care clinicians
- Patients should be re-triaged after operative intervention and before Critical Care admission
- Response to treatment should be used as a triage criterion for Critical Care admission and continuing treatment
- All patients who can be cared elsewhere should be rapidly transferred or discharged
- No patient group should receive absolute priority for Critical Care; all decisions should be made based upon likely benefit.
- Specialist Critical Care nurses to oversee other non-specialists with limited training (e.g. recovery nurses)
- Unit may not be able to offer the normal range and intensity of treatments:
- Offer a limited range of relatively simple treatment; e.g. Intermittent Positive Pressure Ventilation (IPPV), fluids, one inotrope, analgesia. These treatments would likely be adequate for trauma patients who have a reasonable survival chance.
- Unsustainable interventions may have to be withdrawn.

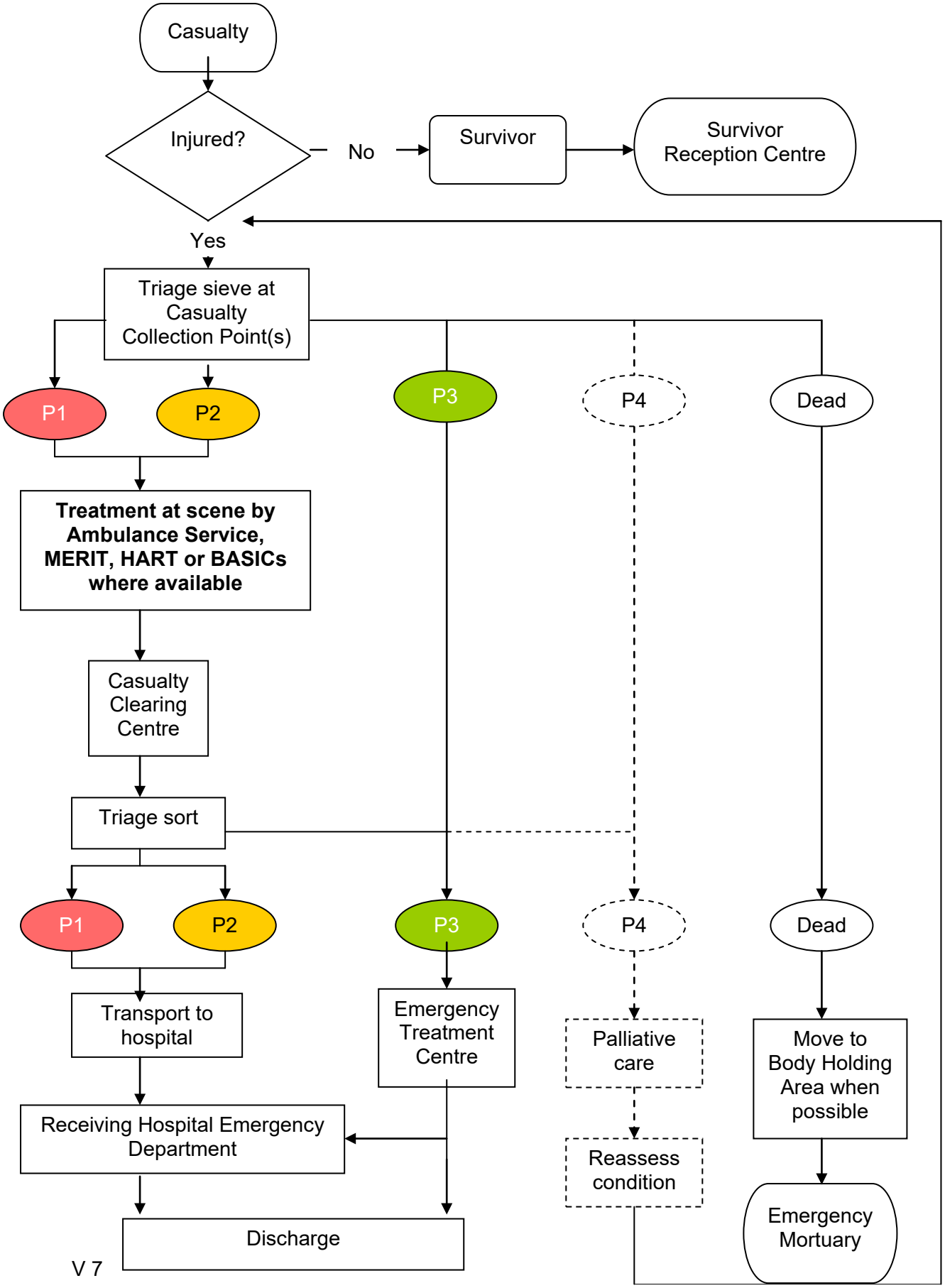
Appendix ED 3 The NASMeD approved triage sieve algorithm



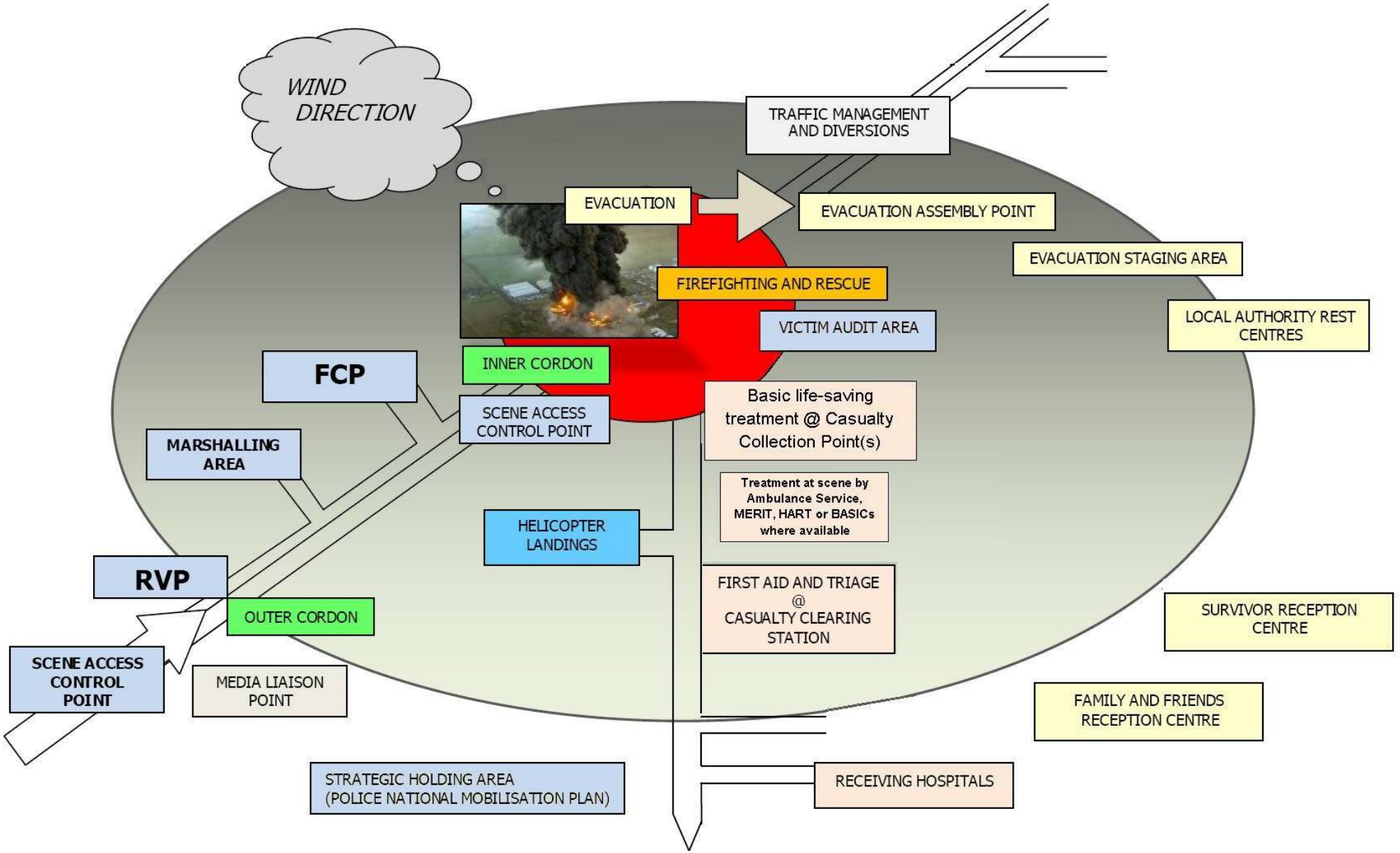
The range of Triage Categories are as follows:

Red	**P1**	Immediate First Priority
Yellow	**P2**	Urgent Second Priority
Green	**P3**	Delayed Third Priority
Blue	**P4**	Expectant (special circumstances only)

Appendix ED 4 - Mass Casualty Patient Care Pathway



Appendix ED 5 Overview of incident management at the scene:



Initial Control

1. Ambulance Service personnel will usually be the first NHS responders. They are trained that the 'First on Scene' are not to become involved in the incident but are to relay specific details to Ambulance Control. It is at this point that first indications of a major incident may be gained. Once on-call Ambulance Service Officers start to arrive, a structured command and control system will be established.

Multi Agency Integration

2. In order to achieve a combined and co-ordinated response, the capabilities of the emergency services must be closely linked with those of the local authorities and other agencies including Ambulance, Police, and Fire & Rescue Service. Management of the response can be divided into three levels - operational (Bronze), tactical (Silver), and strategic (Gold). The requirement to implement one or more of these management levels will depend upon the nature of the incident.

Operational (Bronze)

3. On arrival at the scene of an incident, the emergency services will take appropriate immediate measures and assess the extent of the problem. They will concentrate on their specific task within their areas of responsibility. Should it be necessary, consideration will be given to assigning control for a specific task or area to a designated officer of the emergency services or particular agency called to the scene. The command of the resources belonging to any agency and applied within a geographical area, or used for a specific purpose, will be retained by that agency under their own incident officer. If appropriate, the police will act as the co-ordinator for this response at the scene. The Ambulance Officer at the scene will be called the 'Ambulance Bronze Commander'.
4. For more serious incidents requiring significantly greater resources, it may be necessary to implement the tactical (Silver) level of management. In this case, the Ambulance Bronze Commander will remain at the scene to manage medical resources and operational issues.

Tactical (Silver)

5. A tactical level of command exists to determine priority in allocating resources, to plan and co-ordinate when a task will be undertaken, and to obtain further resources as required. For Blue light services most but not all, of the tactical functions will be discharged at or near the scene. The Silver Commanders should not become involved with the activities at the scene being discharged by Bronze Commanders but concentrate on the overall general tactical management. The Ambulance Officer appointed to this role will be known as the Silver Commander, who may communicate directly with our EDs.
6. If it becomes apparent that resources or expertise beyond the level of the tactical commander is required, or should there be the need to co-ordinate more than one incident/scene (where tactical command has been established), it may be necessary to implement a strategic level of management.

Strategic (Gold)

7. Gold Command is the senior tier of multi-agency management and will usually be based at Gloucestershire Constabulary Headquarters, Waterwells, Quedgeley. This facility will have extensive communications, and is designated only for this function. Gold Command will only be used in a large-scale incident to make strategic decisions about deployment of resources, managing the consequences of an incident, providing information and the restoration of normality. The Ambulance Service Officer at Gold Command will be called the Ambulance Gold Commander and the Health Gold will be the CCG Chief Executive, or nominated deputy.
8. The following pictorial flow chart identifies the chain of command from the scene of an incident up to the Strategic Co-ordinating Group (SCG) at Gold Control in the Police Headquarters in Quedgeley and provides staff with terminology and ranks used:

Appendixes

Appendix 1 – Action Card List

Action cards are available on intranet

The list below documents:

- Action card name/scope
- How the area/individual is notified
- Summary of the role
- Where to report to in the event of major incident.

Action cards on intranet:
G designates Gloucester
C Cheltenham
T is the Trust
No Letter = generic for both sites

Whenever possible the action cards with be generic for both sites.

Trust Action Card **X = allocated via the control room**	**Notified by**	**Role in major incident**	**Report to designated site**
T01 - Executive Director Trust Control Centre	Switchboard	• Role to set the strategy • Communicate with wider health • Communicate with Silver	Trust Control room GRH unless incident at CGH
T11 - On-call Manager Trust Control Centre/ Associate Director of Service Delivery or nominated in hrs	Switchboard	• Role turning strategy into plans/ actions and getting them done. • Communicate with internal Bronze and Gold	Trust Control room GRH unless incident at CGH
T03 - Chaplaincy Support	Switchboard	• Supporting patients /friends and relatives	Fosters Restaurant
T04 - Communications Team	Switchboard	• Monitoring media • Managing incident communication briefings internal and externally	Trust Control room GRH unless incident at CGH
T05 - IT On-call	Switchboard	• Maintain IT critical functions Provide IT support as required	Contact Control room and give contact name and number
T06 - Director of Nursing	Switchboard	• Support matrons esp. of receiving wards- cascade and support control room actions	Trust Control room GRH unless incident at CGH
Trust control room lead roles and responsibilities	Switchboard or nominated by senior manager	• Role turning strategy into plans/ actions and getting them done. • Communicate with internal Bronze and Gold	Trust control room
T08 - Switchboard	ED or senior manager	• Activate Incident cascades	Switchboard
T09 - PME On-call Estates Officer	Switchboard	Nominated contact person for any estates related incident actions required. Provide extra radios for key areas. DLOs work with portering / access and egress	Contact Control room and give contact name and number

Trust Action Card **X = allocated via the control room**	**Notified by**	**Role in major incident**	**Report to designated site**
T10 - SWAST HALO	SWAST	Direct link at GRH between incident / SWAST and ED	ED Bronze control room
T12 - Generic Lockdown Action Card	Switchboard/ security	Describes lockdown to be used by physical and practical application from an incident alert.	
T 9 – Integrated Discharge team (IDT)	Switchboard	Prioritize discharges and expedite.	?? Lead to Control room

01a - ED Nurse in Charge/ Coordinator	Switchboard	Nursing lead for ED Initially combined with 01 until additional staff take 01 – key link between Trust control room and key departments.	ED
2 - ED Consultant	Switchboard	Consultant lead for ED	ED
3 - ED Nurse 1	ED cascade	ED incident coordinator with Site manager	ED
4 - ED Receptionist 1 + 2	Switchboard	Usual role and flagging on PAS patients involved in incident	ED
6 - Senior Site Manager	Switchboard	Clearing ED and ACUA	Liaise with ED.
7 - Junior Site Manager	Cascade to senior site manager	In close liaison with ED co coordinator Co-ordinate transfer of patients already in the emergency department according to medical staff's assessment	Operations centre
9 - Triage Team Doctor	Switchboard/ ED lead if different	Triage from ambulance doors	ED
G0 - ED Nurse 2	ED cascade	Support the ED coordinator and lead on Clearing the department	ED
01- ED Lead Nurse	switchboard	As for action card G01 until role filled separately and key link with Trust control room and key departments.	ED
12 - On-call Consultant Anaesthetist	Switchboard	Prioritization with ED lead	ED
13 - ACUA Nurse in Charge	Switchboard	Lead for ACUA, initially clearing ACUA then receiving incident patients medical or surgical	ACUA and laisse with ED for situation update
17 – Modern matron	Switchboard via bleep system Out of ours by peer cascade as required	Operational leadership for their areas	Trust Control room
18 – CCU lead Nurse – CCU Anaesthetist	Switchboard	Prioritization of work with ED - assisting patient transfer where possible.	CCU
19 - Orthopaedic Surgeon	Switchboard	In liaison with ED and theatres coordinator prioritization of work	ED
T03-Relative and friends waiting area **X**	Chaplaincy and Allocated via control room	Support ,communication and advice during and advice on where to access after the incident	GRH Fosters restaurant CGH West Block OPD
T 07 Staff reporting area **X**	Allocated via control room	Record staff available and in liaison with bank office and control room allocation of resources to where needed e.g. support portering, support wards, admin for ED, ward clerk support, runners for departments /control room	GRH Fosters meeting room 1 &2 CGH Non counter side

Trust Action Card **X = allocated via the control room**	**Notified by**	**Role in major incident**	**Report to designated site**
21 –Ward generic action card	Internal cascade	Follow black escalation reduces demand on Porters, site management, estates, switchboard. Offer help through with staffing /equipment via Trust control room. Cancel meetings, training. Follow ward cascade. Monitor communications.	
22 - Pathology Stores	Internal cascade	Provision of pathology supplies as required	Normal work area
23 - Pathology Department	Switchboard	Provision of pathology services as required to support the incident (including out of hrs)	Normal work area
24 - Portering Services Manager	Switchboard	Prioritization of portering as required. May call on Estates for further support e.g. from the DLOs to work with the porters or for access and egress.	GRH unless CGH is incident site
25 - Discharge Medical Co-ordinator	Switchboard / or ED lead if not the same	Prioritization of discharges with in ACUC and in liaisons with the medical division lead for all other wards	ED /ACUA
26 - Pharmacist	Switchboard	Lead on Directly supporting requirement for ED, ACUA and receiving wards . Expedite TTOs	Pharmacy + liaise with key areas
27 - Lead Nurse Modern Matron	Bleep system	Support their wards esp. the receiving wards. Cascade information and required actions from control room	Trust control room
28 - Theatre Lead Nurse	Bleep system		Theatres
29 - Consultant Physician + On-Call Medical Team	Switchboard	Work in liaison with ED lead	ED
30 - Paediatricians	Switchboard / ED	Responsible for paediatric patients	Liaise with ED attend if paediatrics
31 - Orthopaedic Fracture Clinic	Switchboard	A contingency for ED and an extension of ED depending on the nature of the incident .	ED
32 - Social Services	?		
33 - CGH Volunteer Services Manager	?		GRH Fosters CGH OPD
34 - Radiology	Switchboard	Provision of required services	ED
36 - mortuary service	switchboard	Management mortuary capacity – likely to be a county wide approach	
38 - Sterile Services	Switchboard	Provision of sterile services as required.	

Appendix 2 - LRHP/GHT Emergency preparedness Training matrix

GHNHSFT Training Record of Emergency Planning / Preparation GHT Updates 2014

	Courses													
	Strategic Leadership in crisis course	Tactical leadership in Crisis course	Surviving a public enquiry	Control room set up and management	Site Managers: Action cards inc. On call mangers and ED . Use of Radios in	Loggist training or experience	BCM training in house	Major Incident training in house	Introduction into Integrated Emergency Management (IIEM)	Other Major incident training and experience including exercises	Business Continuity accredited course	Trust CBRN training	IOR CBRN/ HAZMAT	Media Training
Who should attend	Exec Directors/ Directors. Any one acting as Trust Gold	On call operational managers. Any one in charge in the Silver control room. Other managers in control room	Exec Directors/ Directors	Anyone who may find themselves in the control room. General managers/ assistant general managers/ loggists /control room support	All site managers	Anyone logging	All senior managers /department leads/ all critical and essential services / all areas	All senior managers /department leads/ all critical and essential services / all areas	All on call managers and above	ED HMIMMS	IT lead and Estates leads / EPM	All CBRN team 6 monthly training and update on sharepoint. CBRN leads training for updates as required and minimum of annually	ED: Reception staff, Triage Staff/ Leads plus Drs, CBRN/ HAZMAT, Local Dept. Training	Media for heads of service or nominated
Name/group	External	External	External	Internal		Internal	Internal	Internal	External LRF		External		Internal	
Frequency of Training	One off	Every 3 years	One off	Annually	Annually	Annually	Every 2 years	Every 2 years	Every 3 years	One off		Annually	Min. Annually	
Emergency Planning Manager														
Executive Directors:														
Divisional Directors:														
General Managers:														
Matron/ Department Leads:														
Senior Sisters:														
Loggists:														
ED														
Site managers														
CBRN team														

Appendix 3 – Training Exercises

TRAINING AND EXERCISING

☐ A training plan and training needs analysis will be maintained by the Accountable Emergency Officer and reviewed at the quarterly EPRR Planning Group meetings.

☐ An exercise programme will be maintained to deliver training in accordance with the Trust Emergency Risk profile.

Under the Emergency Preparedness Framework and CCA the Trust exercises:

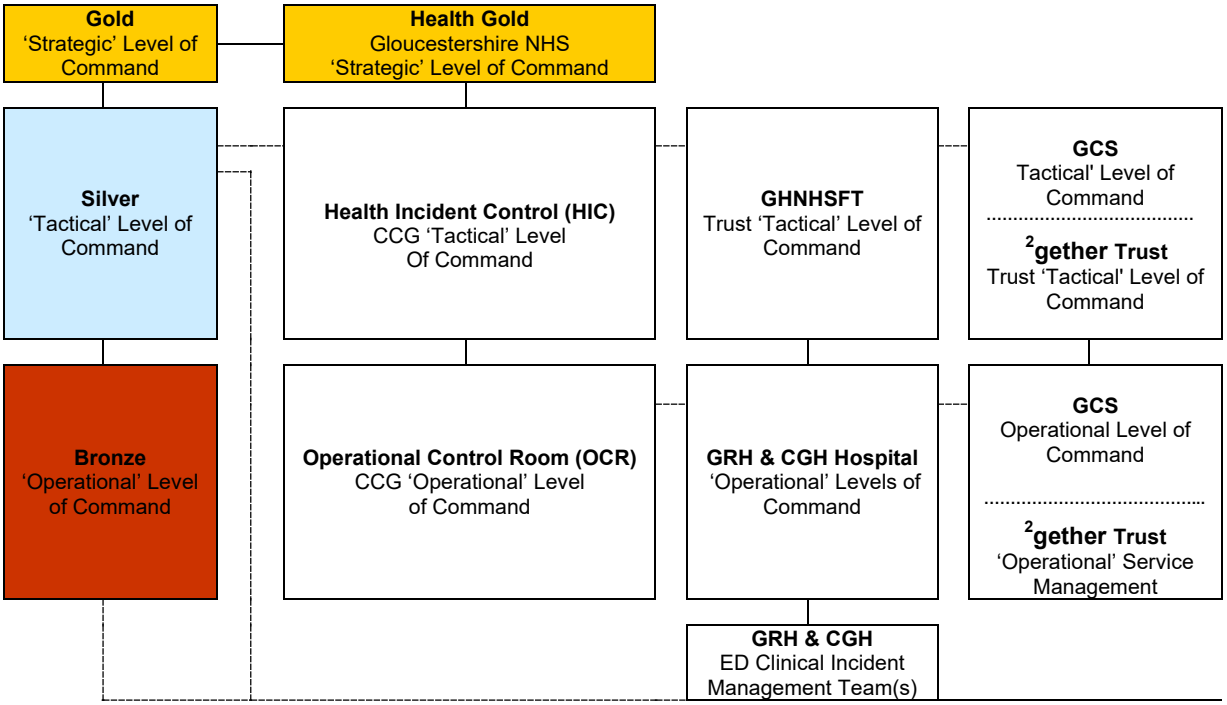
- Communications Exercises test six monthly,
- Annual table-top exercise.
- Live exercise at least every 3 years.(EMERGO exercise April 2015counts for the next three years but after this the EMERGO exercise will not count as live play due to national changes)

All on-call incident commanders (on call directors and on call general managers) will maintain a continuous personal development portfolio demonstrating training, exercise and actual engagement in incident control.

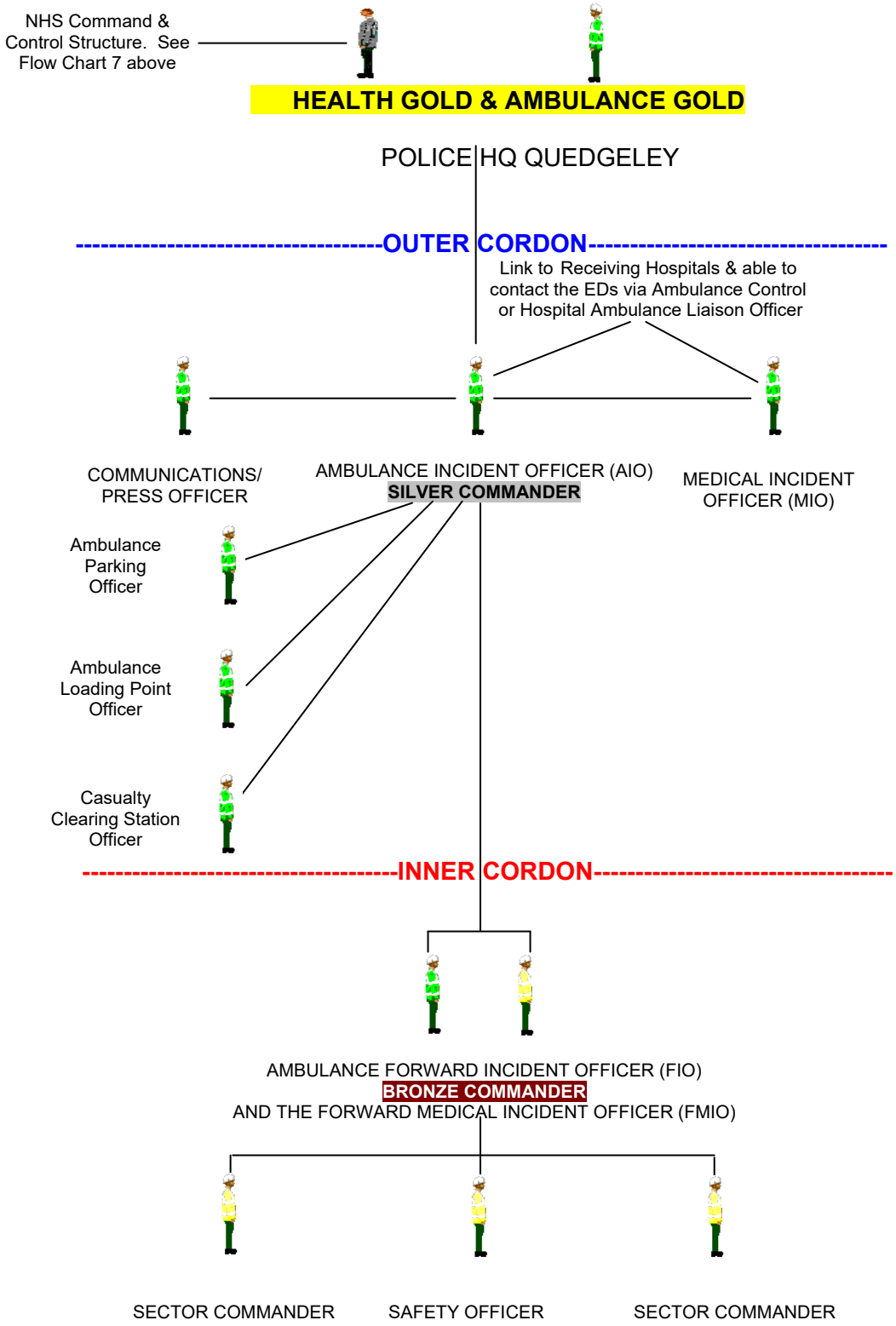
It is the responsibility of individual and departments to access the required training as per the Major Incident Training matrix .Training time tables available via Sarah.Townsend1@nhs.net and for CBRN IOR via EPRR Team ghn-tr.eprr@nhs.net

Departments are required to maintain their own local plans and action cards and deliver local training.
Any changes to plans and action cards must be shared with the EPRR Team ghn-tr.eprr@nhs.net

Appendix 4 - Multi Agency Command and Control Organisation



Appendix 5 - NHS Command and Control Organisation



Appendix 6 - Working with the Police

Introduction

1. Trust staff need to be aware of the role of the Police in a major incident and this section provides details of their involvement. The Police will co-ordinate all emergency services and agencies responding to a major incident. Depending on the type of incident, Gold Command may be formed at the Police Headquarters in Quedgeley.

Police Casualty Bureau and Police Documentation Teams

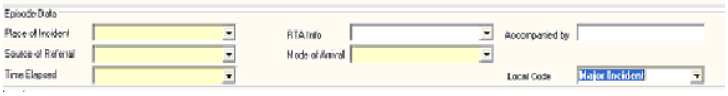
2. If required the Trust will provide facilities for a Police Casualty Documentation Team ED and Fracture clinic action cards have instructions.

3. The Police will provide a Casualty Bureau that will accurately collate details of the dead, surviving, and evacuated persons. It is imperative that no emergency service or local authority officer gives details of casualty numbers to the press. **Only the Police Gold Commander will authorise release of casualty information**.

4. Casualty Bureau staff will receive detailed information from the scene, reception centres, hospitals and the mortuary. At the same time, enquiries will be received from relatives of persons who are believed to be involved in the incident. The Casualty Bureau will collate information from the Police Documentation Teams at GRH/CGH, which will be used to inform next of kin of appropriate information. Flow Chart 11 details the procedures for obtaining the required information:

Flow Chart 11 – Police Documentation Team Information Flow to Casualty Bureau

Casualty information obtained at the scene	SWAST will conduct an at scene triage of casualties and fit a 'Slapper Band' a plastic coloured band available in 4 colours to depict the relevant triage categories as outlined below. Cruciform triage cards are available in ED This band will be removed before the patient leaves the casualty clearing station and has no relevance to the Police casualty identification process. The band will be replaced by a triage card, which will identify the casualty priority categories as follows: 1. Red = Immediate) 2. Yellow = Urgent) There are other colour combinations that 3. Green = Delayed) are only relevant to SWAST at the scene. 4. White = Dead) It may not be possible for SWAS staff to record personal details but a basic description may be used e.g. elderly male. The card has a casualty number which will be used to record transportation details. The pack also contains numbered sticky labels, which can be used during the patient pathway to record movement. The SWAS Loading Officer will record details of casualties leaving the scene including details of the designated receiving hospitals. The casualty number will be used by the Police to assist them in identifying casualties admitted to hospital, those sent home (although their details should be known and recorded against the casualty number), those who die in hospital and those Category 4 casualties remaining at the scene. **This number must remain with the casualty/patient at all stages of the patient pathway and administration and should be entered in the Presenting Complaint section on the Hospital IT systems.** If possible, the Police will have officers at the scene to support the casualty identification process.

Casualty information verified at GRH and or CGH	Casualties will be booked in using Patient Administration System (PAS) and Patient First as follows: • Use the local 'Major Incident' code on booking screen; • The Police casualty number should be entered in the "presenting complaint" field on Patient First;  • MRN will be the identifying number and issued when the patient is booked in. The MI Folders will only be used as paper backup; **Minors**: • Patients will be booked in using PAS/Patient First at the ED Reception; • Use local code of 'Major Incident' • Patients will be triaged by a triage nurse and they will print the casualty card. **Majors**: • Patients will be booked in using PAS/Patient First by the ED Receptionists, at GRH this will be in majors. • Use local code of 'Major Incident', see above; • Unknown patients will be booked in using the 'Unknown' process; • The casualty card and 16 labels will be printed by the receptionist. All Police and GWAS bands must **remain** on a patient **throughout the patient journey** or until removal has been authorised by the Police.
Information sent to the Police Casualty Bureau	The Police Casualty Documentation Team at GRH & CGH will provide all known information to the Police Casualty Bureau to assist with positive identification.
Information provided to next of kin	The Police are responsible for informing friends and family about casualties. This should not be undertaken by Trust staff. Friends and Relatives Reporting Areas may be established in the hospital(s) Outpatient Departments, see Section 2

5. Whilst NHS staff need to co-operate with the Police, they must bear in mind their **duty of confidentiality to individual patients**. Staff should not normally disclose personal information outside the NHS without the patient's consent. In the abnormal situation of a major incident the duty of confidence is not automatically lifted.

Appendix 7 - Key Locations used in Major Incidents

Gloucestershire Royal Hospital

Key Areas	Location	Alternatives and considerations
Triage and Treatment of Casualties- entrance	Via ED main entrance	
Treatment of casualties	ED + orthopaedics if required	
Mass casualties walking wounded P3s	Main Out patients dept	
ED Police documentation team are based	Main office by ED ambulance doors and office in orthopaedics identified for them	
Major Incident Discharge patients	Management to allocate area	
Junior Medical staff report to	Bed management to decide on need	
Relatives, friends and post discharge waiting area	Fosters Restaurant –	May need basic catering provisions out of normal hrs
Staff reporting and briefing area	Fosters meeting rooms 1&2 (through foster restaurant)	
Incident receiving ward	Identified at time by bed management /site manager	Aim to keep incident patients together
Inpatient discharge lounge	Ground floor Gallery wing	
GRH Trust Incident Control room	2 Floor Gallery Wing with Ops centre	
Press base	Away from action and control room consider options,	Give them a person to link with
Local department information		
Action cards kept:		
Staff cascade kept:		
BCM plan kept:		

Appendix 8 - Key Locations used in Major Incidents

Cheltenham General Hospital

Key Areas	Location	Alternatives and considerations
Triage and Treatment of Casualties- entrance	Via ED main entrance	
Treatment of casualties	ED + orthopaedics if required	
Mass casualties walking wounded P3s	Main Out patients dept	
ED Police documentation team are based	Allocate an office / area in ED or orthopaedics for them to use at the time.	
Major Incident Discharge patients	Bed management to identify	
Junior Medical staff report to	Bed managers to identify	
Relatives, friends and post discharge waiting area	West Block OPD **unless** Mass casualties / walking wounded, then management to allocate another area i.e. consider Sandford	May need basic catering provisions out of normal hrs. Consider voluntary RVS
Staff reporting and briefing area	Blue Spar café non counter side.	
Incident receiving ward	Identified at time by bed management /site manager	Aim to keep incident patients together
Inpatient discharge lounge	Bed management /control room to identify an area. ? East Block OPD	
GRH Trust Incident Control room GRH **CGH**	2 Floor Gallery Wing with Ops centre Management office Alexander House	
Press base	Away from action and control room consider options,	Give them a person to link with
Local department information		
Action cards kept:		
Staff cascade kept:		
BCM plan kept:		

Appendix 9 - Incident Debriefing Form

NAME OF INCIDENT / DATE

Name:	
Position:	
Role during the incident:	
Ward or Department:	

Please complete the following to identify what you consider went well and suggest areas for improvement.

What went well and should be highlighted as good practice for future operations?	
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Areas for Improvement:	
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Further ideas that may be relevant to the Trust response to future incidents:	
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Please return the completed form to EPRR Team at: ghn-tr.eprr@nhs.net

Appendix 10 - Trust-Wide CBRN Action Card (from CBRN plan)

Trust control room needs to ensure these actions are carried out as a priority.

CBRN/HAZMAT ED Consultant/Nurse in Charge	**X-1**

Role and Responsibility:
On receipt of the alert from the SWAST for a CBRN Major Incident – 'Standby' or 'Declared':

Actions:

1. Designate two members of staff/ reception to call out the CBRN Team (stating which hospital to attend GRH or CGH). The call out/ contact list and instructions are in the ED CBRN file;
2. Keep a record of those attending the call out and hand this list to the first member of the CBRN Team to arrive;
3. Alert switchboard via 2222 to inform lead nurses, general managers, departmental leads to cascade;
4. Identify a member of staff to initiate 'Lockdown' procedures to secure the area and issue that person with Action Card X-3 for GRH or X-4 for CGH to action 'Lockdown'.
5. Divert all Emergency Department admissions;
6. Evacuate Orthopaedics;
7. Plan to evacuate Emergency Department;
8. Instigated department and hospital lockdown procedure;
9. Instigate ED patient divert (the receiving ED has to close to all none CBRN related patients);
10. Alert neighbouring ED Departments that we have a CBRN major incident;
11. If the incident involves radiation, the physicist should also be called to attend ED to advise the management team e.g. Head of Medical Physics or a team member;
12. Follow ED normal major incident action cards;
13. In the event of stand down, notify switchboard;
14. Casualties will be triaged on site by the ambulance service and decontaminated. Self-presenters to the hospital will be triaged by the hospital CBRN Team and decontaminated;
15. As with any patient, ED will need to undertake their own triage as with any patient once the decontaminated patient enters the department. CBRN agent indicator matrix forms are available in EDs as used by the SWAST and CBRN Teams;
16. Identify areas to manage or isolate patient
17. Only those casualties declared to be un-contaminated by the hospital CBRN Team should be admitted to the department for treatment.
18. **REMEMBER TO RECORD ALL SIGNIFICANT ACTIONS FOR DEBRIEF/INQUIRY PURPOSES**

Appendix 11 - Incident response by SWAST

Incident Reported to Ambulance Control	Ambulances and an on-call officer will be deployed. The first crew to arrive will conduct a dynamic assessment of the scene; a predetermined report will be sent to Ambulance Control. The incident will usually be managed without implementing major incident plans. Ambulance Control will assess the content of the report and decide if it is, or likely to become, a major incident for the Ambulance Service and/or the NHS. Depending on the information, the Ambulance Service may declare a Major Incident 'Standby' or 'Declared', and appropriate alerting action taken. The Ambulance Service is responsible for providing adequate and established clear lines of communication, and for ensuring NHS response is focussed and co-ordinated.
Major Incident 'Standby'	Upon receipt, Ambulance Control will alert one GRH default site or both EDs via a predetermined alerting system and the Trust will implement the Major Incident 'Standby' procedures. **Note**: It is better to receive an early alerting message and be ready to respond than initiate procedures after a major incident has been declared. Wards, departments, teams will respond in accordance with their Action Cards. If, after the initial assessment, there are few or no casualties a Major Incident 'Cancelled' message will be immediately sent by Ambulance Control to the alerted EDs, which will be cascaded to alerted wards, departments and teams. Once casualty numbers have been confirmed, if required, the Ambulance Service will consider initiating a Major Incident 'Declared'.
Major Incident 'Declared'	Ambulance Control will immediately alert the Trust ED(s); the CCG On-call Director will initiate their major incident alerting procedures and establish an appropriate incident management structure, including a HIC at CCG. Community Hospitals will prepare to receive transferred in-patients or, depending on the incident, some casualties with minor injuries. The Acute Bed Management Team will identify and manage decanting of patients. If problems are encountered, the Acute Hospitals will contact CCG to ensure maximum beds are being made available to ensure an efficient decanting operation. If required, CCG may deploy a manager to each of the alerted Community Hospitals to provide support and a line of management/communication. CCG will alert a nominated Health Gold for possible deployment to Gold Command. If required, CCGs will mobilise primary and community care resources to support the Hospitals Trust and Community Hospitals involved, monitor the health of the local population and disseminate health advice.
Major Incident 'Stand Down'	Once the last casualty has left the scene, the Ambulance Incident Officer will inform Ambulance Control for transmission to Receiving Hospitals (our EDs). This information will contain the number of casualties still being transported by ambulance. Although the incident scene is clear of casualties, the incident may still require special arrangement to deal with the aftermath. Individual health providers will implement their own Major Incident 'Stand down' procedures as necessary. This may require the Trust to revert back to a 'Standby' status to provide immediate medical services to emergency responders working at the scene. Where necessary, CCG will support the Trust return to normality. In consultation with CCG, the Health Gold, supported by the Public Health, will formulate a plan for dealing with any long term health implications. See Section 9 regarding restoration to normality and Section 10 relating to the incident debriefing process.

Appendix 12 - Mass Casualty Plan

This is to be used in conjunction with LRF/ LRHP mass casualty plan.

Introduction

1. The Department of Health issued updated guidance on handling mass casualties in February 2004. The following section outlines that guidance. The DH defines mass casualty incidents as those that: '**result from a disastrous event or other circumstances where the normal major incident response of NHS organisations must be augmented by extraordinary measures to cope**.' The following terminology will be used within this section:

    a. **Mass Casualties** will result from **a disastrous event or other circumstances where the normal major incident response of NHS organisations must be augmented by extraordinary measures in order to cope**. An incident will produce large numbers of casualties with life threatening conditions, which could overwhelm medical provision and threaten severe disruption to the Trust, social care, and exceed the collective local NHS capability. Such an incident may consist of a number of related events, which jointly produce enormous numbers of casualties. Usually, it would not be possible to quickly predict the large volume of casualties, so such incidents are recognised by their scale and circumstance. It is very likely that a conventional major incident response would be entirely insufficient.

    b. **Decanting** is the movement of in-patients to other medical facilities, usually Community Hospitals, to free beds for the admission of casualties from an incident. Should decanting become necessary, the Ambulance Service will invoke 'cross border support' from neighbouring Ambulance Trusts to carry out the movement of patients from the Acute Hospitals and, if required, provide ED Ambulance cover for the County.

    c. **Cross Border Support** is the arrangement between Trusts to mutually support their neighbours during a major incident. These plans are formally agreed and require greater inter-operability, standardisation of equipment, systems and training. The NSC will take a proactive lead in guaranteeing the availability of mutual aid and support both within their area, and across NSC boundaries.

Purpose

2. The purpose of this section is to outline the procedures, roles and responsibilities regarding the management of an incident that has, or is likely to, escalate into a major incident involving mass casualties. The Trust plans in place for dealing with an incident(s) involving about 200 casualties (with various injuries) being admitted to both GRH and CGH. Numbers exceeding this will trigger a request for the area team NSC to invoke local and area their Mass Casualty Plan, which supports NHS services during a mass casualty incident.

NB in reality numbers far less than 200 will be a challenge for the Acute Trust if already in escalation and or experiencing winter pressures.

3. A key to successfully managing a mass casualty incident is an early declaration of a category of major incident combined with an accurate estimate of the number of casualties and the type of injuries expected. Levels of response are detailed in Section 1 and categories of alerting are outlined in Section 3.

Role of the Trust

4. The risks associated with incidents that might result in mass casualties have become more prominent in recent times .For mass HAZMAT or CBRN incidents the Trust has decontamination equipment at both GRH and CGH (to supplement the mobile units used by the Ambulance Trust and the Mass Decontamination facility that would be operated by the Fire and Rescue Service).

5. In response to a mass casualty incident, the Trust will need to ensure that resources are mobilised effectively and flexibly to assist in dealing with such an incident. The principle will be to do the ***greatest good for the greatest number*** and it is possible that patient care will not be able to be delivered to the same standards, with the clinical protocols and guidelines that normally apply.

6. Implicit within the Trust's Major Incident Plan is the ability to free up substantial internal resources for example by:

   a. Calling upon additional off duty staff by use of the call out procedures;
   b. Working with natural local partners locally Gloucestershire Care Services / community hospitals and potentially the 2gether Trust to maximise patient transfers (decanting);
   c. Encouraging/accelerating additional discharges to free additional beds;
   d. Consider the use of additional facilities e.g. Day Units, to create additional beds;
   e. Reviewing elective/non-emergency provision.

7. The Trust will call upon Gloucestershire Care Services and CCG staff to assist. Whilst these staff may already be deployed on other activities associated with the incident it is possible that additional resources could be made available to the Trust from this pool of staff. If such assistance is required, the Trust Control room will liaise through CCG with the Health Gold in Gold Command to request required support.

8. Other sources of assistance may be called upon by the Trust Control room. The area team NSC can provide support and the use of 111 could help with dissemination of key messages to the public regarding any major incident.

9. Some incidents may result in a very large number of casualties that could threaten to, or will overwhelm the Trust's ability to cope. In such cases Gold Command will have been activated and will be a source of advice and access to a wide range of external assistance. Where the impact of mass casualty incidents is such that the measures outlined above are not sufficient, then mutual aid e.g. lending staff and equipment or taking patients from the affected area, will be required through neighbouring organisations through co-ordination by CCGs and Area teams.

Operational Objective

10. In dealing with any of these incidents, there needs to be a cohesive countywide NHS response that delivers optimum care and assistance to the victims, thereby minimising consequential disruption to healthcare services and a managed return to normality. This will be achieved by ensuring all plans link, and are capable of working as part of a multi-agency response across organisational and geographical boundaries.

11. It is in the nature of major incidents that they are unpredictable; each will present a unique set of challenges. The task is not to anticipate them, but to have a set of plans with operational links and staff trained to handle the uncertainty and unpredictability of whatever happens.

12. Given the objective stated above, plans must contain:

    a. **Speed and flexibility** which will initially be delivered by the Ambulance Service, supported by Gloucestershire Care Services and CCG. If required, the 2gether Trust and other care providers may be called to ensure an expedient operational response to an incident;

    b. **Cross border support and mutual aid arrangements**. See Paragraph 2;

    c. Reference to a strong **central support capability** detailing DH support to the NSC.

Incidents Impacting Upon the Capacity or Continuity of Clinical Services

13. In the initial phase of any incident, the Ambulance Service will co-ordinate and control all NHS resources deployed to the scene. The Ambulance Bronze and Silver Commanders will ensure that the NHS response is co-ordinated and focussed, that adequate resources are deployed, and lines of communications are established. Depending on the type and duration, the on-site health co-ordination role may pass to other health specialists as the incident develops.

14. CCG will mobilise primary and community care resources to support the Health Community and to sustain those needing care at home, including access to social care support. They will also take steps to monitor and safeguard the health of the local population for the duration of an incident, and be capable of quickly disseminating health advice to the public if required.

15. The NSC will co-ordinate the overall response and aspects of NHS support for the incident and also be responsible for activating links with other CCG and Social Care agencies. Support and advice will be available from the Regional Directors of Public Health and the HPA's local and regional Health Protection Teams.

Incidents that Threaten the Wider Health of the Community

16. For any emergency where the immediate impact is likely to be mainly on Public Health, rather than the day to day operation of the NHS, responsibility for overall health co-ordination and control will rest with the Regional Director of Public Health or nominated representative at CCG. This appointment will have the support and expertise of the HPA and its regional Health Protection Teams, and can also provide a liaison link to Regional Government Office of the South West. The SWSHA will activate their command and control function.

Incidents Requiring National Co-ordination

17. The NSC will establish a regional Major Incident Room at Chippenham or co-locate with CCG, from where support will be co-ordinated and have formal links with the DH. If the scale of an incident escalates beyond the NSC capacity or area, or its duration or nature is such that wider NHS resources are required, the DH may implement national co-ordinating arrangements. These arrangements are intended to support the CCGs, ensure that wider NHS resources are made available, and that Government assistance is accessed if required.

Command and Control

18. Major disruptive challenges or large-scale incidents may impact on the Trust in two main ways:

    a. The incident/occurrence itself, or its aftermath, might rapidly threaten the **capacity or continuity of health service provision**. Large scale accidents, terrorist incidents or threats to the supply chain would be examples;

    b. The incident/occurrence, or its consequences, may not have a rapid impact on health services but may threaten the **wider health of the community,** either immediately or at some subsequent stage. Outbreaks of infectious diseases, food contamination or water or air pollution are examples.

19. The speed and unpredictability with which these incidents can develop is such that it is essential to have clear arrangements for co-ordination, command and control. In the former type of incident, that responsibility will naturally fall to CCGs, supported by the NSC and those NHS organisations providing the front-line response. In the latter, the Regional Director of Public Health England (PHE) will have the specialist knowledge and experience required to provide advice. In each case, the PHE would also have a critical role in providing advice and operational support.

20. However, it has to be recognised that some incidents may have both characteristics from the outset, or that the characteristics may change as the incident develops. It is, therefore, essential that local plans and structures are harmonised, and that the management and Public Health aspects are approached in a fully collaborative way.

Roles and Responsibilities

21. Each part of the health and social care system has a role to play. Every organisation needs to understand not only its own responsibilities, but also those of others that will support and complement its own efforts as follows:

    a. **The Trust** is responsible for deploying the right resources to care for casualties at the nominated hospital site, and for mobilising resources flexibly and to the maximum extent consistent with maintaining essential care.

       The Trust control room will with Site Management Team will work closely with CCGs Gloucestershire Care Services and SWAST and PTS/ ARRIVA to manage a decanting

operation to Community Hospitals and other suitable locations to maximise freeing beds for the admission of casualties from an incident or infectious disease outbreak.

Both the Trust and SWAST plans must include the provision of effective support to any neighbouring service that is substantially affected and, in return, should be able to rely on such mutual support.

b. **SWAST** will respond to an escalating incident in accordance with their Major Incident Plan to provide immediate triage, care and transportation. Cross-border support will be invoked, when required. A key function is to, expediently, establish and co-ordinate NHS communications at the scene.

c. CCG in the mobilisation and direct healthcare resources at short notice, and to sustain patients in the community should hospital services be reduced or compromised. They must also plan to harness and effectively utilise primary care resources, where needed, to support emergency assessment facilities or emergency vaccination programmes. Consideration will also be given to:

   i If required, deploying an appropriate manager to support Community Hospitals;
   ii Maintaining close links with the area teams regarding the provision of primary care to Rest Centres/Place of Safety, and alerting GPs and Community Nurses to support these facilities;
   iii Having the ability to call upon the support of at least 30% of Community Nursing staff within 24 hours;
   iv Alerting and deploying GPs;
   v Supporting the Community Hospitals requests for additional equipment and resources.

   CCG will monitor the incident and keep the Health Gold and NSC briefed on developments and requests for support.

d. Gloucestershire Care Services will initiate the procedures outlined in their escalation plan. If the information received indicates that the incident will require in-patients to be decanted from the Acute Hospitals, consideration must be given to which patients may be identified for early discharge and any planned admissions (elective admissions) suspended. Response to a Level 3 incident may require initiating non clinical locations to receive casualties or decanted in-patients.

e. If required, the ^{2}gether Trust may support the Trust by activating its Major Incident Plan with a view to establishing:

   i Transport availability with a view to making vehicles available as required;
   ii Which staff could be made available to provide support;
   iii What facilities, e.g. Day Centres could be made available;

   This response must be requested and collated through the CCG in the HIC.

f. **NSC** will be able to strategically support of any incident that affects, or seems likely to affect, several LRFs or have a significant impact on primary care. The NSC will ensure that the County NHS has a sound command and control structure, and escalation alerting procedures clearly described and understood. Escalation plans are clearly described and capacity plans are available. Links within the NHS, neighbouring CCGs, regional agencies are effective and robust. To facilitate this, the NSC has appointed the CCG Chief Executive as the lead for emergency planning within the county. As an incident escalates, the NSC will, in discussion with the Health Gold, ensure an appropriate command and control arrangement for the NHS response. This will be reviewed as circumstances dictate. If required, the NSC will establish a Major Incident Room in Taunton to support NHS response.

g. **The Department of Health** is responsible for national oversight and monitoring of all incidents that result in activation of a major incident plan. This does not mean it will necessarily always be involved in all incidents, as most will be handled by CCGs. However, when more than one SHA is substantially affected or when an incident has a ‘national’ characteristic, the DH may establish a national control room to support SHAs in management of an incident (in order to encourage mutual aid and to act as focal point for links across Government).

Appendix 13 - Guidelines for senior managers for conducting interviews

The media can play an important role in broadcasting accurate and timely information to the general public. Anyone interviewed by the media needs to be well prepared and briefed. Confident, well briefed interviewees have a crucial role to play at every stage of an emergency.

To be an effective interviewee you require:

- A clear understanding of what you want to say.
- Good preparation - have the facts at your fingertips.
- Positive presentation - sound confident.

Think ahead - before the interview, ask the reporter:

- What areas will be covered?
- What are the first and subsequent questions likely to be?
- The angle the interview may take
- Who else is taking part?
- Is the interview live or pre-recorded?
- What type of programme is it - news, phone-in etc?
- How long will the interview last?

Establish the facts:

- Why are you being asked/do you want to do the interview?
- Are you appealing for help?
- Asking for public support?
- Promoting the work of the emergency services and partner agencies?
- Answering criticism or allegations?
- Giving public advice and reassurance?

Establish what you must say:

- Make a note of the three most important points
- Consider the likely questions you may be asked
- Decide how your facts support your message. Use examples to illustrate your point
- Don't wait for the interviewer to ask questions, keep talking to get your point across
- Make sure you are briefed and fully aware of the latest situation and approved
- messages.

Remember...

- Always assume the microphone/camera is on
- Look at the interviewer, not the camera
- If being filmed at your desk, tidy the office, check the information on the walls
- Divert telephone calls
- Check your appearance
- Smiling can be misinterpreted, especially in an emergency situation
- Don't be frightened to use your hands to express yourself and emphasis points
- Avoid jargon - keep it simple

Appendix 14 –

Critical areas Staffing numbers not stated as dependant on day of week/service provision/BHD or weekend/working practices.

Minimum staffing levels provided as a guide per clinical area Review doc. nursing staffing is per ward/area agreed minima.

This is a guide and will be dependent on the situation.

	Critical Functions	Roles to deliver the critical functions	Total Number of staff associated with the delivery of the critical function
Corporate Services	**Critical** - Site Management	Key for bed management	2 per site but dependent on incident and incident stage could be more - admin support for data pulling key
	Essential - Integrated Discharge Team (IDT)	Key to patient flow and discharges across the health community	
	Critical - IT Services	See local BCM plans	
	Essential - Operations centre – for patient flow		
Support Services	**Essential/Critical** - Cleaning and Support services - dependant on area and service requirement (i.e infection control risks)		Domestics Christmas service: 2 staff members per ward (=52 GRH, 48 CGH). In an emergency situation (for a limited period) this could be reduced to 1 staff member per ward plus additional staff to cover areas that pose an infection control risk as required.
	Essential - Transport Services to the community Monday to Friday. Transport/Drivers for Specimen delivery	Prioritise transport requests.	Critical: None. Essential: 8 drivers

	Essential - Taxi Contract for the use of transporting Dialysis patients and Oncology patients	Make provision for the contacted Taxi company t	As required
	Essential - Free Wheelers (Charity)		As required
	Essential - Arriva. private ambulance company who undertake a large proportion of our discharges and transfers.		With liaison with GWAST
	Essential - Admin and Clerical - key functions such as: switchboard, ED reception, basic medical sec cover, ACU ward clerks.		ED reception - Critical: min 1 staff member 24hour cover. Essential: 2 in busy times depending on situation
	Essential - Portering and waste removal		Critical: 16 staff members per site (24hour cover). Waste: 3 staff members per site
	Essential - Estates Services (estates officers, tradesmen and helpdesk staff) both in hours and on call to both acute hospitals and all community hospitals, health clinics, GP surgeries. To undertake urgent repairs and maintenance to equipment and premises.		2 staff members per site
Surgery	**Critical** - Theatres	Emergency theatres CGH and GRH require Radiology/pathology	Minimum as on-call service but dependent on nature of incident.
	Critical - Critical Care		
	Critical - SSD	BH/W/E cover	CGH Christmas working: 1 manager on call out of hours. Saturday working: 6 staff. GRH Saturday: 10 staff (estimate)
	Critical - Fracture Clinic	After 3 days	
	Critical - On call services	Across all areas	

	Essential - Outpatients	2 week waits, urgent new patients, follow ups awaiting results, patients in a timed pathway	
	Essential - Cancer and urgent elective surgery		Prioritise
	Essential - Vascular lab	For Stroke and vascular pathways	Prioritise
Diagnostics and Specialties	**Critical** - Inpatient Imaging service	Staff would be prioritised to cover	Imaging (similar levels required at both sites) If 1 day issue; 0800 - 17.00 hrs = 6 x Radiographers, 2 x Sonographers, 3 x support staff, 1x secretary, 1 x Radiologist.17.00 - 24.00 hrs = 3 x Radiographers, 1 x support staff, 1 x radiologist 24.00 - 08.00 = 1 Radiographer. Imaging GRH = 3 Day issue; 08.00 - 17.00 hrs = 8 Radiographers, 3 x Sonographers, 4 x Support staff, 2 x Secretary, 2 X Radiologist,17.00 - 24.00 hrs = 3 x Radiographers, 2 x Support staff, 1 x radiologist. 24.00 - 08.00 hrs = 1 Radiographer.
	Critical - Imaging support to ED, 24/7	Staff would be prioritised to cover	
	Critical - Haematology/ Blood Transfusions		Critical: 4 Biomedical scientists/2 MLAs. Essential: 12 Biomedical scientists/2 MLAs. Transfusion: 4 (including 2 for 24 hour cover).
	Critical - Chemical Pathology		Critical: 4 Biomedical scientists/2 MLAs. Essential: 13 Biomedical scientists/ 2MLAs
	Critical - Specimen Reception (PAN)		Critical: None Essential: 10 MLAs
	Critical -Phlebotomy (inpatient)		Critical: 14, Essential 25
	Critical - Microbiology		Critical: 2 Biomedical scientists. Essential: 16 scientists, 12.5 MLAs
	Critical - Histology (Frozen section service)		Critical: 1 cons/1 Biomedical scientist.
	Critical - Non-gynae cytology		Critical: 1 Biomedical scientist. Essential: 1 Biomedical scientist

	Critical - Pharmacy (all in-patient & chemo related work)		CGH (Planned Saturday working staffing) 1 pharmacist and 1 technician on wards for UTOPIA 9-2pm. Dispensing: 1 pharmacist, 1 technician, 1 ATO. GRH: 2 pharmacists, 2 technicians, 1 assistant. If for example strike action was mid-week, would plan to double staffing numbers
	Critical - Rendcomb Ward CGH	Requires transport to bring patients in and return home following treatment and requires staff to be able to travel to work to provide the service	
	Critical -Lilleybrook Ward and 24hour Chemotherapy Helpline assessment area CGH.		
	Critical - Chemotherapy and Supportive treatment Day Care provision in Oncology Outpatients CGH		
	Critical - Edward Jenner Unit GRH		
	Critical - Radiotherapy		
	Essential - Nuclear medicine	The EDTA service would need to run as result is used to calculate chemo doses. NM therapies are also an essential patient treatment	
	? Essential - Domiciliary Dietetic visits to home enterally fed patients	Some of these patients may end up being admitted if not able to visit at home	
	? Essential - Occupational Therapy (dependant on length of time)	Cars used for home visits with/without pt, for purpose of assessment and clinical decision making, to facilitate discharge and/or supply and fit equipment vital for safe discharge - GIS deliveries to equipment sub stores could be hampered creating problems for discharge home	
	Essential - Phlebotomy (outpatient and primary care)		

	Essential - In-patient Physiotherapy		1 Physio per site required for out of hours/weekend on call. For Christmas day type cover 8-9 physios required per site, for up to 3 days 24-27 required per site.
	Essential - Radiopharmacy		
	Essential - Health Records		
	Essential - Out-patient Nursing (dependent on length of time)	Priorities only / redistribution of staff or use of area to support incident	
	Essential - Infection Control Team		
	Essential - Palliative Care Services		
	Essential - In-patient SALT		? Dependent on situation
	Essential - Booking office for cancelations/ rebooking		
Women's and Children's	**Critical** - Acute care in Paeds	Key staff paediatrics - Paeds nurses who follow up children at home	
	Critical - Paeds Oncology		
	Critical - Neonatology		
	Critical - Paed arrivals via ED		
	Critical - Deliveries and emergency C Sections	Key staff maternity - community based midwives	
	Critical - Fetal medicine		
	Essential - Gynae oncology surgery	Prioritisation only	
Medicine	**Critical** - Renal dialysis including PTS and taxi service		
	Critical - Respiratory Assisted Discharge team (COPD)		

	Critical - Cardiac Investigations and Cath Lab		
	Critical - Consultant on call service		
	Critical - Emergency Department / activity		
	Critical - Unscheduled care including ACUs		
	Critical - Endoscopy (due to current demand)		
	Essential - 2 ww outpatient services		
	Essential - outpatient services	Prioritised	
	Essential -Urgent elective inpatient activity	Prioritised	
Catering	**Essential** - Catering services		Hot/partially hot food service to patients: 10 GRH, 9 CGH. Basic cold service to patient's: 6 GRH, 6 CGH. Reduced basic food service for staff: 2-3 staff members at each site
Estates and Facilities	**Critical** - Incident support and maintenance of core services/ utilities		
	Critical - Switchboard		

Appendix 15 – Incident Restoration to normal Action Plan

No	Issue or Service Suspended	Actions to Restore to Normality	Lead	Target Date	Date Recovered
1.		1.			
2.		1.			
3.		1.			
4.		1.			
5.		1.			
6.		1.			
7.		1.			
8.		1.			
9.		1.			
10.		1.			
11.		1.			
12.		1.			
13.		1.			
14.		1.			
15.		1.			
16.		1.			
17.		1.			
18.		1.			
19.		1.			
20.		1.			
21.		1.			
22.		1.			
23.		1.			
24.		1.			
25.		1.			
26.		1.			
27.		1.			
28.		1.			
29.		1.			
30.		1.			

Appendix 16 Escalation and de-escalation levels (Appendix one of) NHS England Preparedness Resilience and Response Framework November 2015


Escalation and Alerting
Coordinating Organisation
NHS Incident Level
Provider
Spec. Comm. and Primary Care
• Capacity and demand reaches, or threatens to surpass, a level that requires wider resources that cannot be accessed by the provider
• A business continuity incident that threatens the delivery of patient services
• Responding to a declared major incident or major incident standby
• A media or public confidence issue that may result in local, regional or national interest
• A significant operational issue that may have implications wider than the provider e.g. public health outbreak, suspect Ebola, security incident, Hazmat incident
Provider with CCGs
1
CCGs
• Capacity and demand reaches, or threatens to surpass, a level that requires wider resources that cannot be accessed by local CCGs
• A business continuity incident that threatens the delivery of essential patient services (in line with ISO 22301)
• Responding to a declared major incident or major incident standby
• A media or public confidence issue that may result in local, regional or national interest
• A significant operational issue that may have implications wider than the local health economy e.g. public health outbreak, suspect Ebola, security incident, Hazmat/CBRN incident
CCGs with NHS England
2
NHS England
Regional team
local office
• Capacity and demand reaches, or threatens to surpass, a level that requires regional coordination or NHS mutual aid e.g. ECMO, PICU, Burns, other specialist function
• A business continuity incident that threatens the delivery of an NHS England function
• A business continuity incident impacting on more than one providers' essential services
• Responding to a declared major incident and/or the establishment of an NHS England Incident coordination centre (ICC)
• A media or public confidence issue that may result in regional or national interest
• A significant operational issue that may have implications wider than the remit of the local office of the regional team e.g. public health outbreak, suspect Ebola, security incident, CBRN/Hazmat incident, Critical National Infrastructure (CNI)
• An incident that may require the request and activation of a military MAC A
• An incident that may require the activation of the National Ambulance Coordination Centre (NACC)
NHS England Regional team
3
NHS England
Regional team
• Capacity and demand reaches, or threatens to surpass, a level that requires national coordination or NHS mutual aid e.g. ECMO, VHF, Burns, other specialist function
• A business continuity incident that threatens the delivery of an essential NHS England function or a protracted incident effecting one or more NHS England sites
• A business continuity incident with the potential to impact on more than one region
• A declared major incident which may have a significant NHS impact and/or the establishment of an NHS England Incident coordination centre (ICC)
• A media or public confidence issue that may result in regional, national or international interest
• A significant operational issue that may have implications wider than the remit of the regional team e.g. flooding, security incident, Hazmat/CBRN incident, Critical National Infrastructure, collapse of a commissioned supplier that provides services to more than one region
• An incident that may require the request and activation of a military MAC A
NHS England
National team
• Capacity and demand reaches, or threatens to surpass, a level that requires international coordination e.g. ECMO, VHF, Burns, other specialist function
• Invocation of central government emergency response arrangements
• Issues that may require invocation of 'Emergency Powers' to be invoked under the CCA 2004 or measures under Sections 252A or 253 of the NHS Act 2006
• A business continuity incident with the potential to impact on significant aspects of the NHS e.g. NHS Supply Chain, NHS Blood and Transplant
• A business continuity incident with the potential to impact on significant aspects of the delivery of NHS England
• A declared major incident which may have national and/or international implications e.g. CBRN, MTFA
• A media or public confidence issue that may result in national or international interest
• A significant operational issue that may have implications wider than the remit of the NHS e.g. Critical National Infrastructure
• An incident that may require the request and activation of a military MAC A
NHS England National team
4
Department of Health