The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	25 July 2011
Title:	Emergency Preparedness
Executive Summary:	This report covers the following areas: • An update on Emergency Preparedness activities for quarter 1 (April – June 2011) • Revision of the Major Incident Plan
Action Requested:	To Note: Activities undertaken for Emergency Preparedness in quarter 1. To Approve: Revised Major Incident Plan
Report of:	Director of Planning & Contracting
Author: **Contact Details:**	Head of Emergency Preparedness Tel:01902 694470 Email:diane.preston@nhs.net
Resource Implications:	Nil
References: **(eg from/to other committees)**	Emergency Planning Committee Major Incident Sub Group Business Continuity Sub Group
Appendices/ **References/** **Background Reading**	Appendices Appendix 1 – Major Incident Plan Background Reading/References Civil Contingencies Act 2004 (CCA) Emergency Planning Guidance 2005 Emergency Response & Recovery Guidance Aug 2009 Revision to Emergency Preparedness Chapter 5 Emergency Planning – Cabinet Office The Operating Framework for the NHS in England 2011/2012, DOH December 2010 Public Health White Paper

NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Trust Management Team should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Update of Emergency Preparedness Activities QTR 1

1.0. Introduction

In line with the CCA requirement of informing and sharing, the Trust Board will be updated on a quarterly basis in relation to emergency planning activities. This report sets out the activities for quarter 1.

1.1. Major Incident Planning

In accordance with Civil Contingencies Act and Emergency Preparedness guidance a revision of the Major Incident Plan has been undertaken. The main changes are as follows:-

- Legislative changes that have occurred since 2010 – CCA is continual being reviewed at the moment as part of the 4 year delivery plan of the Civil Contingencies Act Enhancement Programme.
- Changes to the operation of ERMA Command – now known as Emergency and Resilience Management Arrangements
- Review of Local Policies and their impact on the Major Incident Plan
- Introduction of a central check in point for extra staff in the event of a Major Incident.
- Changes to Silver Control with the introduction of the Community Services On Call Manager; now working as part of the Silver Control Team.
- Changes to some sections with the integration of the community services.

It is recognised that more detailed work needs to take place with the integration of community services and therefore this plan is the start of that integration.

The revised Major Incident Plan is in Appendix 1 for approval.

1.2. Business Continuity Management

The Business Continuity Strategy for the Trust is currently under review along with the

	Directorate business continuity and the community services plans. An up-date on this will be provided as part of the quarter two review of emergency preparedness activities in October 2011.
1.3.	Heatwave Plan The revised Heatwave Plan has been developed and reflects the changes in the National Heatwave Plan for England 2011. The key changes to the National Heatwave Plan for 2011 are few, to reflect changes to some structures and organisations since 2010. The Trust's revised heatwave plan now includes the merger of actions for community services and is available on the emergency preparedness intranet site.
1.4.	Training Undertaken ➢ Loggist Training – 31st May 2011, 23rd June 2011 and 18th July 2011 ➢ Silver Command Training – 24th June 2011 – this was the first combined emergency preparedness training with the community services managers, which highlighted some actions to be taken forward as part of the integration of community services in emergency planning. ➢ ERMA command training led by the West Midlands Conurbation Health Emergency Preparedness Team for Directors. ➢ Business Continuity Training for Emergency Planning Lead on Training and Exercising. I.T Business Continuity Exercise planned for 24th August 2011. ➢ Trust induction awareness sessions
1.5.	External Assurances Emergency Planning, Business Continuity and Governance Audit 2010/2011 This Audit took place during the last financial period. The aim for this was for the SHA to create a rich picture of health sector resilience across all Trusts to identify more clearly the strengths and particular issues that need to be prioritised for further development going forward. The overview assurance has been shared with the SHA's Operational Management Executive Committee (OMEC), which provided an overview of the RAG rating and ranking of Trusts across the region in relation to levels of compliance. The outcome of this audit was issued in July 2011, along with the Trust's overall rating and the particular areas of compliance that indicated areas for further development. In summary the Trust was RAG rated as Amber. There were 11 areas which needed further development. Some of the areas for development had already been highlighted

	as part of the work programme for 2011/2012 and other areas of development are being built into the work programme for this year. A further audit will be conducted near the end of the current financial period in order for the SHA to gain the necessary assurances that overall levels of compliance and resilience have improved.
1.6.	<u>CBRN – Chemical, Biological, Radiological and Nuclear</u> A CBRN review took place in March 2011, by the West Midlands Ambulance Service. Formal feedback has now been received. It was recognised that the Trust has a very proactive approach to CBRN preparedness and very good procedures in place supported by action cards which are tested on a regular basis through training. It was also noted that the Trust has a good and well evidenced training programme in place for both induction of new staff and ongoing specific training. There were no recommendations made. The next CBRN Audit will take place in January 2012, details of which will be sent during October 2011.

The Royal Wolverhampton Hospitals NHS Trust

Major Incident Plan
July 2011

If the Major Incident Plan has been activated, and you have not read this document for a while, do not attempt to do so now.

Find your relevant action card and follow the instructions

Version:	6
Status:	Draft
Document Purpose:	This plan has been developed to ensure that the Acute & Community services of the Trust are capable of responding to major incidents of any scale in a way that delivers optimum care and assistance to victims, that minimises the consequential disruption to healthcare services and brings about a speedy return to normal levels of functioning.
Related documents	Major Incident Addendum for Mass Casualties, CBRN/NAIR Plan, Business Continuity Plans, Pandemic plan
Equality Impact Assessment	This plan will have no impact.
Accountable Director:	Director of Planning & Contracting
Author:	Head of Emergency Preparedness
Board Approval Date	TBC
Review Date Superseded Documents	2012 June 2011

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Appendices

Glossary of Terms

A&E	Accident & Emergency Department
CBRN	Chemical, Biological, Radiological and Nuclear
CCA	Civil Contingencies Act 2004
CCAEP	Civil Contingencies Act Enhancement Programme
DOH	Department of Health
EAU	Emergency Assessment Unit
ERMA	Emergency and Resilience Management Arrangements
HPA	Health Protection Agency
HSE	Health & Safety Executive
HALO	Hospital Ambulance Liaison Officer
LSMS	Local Security Management Specialist
METHANE	Major Incident, Exact Location of Incident, Type of Incident, Hazards, Arrival Time, Number of Casualties, Emergency Services activated.
NAIR	National Arrangements for Incidents Involving Radioactivity – this is a scheme for dealing with incidents involving radioactivity material.
PPE	Personal Protective Equipment
PCT	Primary Care Trust
RWHT	Royal Wolverhampton Hospitals NHS Trust (the Trust)
RCMT	The Trusts - Royal Capacity Management Team
STAC	Scientific & Technical Advice Cell – provides advice on the health and environment consequences of an incident.
SHA	Strategic Health Authority
WMAS	West Midlands Ambulance Service
WMFS	West Midlands Fire Service

FORWARD BY CHIEF EXECUTIVE

The Royal Wolverhampton NHS Trust (RWHT) recognises that planning for emergencies is an integral part of good business practice for any organisation. It is particularly important that public service organisations can continue to deliver their essential functions and that are able to respond to the needs of the community in emergency situations.

The changing environment presents new challenges for RWHT, NHS and partner organisations. Structural or organisational changes, or new ways of working, potentially challenging the ability to deal with emergencies. RWHT will continue to fulfil its statutory duties under the Civil Contingencies Act and the Operating Framework whilst undergoing this transition as part of the latest NHS reforms and its acquisition of community provider services.

We will continue to have a core role in planning for and responding to any incident with major consequences for health or health services, in partnership with our local multi-agency organisations; PCT Clusters and the emerging Clinical Commissioning Groups, Wolverhampton City Primary Care Trust, Wolverhampton City Council, other parts of the NHS and the emergency services.

RWHT has reviewed its existing Major Incident Plan in line with new legislation and has updated the plan as necessary.

The procedures in this plan should not be regarded as rigid but rather as flexible guidelines to be used to address any unanticipated emergencies. It is the responsibility of all staff to familiarise themselves with the Trusts response to a major incident, and that they make themselves aware of the requirements that will be expected of them as contained in the action cards available on the Trust intranet http://intranet/emergencypreparedness/major_incident_cards.html; or within each service across the Trust, in order to be able to manage such incidents.

Every member of staff plays a vital role in ensuring a professional NHS response. As such it is essential that you are familiar with how the Trust will operate, what role you may play and how we will work with other organisations.

An emergency, by its nature, is a stressful and uncertain situation. As such it is vital that you feel supported by an effective management team, who will work with staff to co-ordinate the response. There may be a need for staff to be flexible, work in unfamiliar environments and for extended periods and we rely on your co-operation and support in order to manage any crisis effectively

The arrangements contained in this major incident plan will be rehearsed regularly through communication exercises every 6 months, table top exercises at least once a year, and a live exercise every three years as a minimum. It is important for staff to become fully involved in these exercises, as they provide the impetus for the plan to be updated and improved in the future.

Signed

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David Loughton CBE

Chief Executive
The Royal Wolverhampton Hospitals NHS Trust

Statement on Health and Safety

The Health and Safety Executive (HSE) is the enforcing Authority for Health and Safety law in relation to the health services. The HSE will be involved in any criminal investigation of a Health Authority's or Trust's role in a major incident, but the police would lead the investigation of any possible manslaughter case.

In a major incident it is very easy to become absorbed by the events unfolding around you and to forget that the usual rules and regulations regarding health and safety apply. Reference to the RWHT Strategy for the Management of Health and Safety within the Trust, HS 01 Management of Health and Safety and Health and Safety Polices on the Trusts Intranet should be referred to.

It is essential that these regulations are observed during a major incident and that the same thought processes with regard to risk assessment and management are adhered to in the same manner as any other task during the working day.

Appropriate personal protective equipment (PPE) and procedures must be used and followed, as must Trust Policy and Procedures for issues such as infection control, manual handling or the safe use of hazardous substances. As with any other task if you are unsure of anything during a major incident seek advice from the appropriate person.

Statement on the Preservation of Evidence

Major incident scenes are considered to be scenes of crime until proven otherwise and consideration must be given to the preservation of forensic evidence. Such evidence – clothing, debris may leave the scene with casualties and as a result be present in the A&E department and other areas of the hospital.

Major Incidents may be caused by criminal acts and are likely to be subject to subsequent investigation. This may be in the form of a Criminal, Judicial or Coroners enquiry.
The preservation of life and clinical necessity will always take precedence over the gathering of evidence and the maintenance of the chain of evidence. However, staff must not use this principle to obstruct deliberately or tamper with evidence in any way.

Although you are working under considerable pressure at the time of an incident all documentation should be adequate, clear and accurate. The pressures of a major incident do not remove your professional accountability for practice, and you may well be asked to justify any actions that you take at a later date.

It is essential that all staff bear in mind the absolute need for ALL paperwork, patients' property and clothing to be preserved. It is essential that any dry wipe boards used are preserved until they can be recorded using cameras for submission to the relevant investigating agencies.

All Local Security Management Specialists (LSMS) are crime scene trained and the Trust's LSMS will offer advice/support in the event of an incident which is caused by criminal act.

AMENDMENT RECORD

No unauthorised amendments permitted.

This plan is a living document and is under constant review. A record of amendments follows any comments or suggestions for future versions are appreciated and should be directed to the Emergency Planning Team.

Amendment Number	Amendments Made	Incorporated By	Date of Amendment
1	Review of Major Incident Plan by Leads for the plan and wider trust who originally contributed to the plan	Head of Emergency Preparedness Clinical Lead for Major Incident Planning	May/June 2010
2	Forward page 5 – statement re Operating framework for England 2010/2011	Head of Emergency Preparedness	24 June 2010
3	Pg 16 Training Section – updated in line with the training activities defined for the Trust.	Head of Emergency Preparedness	24 June 2010
4	Pg 20 Switchboard Cascade list to incorporate Head of Portering & LSMS – a review of personnel on standby.	Head of Emergency Preparedness agreed with Head of Hotel Services and LSMS.	24 June 2010
5	Included the role of LSMS and throughout the plan.	Local Security Management Specialist	22 June 2010
6	Pg 7 updated statement on the Preservation of Evidence	LSMS	22 June 2010
7	Pg 23 All agencies section – inserted Trust Category Responder status	Head of Emergency Preparedness	22 June 2010
8	Pg 40 updated Role of RCMT team in relation to EMS (escalation management system)	Deputy Capacity Manager/Head of Emergency Preparedness	22 June 2010
9	Pg 27 included the role of Loggist and Admin at Silver Command level.	Head of Emergency Preparedness	24 June 2010
10	Pg 45 Updated Security Section	LSMS	22 June 2010
11	Update on legislation and Trust policies have been reflected throughout the plan.	Head of Emergency preparedness	13 July 2011
12	Pg 20 Cascade - call out list updated to incorporate therapy services and community services.	Clinical Lead for Major Incident Planning	8 July 2011
13	Pg 26 updated team roles for Silver Command to incorporate community services	Head of Emergency Preparedness	14 July 2011
14	Pg 29 updated membership of Gold command.	Head of Emergency Preparedness	14 July 2011
15	Pg 31 Updated ERMA to reflect 6.6v of CONOPS plan	Head of Emergency Preparedness	13 July 2011
16	Pg 41 – OPD becoming a check point for staff to report into in the event of an incident.	Head of Emergency preparedness/Health Records Manager	8 July 2011
17	Review of appendices to the MIP	Head of Emergency	8 July 2011

		Preparedness	

Section 1 – Introduction

The statutory NHS Emergency Planning Guidance of 2005 places the responsibility of emergency preparedness with the Chief Executive within each NHS organisation. This, together with the Civil Contingencies Act 2004 (CCA) and the Civil Contingencies Act Enhancement Programme (CCAEP) and the review of Chapter 5 Emergency Planning; revision to Emergency Preparedness places a greater emphasis on major incident planning in the NHS.

Although the Hospital's role is primarily providing medical care and advice as necessary, it is also defined as a category 1 responder under the Civil Contingencies Act 2004. (*Category 1 responders are those emergency services which are likely to be in the forefront of the response such as health and the Police, Category 2 responders are those organisations whose function is likely to be in support such as transport.*)

This places a statutory duty on the Trust to undertake certain additional functions:

- To undertake the risk assessments relevant to the area served
- To maintain plans to ensure that, if an emergency occurs, the Trust can continue to perform its essential functions
- To arrange for the publication of all/part of the plans made
- To maintain arrangements to warn the public and to provide information and advice to the public if an emergency occurs.

To ensure that the Trust is able to fulfil these obligations, it is important that it is involved in the wider planning process with partner organisations.

NHS Trusts have a duty to protect and promote public health, to plan and to be able to respond to any incidents, which threaten the health of the population or health services.

Major Incidents can take many forms, and the effects may be complex and unpredictable. This plan is intended to be implemented in whole or part to suit a range of circumstances.

Recent years have seen a diverse range of emergencies and disasters; with the increased threat of terrorism and possible disasters attributable to natural causes such as extreme weather, indicate the need for health organisations to plan for much larger incidents. We are in a time of increased awareness and knowledge and being prepared is part of that culture.

This plan draws together the requirements of the Civil Contingencies Act 2004 and the planning work performed by the many people involved in responding to a major incident. The document is laid out in three parts, the first of which gives the detail of the roles and responsibilities of each department and / or service; the next is the summary of the major incident plan – this is the section that can be referred to for speed in understanding the concept of the plan; the final part is that of the individual action cards which give the action to be performed at stand-by, at declaration and at stand-down of a major incident for individuals and departments. The action cards available on the Trust intranet http://intranet/emergencypreparedness/major_incident_cards.html or within the individual services and should be enacted as part of the plan.

The plan is simplistic in its conception: the A&E Department clears existing patients to the Emergency Assessment Unit, Ward D1 receives incident patients who require admission, supported by theatres and the Integrated Critical Care Unit; and the Outpatients Department handles incident patients for discharge and operates the staffs reporting/check point in the event of an incident. To support discharge and transfer of non-incident patients both adult and paediatrics, community services will be enacted. Any children from the incident will be admitted to the paediatric unit. Clinical and

non-clinical support departments respond to requests for investigations and support the prime responding departments and wards as required.

The information in this plan will ensure that the Trust's approach to emergency planning is in line with ensuring a multi agency integration and management approach.

The Royal Wolverhampton Hospitals NHS Trust is committed to providing a robust system for responding to Major Incidents.

Whatever the incident, our response needs to be flexible and appropriate to the need. To help us to do this we need not only a good Major Incident Plan but also well trained staff who are familiar with and understand their roles within the plan and are able to take the action assigned to them swiftly. This in turn requires systematic, high quality training with refreshers at regular intervals, as well as exercises to translate theory into practice. This will build confidence and familiarity.

The NHS service-wide objective for emergency preparedness and response is:

"to ensure that the NHS is capable of responding to major incidents of any scale in a way that delivers optimum care and assistance to the victims, and minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of functioning; it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries."
(DOH Handling Major Incidents: An Operational Doctrine, May 2004)

1.1 Civil Contingencies Act 2004

http://www.cabinetoffice.gov.uk/content/emergency-preparedness

The Civil Contingencies Act 2004 (CCA 2004) places legal requirements on a wide range of public bodies, including all NHS organisations together with Foundation and Mental health Trusts.

The CCA requires acute NHS organisations to undertake risk assessments on local risks and hazards, and to tailor their emergency plans to the actual risks that are faced. These may be external risks such as the transport infrastructure of the local area, or internal risk, such as loss of staff or premises.

The CCA, and accompanying regulations and non-legislative measures, will deliver a single framework for civil protection in the United Kingdom capable of meeting the challenges of the 21st century.

The CCA designates a wide variety of public sector organisations as "Category 1" responders. Within the NHS, this includes all acute and ambulance NHS trusts and all Primary Care Trusts. Strategic Health Authorities are designated as "Category 2" responders (Appendix A).

Community, Mental Health and Specialist Trusts are not formally categorised under the CCA, however the Department of Health Guidance expects them to plan, prepare and respond for such events in the same way as those designated as category 1 responders. Hence the Healthcare Commissions' Core Standard 24 monitors all NHS organisations against the same criteria.

These bodies face statutory duties in six specific areas:

1. Co-operation with other responders
2. Risk assessment
3. Emergency planning
4. Communicating with the public
5. Information sharing

1.2 Definition of a Major Emergency / Incident

The Civil Contingencies Act (2004) defines a Major Emergency as:

'An event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, war or terrorism which threatens serious damage to the security of the UK.'
(Civil Contingencies Act, 2004)

For the NHS, "Major Incident" is the term in general use. With the implementation of the Civil Contingencies Act, the term "emergency" may be generally used. However, it has been agreed that the NHS will continue to use the term "major incident" to avoid confusion with other services which it provides.

Within the NHS The Department of Health Emergency Planning Guidance (2005) states:-

'A major incident is any event whose impact cannot be handled within routine service arrangements. It requires the implementation of special procedures by one or more of the emergency services, the NHS, or a Local Authority to respond to it.'
(Emergency Planning Guidance, 2005, Department of Health)

Any Occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organizations.
(Emergency Planning Guidance, 2005, Department of Health)

"Major Incident" is therefore a term used to describe an event, incident or set of circumstances that requires the implementation of special arrangements to manage it effectively. There are various types of events that may give rise to a major incident. They are:

- Big Bang – e.g. a serious transport accident, explosion, or series of smaller incidents
- Rising Tide – e.g. a developing infectious disease epidemic, or a capacity / staffing crisis. Pandemic flu is the major concern at the time of writing.
- Cloud on the Horizon – a serious threat such as a major chemical or nuclear release developing elsewhere and needing preparatory action
- Headline news – public or media alarm about a personal threat
- Internal incidents – such as fire, breakdown of utilities, major equipment failure, hospital acquired infections, violent crime [these are dealt with under the Hospitals Business Continuity Plan]
- Deliberate release of chemical biological or nuclear materials
- Mass casualties – where it is not possible for one organisation to cope with the number of people affected.
- Pre-planned major events that required planning, demonstrations, sports fixtures, air shows".

[Emergency Planning Guidance 2005, Department of Health]

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121072

It is also possible that a significant event in another part of the country or internationally could require emergency response and preparations, as was the case with the fuel crisis, September 11th 2001 and July 7th 2005 in London.

Historically, the NHS has been expected to respond, more or less independently, to emergencies arising. It is now expected that all Catergory 1 responders (as defined by the Civil Contingencies Act 2004) will liaise with each other in the preparation of emergency plans, to ensure a joined up approach to any response.

In an ever changing global society, the preparation of emergency plans must also now consider escalation levels above anything previously considered before. The Department of Health has categorised major incidents on a scale, according to their impact on the NHS. The levels of incident for which NHS organisations are required to develop emergency preparedness arrangements are:

- Major (Level 1)

Individual ambulance trusts and acute trusts are well versed in handling incidents such as multi-vehicle motorway crashes within the long established major incident plans. More patients will be dealt with, probably faster and with fewer resources, than usual. It is possible to maintain the usual levels of service or resume 'normal' service shortly after.

- Mass (Level 2)

Much larger-scale events affecting potentially hundreds rather than tens of people, possibly also involving the closure or evacuation of a major facility (for example, because of fire or contamination) or persistent disruption over many days. These will require a collective response by several or many neighbouring Trusts.

In the event of a mass casualty incident Emergency Pods of supplies (Appendix B) are held at West Midlands Ambulance Service Headquarters at Dudley. These pods contain additional supplies, which will be required in the event of a mass casualty incident.

- Catastrophic (Level 3)

Events of potentially catastrophic proportions that severely disrupt health and social care and other functions (for example, mass casualties, power, water etc) and that exceed even collective local capability within the NHS.

There are also other events that are not usually associated with major Incidents that may lead to unnecessary strain on the NHS, and require a Major Incident response. Examples include: fire, power failure, national fuel strikes and drought. These events should be covered by Business Continuity Plans of the organisation.

In the examples given below it may be more appropriate to invoke the Business Continuity Strategy http://intranet/emergencypreparedness/business_cont.html and local business continuity plans.

- If the Hospital is experiencing a greater number of inpatients than its available capacity
- If the integrity of buildings have been compromised, e.g. fire, flood, explosion
- If the A & E Department has to activate its decontamination procedure.

The major incident plan may also be activated through internal routes where a clinical area is forced to close due to an emergency this decision would be made by an Executive Director following discussions with the on call manager. The plan could be activated due to a major fire, contamination, explosion, utility failure, flood or security emergency.

1.3. Aims of the Major Incident plan

The aims of the plan is to ensure that The Royal Wolverhampton Hospitals NHS Trust (RWHT) is;

- able to respond to a major incident in a co-ordinated manner in a way that minimises the impact of the emergency situation on the functioning of the organisation.
- provides an effective response to the incident
- supports and protects the sick and the vulnerable
- ensures that the Trust returns to normality as soon as possible, whilst understanding the impact that the event has had on the staff, resources and primary objectives.

1.4 Risk Assessment

The Trust has a duty to assess the various risks and hazards that are likely to cause activation of the Trust Emergency response. Emergency preparedness is identified as a risk on the Trust's Risk Register.

Together with the risks that are specific to the Trust, there are also those common to all emergency services and supporting agencies. These risks form part of the Community Risk Register, which is co-ordinated by the Wolverhampton Resilience Forum and provides details of the hazards that exist in the local area and the control measures that are in place to mitigate their impact.

The principle external risks for the Trust are considered to be:

Transport Incidents

- Road Traffic Collisions
- Railway incidents
- Problems could arise because of industrial action or natural disasters, and could adversely affect staffing, movement of patients including discharges and supplies. Contingency plans exist for national fuel shortages.

Civil Disturbance / Mass Gatherings

- Large gatherings / crowd related incidents

Environmental Pollution

- Hazardous industrial sites

Terrorism

In addition to any foreseeable road/rail incidents, or industrial emergencies, all Category 1 responding agencies must acknowledge that the UK terrorist threat is very real and credible. Evidenced recently by incidents in London, Manchester and Glasgow Airport, and the arrest of several persons engaged in plotting terrorist attacks.

The Government has clearly warned us that:

"In the case of a large scale terrorist attack in the UK, is not a matter of it, but when"

We must consider the potential terrorist threat, and be prepared to deal effectively with the potential for a "mass casualty Incident"

The current terrorist threat includes a risk of a major Chemical, Biological, Radiation or Nuclear (CBRN) attack within the UK. In such an event there is a real risk of a contaminated patient(s) self presenting at Accident and Emergency. In order to protect staff and patients, the Hospital may have to restrict access and implement "Lock Down" procedures.

The internal risks that pose problems for the Trust are:

- A Pandemic Flu or an Outbreak of an infectious disease
- Loss of staff – either through illness such as an infectious outbreak or through inability to work
- Loss of hospital premises – due to a fire, bomb threat or contamination
- Loss of utility arising as a result of external failures or internal damage, whether accidental or malicious. The services concerned could include gas, oil storage, electricity, water, drainage and medical gases. Contingency plans have been produced by the Estates department, although the likely effectiveness and length of time the hospital could function under these varies substantially according to service.
- Loss of communications again could arise as a result of external or internal damage, whether accidental or malicious. The services involved could include our IT systems, including the Patient Administration System, departmental patient related systems like Pathology, telephone systems including mobile phones, bleeps, pagers, and radios. Alternative communication means will have to be used in the event of system failures.

The arrangements for the Trust to deal with a Pandemic Flu outbreak are dealt with under a separate plan. (http://intranet/emergencypreparedness/pandemic.html)

1.5 Business Continuity

The CCA places a statutory responsibility on every Category 1 Organisation to prepare and maintain business continuity plans; with the aim of protecting the essential services of the organisation throughout the duration of an emergency.

All health organisations have practised business continuity planning to some extent, often as part of other work such as IT development, general risk management etc, the CCA makes comprehensive business continuity a statutory requirement.

It is important to separate business continuity from a health organisation's role in playing its part in managing external incidents. Business continuity can be described as being part of internal emergency planning. It links to emergency planning where an external incident – e.g: a major incident close to a hospital or a major breakdown in the supply of utilities; reduces the hospitals' ability to function normally. An internal incident, which would of itself impact on business continuity, would rarely also be declared to be a general multi-agency emergency.

The main concept of business continuity is the preservation of essential services, in relation to disruption within the organisation (for example from lack of staff, interruption of a utility or loss of a building).

The main business continuity threats to Royal Wolverhampton Hospitals NHS Trust currently are:

- Loss of staff due to illness – such as pandemic flu or an infectious outbreak
- Loss of staff due to child care commitments/dependents illness (as with pandemic flu)
- Interruption to essential supplies and catering
- Loss of building due to fire, bomb threat or contamination
- Interruption/loss of telephone or IT system
- Interruption to a utility, such as electricity, gas or water (drought)
- Loss of medical gas system within the hospital site.

Facilities and Estates staff are responsible for maintaining arrangements to ensure that essential supplies (such as electricity, gas, water) are maintained.

If the impact of an incident is likely to exceed 48 hours and require significant reduced working and restriction to core services the decision to reduce or continue services will be made by the trust Gold Command in the Gold Control Room located in the IT Training Room in the McHale Building.

1.6 Objectives of the Major Incident Plan

The Trust major incident plan draws on a wide range of guidance that is published on emergency preparedness and response – see national reference documents.

The objectives of the plan are as follows:

- Provide an overview of the Trust's key arrangements for responding to a major incident
- Act as a framework for the Trust, its staff and partners, as well as the public, to support the response arrangements of the Trust.
- Ensure that Trust is able to respond appropriately in the event of a Major Incident.
- To provide training, testing of the plan through exercises
- To ensure there is recognition that staff may be traumatised by the effects of responding to an emergency, and to put in place a mechanism to deal with this.
- To ensure a smooth transfer of control for business continuity consequences to minimise the consequential disruption to Healthcare Services.

1.7 Dissemination of the Plan

The Major Incident Plan will be presented in a loose leaf format; to facilitate changes without waste. A numbered high-visibility folder will aid easy recognition. Each area that receives a Major Incident Plan will be asked to sign for their copy. This is to ensure that everyone is working from the same document and that any, which become misplaced, can be returned. The plan will also be available on the Trust Intranet. http://intranet/emergencypreparedness/major.html

1.8 Review of the Plan

The plan will be reviewed annually and if necessary, amended and undergo a complete revision and re-issue every 3 years. Updates will be made as appropriate following any new guidance received from the Department of Health, changes to national policies or following lessons learnt from training exercises and or major incidents. Any updates to the plan will be disseminated appropriately. Any changes occurring within departments that may alter the actions of those departments during a major incident should be documented and sent to the Head of Emergency Preparedness in Hollybush House.

1.9 Training, Exercising and Testing

Major incidents are rare but they do happen. Many factors cannot be controlled, such as the type and location of the incident or the time of day. What can be controlled is the degree and quality of the preparation; the planning, testing and training that has taken place prior to the event.

The Civil Contingency Act 2004 requires Chief Executives of NHS organisations to ensure that arrangements are in place for training, exercising and testing of plans.

1.9.1. Training

Within the Trust's Emergency Preparedness Strategy each department is responsible for identifying the people involved in the action of their plans, and noting the training requirements. (http://intranet/emergencypreparedness/index.html).

This will range from formal training to reading and understanding of the departmental response. The Trust Training Database, Kite has a section dedicated to Major Emergency Planning and provides monitoring of all the relevant training. It is however the responsibility of Departmental Heads to ensure that staff are trained appropriately for their role in an incident.

- Formal training will take place for key members of A&E staff involved with decontamination and radiation preparedness on a yearly basis, which will be led by the Trust's Lead for CBRN (Chemical, Biological, Radiological and Nuclear).

- As part of the Trust's response to a major incident, managers who are members of the Gold and Silver Control teams will receive training at least yearly, with updates in between times if changes occur.

- For all other staff, as a minimum they will be required to have read their own action cards for their department/service and be able to respond when an incident occurs. An assurance to this effect must be gained by signature from the department lead.

- Awareness training for emergency preparedness forms part of the Trust's induction which is available to all new comers to the Trust on a monthly basis.

- Media Training is offered for those that may have to respond to the press by radio or TV.

- Training & exercising in partnership with other NHS organisations, the emergency services and local authorities is encouraged.

1.9.2 Exercising & Testing

The Trust is required to carry out a number of validating exercises. These may take place in and out of hours. Exercises are designed to test systems and not individuals. They should help all of us to respond effectively to stressful events.

The minimum requirement for tests and exercises is as follows:

- A 'live' exercise every three years (unless the Trust is involved in an actual major incident, in which case this can be classed as a live exercise)
- A 'table top' exercise every year
- A test of communications cascades every six months

[*Health Emergency Planning Guidance 2005]*

Any message that is received or given, in relation to an exercise, must have the word EXERCISE clearly stated every time. If there is any doubt, staff must ask the caller if it is an exercise – DO NOT presume.

After an exercise, as per a real incident, a debrief of all participants involved will be undertaken along with a report written both by the Trust and other participants to capture lessons learnt and any changes which may need to be made to the plan.

The Trust produces on a yearly basis, a training and exercise programme to test various elements of the Trust's Major Incident Plan; which also covers Business Continuity and Pandemic Influenza planning.

Section 2 – Activation of the Plan

The Emergency Services at the scene will make judgements as to the nearest or best able Hospital to receive casualties. The chosen Hospital is called the "Receiving Hospital" and a number of others may be given the role of "Supporting Hospital". This alerts the locality to the possibility of self presenting casualties and informs the supporting hospitals that they may be stepped up to receiving status, if required. This Trust will use the standby command if nominated as a supporting hospital.

A Major Incident may be declared by either external or internal sources:-

External Sources could be

- The Emergency Services
- The Primary Care Trusts
- The Health Protection Agency
- The Strategic Health Authority
- Any other external agency, which requires NHS support

Internal Sources could be

- The Chief Executive
- On Call Duty Director
- A & E Consultant following liaison with the Chief Executive or On Call Director

The traditional method for activation of The Royal Wolverhampton Hospitals NHS Trust Major Incident plan is for the Emergency Services, usually the Ambulance Service to notify switchboard or A&E via a designated hotline; who will then activate the Major Incident Plan.

The A&E Department Consultant may feel the need to activate the plan in certain circumstances, should the Consultant deem this necessary they should consult the Chief Executive or the On Call Director of the Trust. If the decision taken is to activate the plan, the Nurse in charge of A/E must notify switchboard by dialling 2222.

There are several reasons why this could happen:

- Self presentation of casualties from one or more incidents at A&E in a short space of time without notification from the emergency services.
- The self presentation of patients to A&E Reception who may be contaminated with chemical, biological, nuclear or radioactive agents, it will then be necessary to activate the Decontamination Procedure.

- The A&E Department may well be able to deal with a road traffic accident involving a number of casualties, without calling a Major Incident. This will be left entirely to the discretion of the A&E Consultant on duty at that time.

Example

In the event that RWHT declare an internal major incident ie for a fire, contamination, explosion, utility failure or flood on Trust premises.

The switchboard and West Midlands Ambulance Service should be notified immediately.

Switchboard via 2222
*WMAS Control *3035*

However, internal pressures on bed capacity would not be considered a reason for triggering a major incident response internally.

There are four standard messages:

- Major Incident Standby
- Major Incident Declared
- Major Incident Cancelled
- Major Incident Stand down

2.1 Major Incident Standby

Is a potential pre-cursor to a full declared Major Incident. It usually means that the emergency services have been notified of an incident, and are yet to undertake a full assessment of it. For example, a fire has occurred in a building where a number of the occupants are unaccounted for.

The standby command may be received to alert the Hospital to a supporting Hospital status, this status can change at any time.

A Major Incident Standby does not always lead to a full declared major incident. Consequently, the Trust response is to limit the amount of people who are informed, to prevent unnecessary interruption to normal services. However at Standby the Local Security Management Specialist (LSMS) should also be notified.

Upon receiving the command '*MAJOR INCIDENT STANDBY'* the Trust will make preparations to get ready for casualties to be received in the A&E Department. Switchboard will call a limited number of departments and services, from the Call Out List (See 2.6 Cascade Call Out for further information), and inform them "Major Incident Standby". They will make an assessment for a response in the event of the incident being declared. This can range from the checking of Duty Rotas, for numbers of staff available; to assessing the amount of capacity in the Trust.

2.2. Major Incident Declared

(This message may come after a Major Incident Standby or without prior warning). A major incident that is formally declared means that the ambulance service have assessed the situation, designated "receiving" hospitals (of which The Royal Wolverhampton Hospitals NHS Trust is one), and will transport major incident patients to these hospitals.

Upon receiving the command '*MAJOR INCIDENT DECLARED'* the Trust will activate the whole Major Incident Plan. The Switchboard will contact all departments and services on their Call Out List (see 2.6 Cascade callout), with the command 'Major Incident Declared'. This alerts the relevant Wards and departments to activate their plans immediately.

If the Trust plan is activated internally, The Royal Wolverhampton Hospitals NHS Trust switchboard must be informed to initiate the "Major Incident Declared" cascade process. Communication of the activation of a major incident for the Trust must be made to the ambulance service.

2.3. Major Incident Cancelled

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

2.4. Major Incident Stand Down

At the scene of an incident the stand down procedure will be initiated by the Senior Police Officer at the site after consultation with the liaison officers of the other emergency services. They will determine when the site has been cleared and the Major incident can stand down.

The Ambulance Incident Commander will ensure that all designated hospitals are informed via the Ambulance Liaison Officer as soon as all live casualties have been removed from the scene. They will inform where possible whether any casualties are still en-route.
It may be a little while afterwards, however, that the A&E Department has treated and cleared the casualties, and can return to normal working. The A&E Consultant and / or Nurse In Charge will discuss with the Silver Control team Leader, and when an agreement has been reached, the Silver Team Leader will give the command for '*MAJOR INCIDENT STAND DOWN'*. The Hospital Switchboard will then give this command to the people on the Call Out List (shown as table 1). It is expected that this will be communicated directly to the Director on call.

When the stand down message is received, All staff should be made aware of the situation. Although a stand down message has been received, it may be some considerable time before a return to normality is achieved; as some staff may be required to continue with their major incident role until activity returns to normal.

IT IS ESSENTIAL FOR ALL COMMUNICATIONS AND CASCADE CALL OUT TO USE THE CORRECT LANGUAGE AND STANDARD MESSAGES.

On receiving a major incident stand by or declared message from the emergency services, the receiver of the call should complete the Major Incident Information Record Sheet (METHANE sheet) (Appendix C). METHANE is the standard message used by the emergency services to gather details of an incident quickly and consistently. You will receive as much information as is available at the time of the call.

Switchboard should notify The Accident and Emergency Department via the ALERT phone of the information received; followed by two faxes of the METHANE sheet to A&E reception. One will be given to the Nurse in Charge in A/E and the second delivered to the Silver Control Room.

2.5. Cascade Call Out

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

All staff are requested to ensure that line managers have current contact details and telephone numbers. Please update this annually as a minimum frequency.

If you are off duty you may hear about an incident via the media

Please do not come to the hospital unless contacted – you may be needed later, or the following day.

Staff who are off duty are requested not to call the hospital as they will be called by their appropriate manager should their services be required.

Dependent on the extent of the incident, the number and type of casualties and the nature of injuries it is possible that it may be necessary to contact off duty staff. This may be with a request to relieve colleagues who may have already worked long hours.
The Hospital Switchboard is responsible for commencing the cascade of call out for all services and departments in the event of a Major Incident. Switchboard will use either the standby or declared list of people to call, dependent upon the command (*shown as table 1 below*). If the Emergency Services have used the emergency telephone in the A&E Department, then the A&E Department will call Switchboard to activate the call out. The employment of this system activates everyone in the hospital that needs to respond to a Major Incident.

Table 1: Switchboard call out list

CONTACT ALL ON DECLARATION CANCELLED AND STAND DOWN	FOR STANDBY ONLY:	A&E Department
		Matron
		On Call Trust Manager
		On Call Community Manager
		Renal Consultant On Call
		Capacity Manager
		EAU
		Security
		D1
		IT Technician
		Telecoms Manager
		Director On Call - Chief Executive - Chairman - Other Directors if necessary - Gold Control Room
		West Park Hospital
		Hotel Services - Catering - House Keeping - Portering

	ON DECLARATION:	Junior Doctors - Medicine - Surgery - Orthopaedics - Anaesthetics - Paediatrics - Maxillo Facial / ENT
		Consultant Orthopaedic Surgeon
		General Surgery Surgeon On Call
		Senior Nurse Outpatients [during normal working hours]
		Pharmacy
		Haematology
		Clinical Chemistry
		Medical Equipment Library
		On-call Engineer and on-call Building Engineer
		IT Manager
		Chaplains
		Therapy Services
		Stores

As its name suggests the standby list of departments will be called if the Emergency Services have given the command "Major Incident Standby". If the major incident then becomes declared the standby list will be called again and the further departments called.

The command "Major Incident Declared" will trigger the switchboard to call all departments on the callout list.

The command "Major Incident Cancelled" cancels either of the first two messages.

Upon receiving the command "Major Incident Stand Down" from the Silver Control Team, or Director, switchboard will call the total callout list to inform them "Major Incident Stand Down".

The Hospital Switchboard is responsible for contacting the prime people and departments in the event of a Major Incident.

The callout list is in two sections. The first covers the people to be called on standby, these are:

- A&E – This is a confirmation call to the Red Emergency telephone to verify that A&E are aware of the Incident
- Trust Manager on call – The Manager will be contacted by mobile phone using the managers on call rota, the Manager will then call a colleague who can perform the Nursing role within the Silver Control Room.
- Community On Call Manager
- West Park for discharge capacity
- Capacity Manager
- Head of Portering/Charge Hand

- Hotel Services Manager is called or deputy
- Renal Consultant on call – The consultant will be contacted by mobile phone using the Physicians on call rota
- EAU – The call will be made to the Receiving Room to the Nurse in Charge
- D1 – The call will be made to the Nurse in Charge
- Security/Local Security Management Specialist (LSMS)
- Director on Call – The Director will be contacted by mobile phone using the managers on call rota
- Telecommunications Manager
- IT Technician

The second part of the callout list is when a major incident is declared. For declaration without a standby call then both parts of the callout are made. If the Hospital is on standby then the standby list will need to be called again. The list consists of:

- Junior Doctors – Registrars and SHOs from the specialties of Medicine, Surgery, Orthopaedics, Anaesthetics, Paediatrics and Maxillo Facial / ENT are called. The switchboard bleeps the on call / shift doctor with the message 6666. The doctors have been instructed to attend their usual ward of working and await instructions from their Consultant
- Consultant General Surgery Surgeon
- Consultant Orthopaedic Surgeon – The Surgeon will be called using the on call rota
- Senior Nurse Out Patient Department – The call will be made to OPD1 during normal working hours, Silver Control will call out the nurse out of hours
- Pharmacy – The on call pharmacist is called
- Haematology – The Biomedical Scientist for Haematology is called
- Clinical Chemistry – The Biomedical Scientist for Clinical Chemistry is called
- Medical Equipment Library – the on call Renal Technician is called
- Engineer – the on call / onsite engineer is called
- Health Records Manager
- IT Manager
- General Office
- Education and Training – Head of Training & Education/Deputy to open and set up press office
- Chaplain – the on call Chaplain is called
- Therapy Services
- Stores

The Departments will then cascade within their own areas for their colleagues and support areas to respond to the major incident. Where possible automated messaging occurs, including the use of standard text messaging to cascade the response quickly.

It is the responsibility of each ward or departmental manager to keep up to date and accurate contact lists for their staff members who may be required to attend a major incident. These lists should be held by the individual units and only actioned when an incident is declared, based upon the time of day and business continuity needs. *Note: if an incident occurs during the day it is counter productive to call in night staff as they will be required to fulfil their normal duties.*

2.6. ID Badges

STAFF SHOULD CARRY THEIR ID BADGES WITH THEM AT ALL TIMES

All members of staff who are involved in responding to a major incident should be clearly identifiable with a Hospital identification badge.

ID badges MUST be worn by those attending the Hospital in the event of Major Incident. This will be checked as part of the process for extra staff support as outlined in section 7.1 and will provide access to car parks and buildings. All staff should ensure that they are confident that people presenting at the Hospital are legitimate, and will be denied access if they cannot prove this.

If an incident is associated with a high level security, you may not be allowed access to the site without identification.

2.7. Action Cards

Each ward and department should hold their own action card, ensuring that they are readily available giving key instructions of what is expected of staff during a major incident. Where possible, staff will be assigned roles consistent with their routine work.

Action cards will also be accessible on the Trust intranet - http://intranet/emergencypreparedness/major.html

Each ward or department manager is responsible for maintaining and updating their action cards; and ensuring an up to date copy is made available within their area and to the Head of Emergency Planning for inclusion in the Silver control room.

2.8. Phases of a Major Incident

- Pre-Major Incident Plan Phase: this is usually only seen where there is a pre-planned response to a specific type of incident. An example is a flood plan, where a pre-major incident plan warning of impending floods is given to enable organisations to put command structures and key response elements in place in anticipation of the incident.

- Response Phase: this is the first phase for most major incidents. This phase covers the period from initial attendance at the scene by the emergency services to the time when it is deemed the incident is under control and all life that can be saved has been saved. This phase is one of high activity.

- Recovery Phase: this phase follows on from the response phase. This is the phase where an action plan should be identified to restore the scene/Trust back to normality. This phase can run for days, weeks or even years in extreme cases. Recovery is an integral part of the Major Incident management process. In order for RWHT to be prepared for the recovery phase a template is available in the Gold Control Room which is an outline of some general principles and actions to support this. This list is by no means exhaustive and can be adapted to meet the needs of the Trust during the recovery phase of any major incident.

- Normality: this is the final phase where the health community is returned to the state prevailing before the incident occurred or where the scene has been remediated as far as is possible to allow normal life to return.

Section 3 – Command, Control and Coordination

One of the major differences between day-to-day hospital operations and hospital major incident response is the need for a clear command structure.

The key to the successful management of an incident is early command and control which is maintained throughout the incident.

Very few staff will have had prior experience of a major incident and will require direction if they are to work well. An incident command and control structure is important to achieve this.

Command is the direction of the members and resources of an organisation in the performance of its role and tasks. Command relates to organisations and operates vertically within the organisation.

Control is the authority to direct strategic and tactical operations in order to complete an assigned function.

Coordination is the harmonious integration of the expertise of all the agencies involved, with the object of effectively and efficiently bringing the incident to a successful conclusion.

Nationally the responsibility for Emergency Planning is with the Cabinet Office. In the event of an Incident / Emergency occurring, the response will be lead by the most appropriate Department. For some emergencies, this is pre-determined, for example rioting would be controlled by the Home Office. If there is no obvious lead, the Cabinet Office will nominate the Department to take control.

3.1. All Agencies

Responders in emergency planning are split into two categories; this represents core responders [category 1] and co-operating responders [category 2]. For planning purposes the CCA Act requires collaboration and co-operation for when the agencies respond to an incident. The arrangements for command and control in this context are that of strategic, tactical and operational commands. The Trust is defined as a category 1 responder.

3.1.1. Strategic

The term strategic refers to the role a person fulfils who is in overall executive command of their organisation (health, including ambulance services, police, fire etc) with responsibility for formulating with others the strategy for responding to the incident response. Each strategic commander (sometimes called Gold) has overall command of the resources of their own organisation, but delegate's tactical decisions to their respective tactical commanders.

3.1.2. Tactical

The term tactical (often referred to as Silver) refers to those who will be at or near the scene, providing overall management of the response to an emergency. Tactical managers determine, with others, priorities in allocating resources, obtaining further resources as required, planning, and co-ordinating tasks. Tactical managers are responsible for formulating the tactical plan for implementation by their organisation to achieve the strategic direction set by Gold. Tactical command should oversee, but not be directly involved in, providing any operational response in the incident(s).

3.1.3. Operational

The term operational refers to those who will provide the main operational response (sometimes referred to as Bronze) in an incident, that is, be closest to the scene, and control the management of resources of their respective organisation within a specific area of the incident. They will implement the tactical plan defined by Silver/tactical managers.

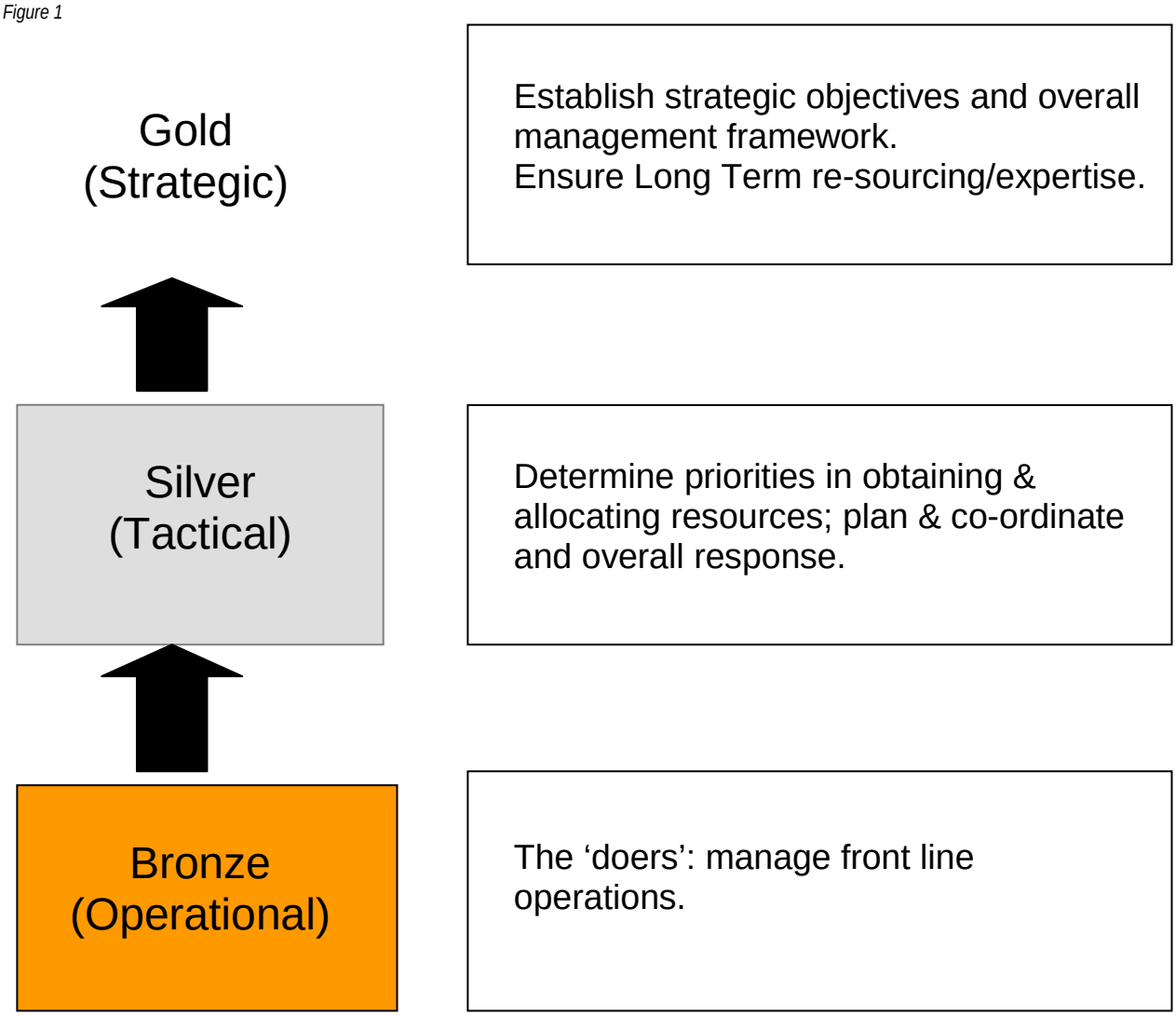
Further Guidance can be obtained from Department of Health (2007) Emergency Preparedness Division. Strategic Command Arrangements for the NHS During a Major Incident.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081507

It is characteristic of the command and control structure that it is created from the bottom up. The operational level being activated first, with the other levels being activated as the incident escalates, or there is a greater degree of awareness of the situation.

A three tier command and control system is used by all other agencies – see *figure 1*; to maintain continuity the RWHT utilises the same tiers depicting the strategic, tactical and operational areas; these tiers relate to Gold, Silver and Bronze terminology used by external agencies.

Figure 1



To maintain clarity within this plan, the terminology used for the hospital command and control will be as follows bringing us in line with the other external agencies:-

The three levels of command and control are :-

Strategic Level (Gold Command)

This is the senior tier of management usually based in a pre-planned location with extensive communication facilities away from the scene of the incident.

Gold command will be managed by either the Chief Executive or Executive on call. This level would have overall executive command of the Trust during a Major Incident; making strategic decisions about deployment of resources, providing information in order to ensure the maintenance of the normal functioning of core services across the trust as far as possible and restoring normality as early as possible.

This level will agree and oversee external communications.

Gold Command for the Trust will be located in the IT Training Room in McHale Building.

Tactical Level (Silver Command)

A tactical level of command will be activated when a major incident is declared. This level will lead and oversee the implementation of the Major Incident Plan at for both the hospital and the community provider services, to ensure there is a coordinated response and maintenance of the normal functioning of core services as far as possible. At this stage the Hospital Silver Control Room will be activated and manned accordingly by the Silver Control Team based in the A & E Registrars Office at the back of A & E.

This level will not be directly involved in providing an operational response.

Operational Level (Bronze Command)

An operational level control is at the focus of the incident, manned by the staff of that department with support from the management team or external agencies.

Bronze control would be the Emergency Department in response to an external incident, although other bronze teams may be activated dependent on the incident.

The Bronze control will assess the extent of the problem and concentrate upon their specific tasks within their areas of responsibility.

3.2 Staff Roles and Responsibilities

It is imperative that all staff know and understand their specific role in the event of a major incident; and the roles identified on their individual action cards contained in appendix A and located in each ward or department. A full set of action cards can also be located in the Silver Control Room.

The Chief Executive must ensure that RWHT has a major incident plan that meets the criteria set out in the NHS Emergency Planning Guidance 2005. He/She has overall responsibility for ensuring appropriate arrangements are in place to support the emergency planning process and that these arrangements are adequately resourced in terms of funding, management time, equipment and any other essential elements. He/She will designate a senior and experienced manager with adequate support to lead a planning team.

The Director of Planning & Contracting is responsible for ensuring that RWHT has a Major incident Plan in place; and ensures that the Trust Management Team and Trust Board receive regular reports regarding emergency preparedness.

The Head of Emergency Preparedness is the Lead for the Trust who will have designated responsibility for emergency preparedness on behalf of the organisation and will support the Director of Planning & Contracting.

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

All Staff should familiarise themselves with the content of this document and be aware of how it may involve them and their colleagues in the event of a major incident. Everyone has a responsibility to know what is expected of them in this regard with this responsibility becoming more onerous in line with management seniority and personal responsibilities for auctioning and participation in elements of the plan. Staff should ensure they adhere to the plan and ensure they are fully aware of where to locate the plan and their appropriate action cards.

3.3. Bronze Command

The A&E Consultant will coordinate the initial response to an external major incident; casualties will be triaged as they arrive in the department, they will be reassessed, re-triaged and receive emergency treatment in the Department. Following this some patients will be admitted for further definitive care although many will be discharged from the department. In the event of a mass casualty incident further bronze commands will be established.

3.4. Silver Command

A Silver Control Team is designed and intended to put in place a more senior tier of incident command and control, with enhanced communication ability and systems to ensure the effective overall organisational response management of a Major Incident.

The Silver Control Team will be located at the rear of the A&E Department accessed through the Registrars Office (near the Seminar Room). It is a small self contained room with dedicated telephone lines which are activated upon switchboard being notified of a major incident. Facilities available are: major incident plans; copies of all action cards; Trust site map; computers; wipe boards; local area map, incident log books, fax (5663) and telephones, telephone numbers 5990, 5991, 6990 and 6993, email: TBC – currently being set up.

If this control room is affected by any internal disruption, for example, fire/smoke or other untoward circumstances, which makes it unusable, all functions may need to be transferred to the McHale IT Training Room.

The Team consists of the Trust Manager on Call, Community On Call Manager, a Medical Co-ordinating Officer (Renal Physician on Call), a Matron - if the Matron is the Trust on call Manager they will need to call in an additional Matron to carry out this role; Capacity Manager, a nominated Loggist and Admin support. The Clinical Night Manager will respond between the hours of 20.00 to 07.00 hours to set up the room until the Trust on manager or matron can attend.

3.4.1. Responsibilities of the Team

<u>Senior Manager</u>

The Trust on Call Manager will be the Silver Control rooms Team Leader having overall responsibility for the team's function; coordinating the hospital response, as well as being responsible for overseeing the provision of support services, portering, catering, traffic control, and security.

<u>Medical Co-ordinating Officer (Renal Physician)</u>

The Medical Co-ordinating Officer will be responsible for overseeing the medical response to the incident. He/she will also be responsible for maintaining contact with Wolverhampton PCT.

Community On Call Manager

The Community On Call manager will be responsible for ensuring that the community services provide discharge support in readiness for the Hospital to receive incident patients, working closely with the Capacity Manager to establish capacity and capability.

Matron

The Matron is responsible for all nursing matters relating to the major incident response. They are responsible for ensuring that clinical areas are prepared and adequately staffed and equipped, you provide the link to other services in the hospital with regard to nursing matters.

Capacity Manager

The Capacity Manager is responsible for identifying and organising the freeing up of beds to accommodate patients from the incident. Liaising with the nurse in charge on each ward and requesting them to identify appropriate patients that may be transferred or discharged.

An accurate bed state should be obtained and entered onto the wipe board to enable the Silver Control Team to make an assessment of the available capacity based on the information collated.

Loggist & Administrative Role

The role of the loggist is to record a clear factual account of the decisions made by the Silver Command team, the time they are made and the rational behind them

The loggist will work alongside the Silver commander and log decisions that are made during the incident utilising the standardised incident log book. These notes may be called for in the event of an investigation post incident and therefore all log entries must be CLEAR, INTELLIGIBLE AND ACCURATE.

NB the Loggist is not a Minute Taker, s(he) is acting on behalf of the silver commander.

The administrative role is to provide support to the Silver Control team.

3.4.2. The role of the Silver Team

To work together to:

a) Make an assessment of the scale, magnitude and possible consequences of the incident.

b) Co-ordinate the Hospital Response and deploy staff effectively.

c) Ensure the safety and welfare wherever practical of all people's staff or patients affected by the incident whilst on Trust premises.

d) Maintain close liaison with Bronze Control

e) Maintain an over view of the incident and the impact on the Trusts resources i.e beds and staffing.

f) To ensure that the Hospital has the capacity for incoming casualties (including ICCU and Theatres). Silver Control will need to make an assessment of capacity based on information collated from A&E. A view will need to be taken of capacity required in each of the following time periods.

- Available immediately
- 1 – 2 hours
- 6 hours
- 12 hours
- 24 hours

If the impact of the incident is likely to go beyond 24 hours, an assessment will be required of capacity for the next 2 – 3 days this should be escalated up to Gold Control to consider.

g) To maintain an accurate record of events

h) To track patients through the Hospital from the incident

i) Maintain patient and staff safety.

j) Ordering of additional supplies to deal with the incident.

k) Communication, both internal and external, and with outside agencies ie GP walk-in centres, GP surgery's etc

l) To keep the Gold Control Room informed every 30 minutes of the Trusts capabilities, template to be used by Silver and Gold command when escalating information is available in the control rooms.

This list is not exhaustive.

3.4.3 Upon arrival the Silver Control Team will set up the Control Room, making use of the wipe boards, and getting a status report from A&E. It is expected that the status board will be used (set up in Silver Control room) to inform decisions on capacity and capability. The status report can be amended to suit the specific circumstances of the incident.

3.4.4. The named departments are expected to give an initial report by fax or email to the Silver Control Room and then on a half hourly basis. Any department may call with issues that need to be resolved, for example staffing or equipment issues. The other departments named in the plan are asked to fax, email or call the Silver Control Team with exception reporting only. In the event that there is difficulty with email or phones a runner should be used.

3.4.5. Communication will be made by telephone, fax, email or runner. A separate system of two way radio is also available for use between Silver and Gold Control, and will be delivered to the Team by Security on request. Details of its use are available in the Silver Control Room.

3.4.6. Casualties attending the A&E Department will be entered at the earliest opportunity onto the MSS system which is the data collection method for all A&E patients. A unique patient number will be given and patient details entered as far as possible.

3.4.7. The computer in the Silver Control Room has access to MSS (previously EDIS) and the A&E Reception staff/IT support staff will set up the access for the purpose of checking patient status, numbers of casualties and general updates. No patient identifying information can be given to anyone who does not have the authority to

receive it. Information should be given to Gold Control giving the number of casualties, types of injuries, notable information e.g. pregnancy, if notable or famous people are involved in the incident, etc.

3.4.8. An accurate list of casualties should be maintained by the team to enable them to decide when the hospital cannot take any more casualties, this will be done inconjunction with A&E.

3.4.9. During a Major Incident there may be a need to prioritise clinical activity in order to accommodate patients from the incident. This will be dependent on the number and type of patients from the incident.

3.4.10. Elective Activity – it may be necessary to suspend elective activity to free up capacity in key areas or to free up staff to be redeployed to assist departments or wards, this is a decision made inconjunction with Gold Command.

The reduction of elective activity will commence as follows; with the lowest priority identified first.

- Patients undergoing routine procedures / appointments / investigations
- Patients with long waiting times
- Clinically urgent patients

This will apply to all elective activity including in-patients, day cases, out patients, diagnostic procedures.

The Capacity Manager will need to liaise with the Silver Control Team and then discuss with Gold Control for confirmation to suspend elective activity. If the decision to suspend activity is agreed then contact one of the Health Records Managers from the list below instructing them the elective activity to be suspended; they will initiate their action card to ensure this is carried out, reporting back to the Silver Control Team as appropriate:-

- Elective Waiting List and Admissions Manager
- Referral and Booking Centre Manager
- Health Records Administration Manager

(Note contact numbers will be on your action card)

A record will need to be kept by each department of cancelled elective patients to ensure the re-booking of appointments at a later date.

3.4.11. The team must also recognise the fact that the declared state could last for days; therefore arrangements for relief of the team members should be identified. Staffing of the control room must be maintained, however long the incident lasts. It will only shut when the Silver Control Team decides it is no longer necessary to keep it open.

It is advisable for all team members to maintain a personal log of actions taken.

3.5 Gold Command

This is the focal command point for the management of the incident; this team will be responsible for maintaining business continuity and managing the consequences of the incident.
The team will need to consider how RWHT will recover from the incident, the team will need to consider the following consequences:-

- Managing the return to normal service delivery
- Priority of elective services including the impact on targets
- Staffing levels in the immediate future
- Identify patients who require further surgical intervention or follow up arrangements following the incident
- Number of beds occupied by major incident casualties including critical care beds and other specialist beds
- Support of staff welfare including appropriate counselling
- Re stocking of supplies and equipment

- Infra-structure and Estate issues
- Auditing and reporting of the incident
- Communication internally and externally to core stakeholders.
- Financial implications and financial recovery plan

The Gold Control Room accommodates the following personnel:-

- Gold Commander - On Call Director (it will be the responsibility of this Director to call appropriate support from a fellow director)
- External Liaison Officer (ie link to ERMA)
- Press/Media Liaison Officer
- Silver Liaison Tactical Adviser
- Security, Utilities and Recovery Advisor
- Secretarial Support
- Loggist

Who are responsible for external communication and corporate decision making. Supported by secretarial staff, the role is to ensure that the organisation has a controlled response to the events; that press briefings are issued; and that the Strategic Health Authority (SHA) is kept informed of the status of the Hospital and any issues that may arise. As the incident develops it may be necessary to call in additional Directors to either support/advise current staff or to relieve staff should the incident progress over a long period. The IT Training Room in the McHale building is the prime location; having sufficient communication and IT soft ware facilities. The Director on Call will ensure that the Chief Executive and Chairman have been informed of the incident and give brief details. In the event of an incident extending beyond the capability of a single NHS Trust then Emergency and Resilience Management Arrangements (ERMA) will be invoked. If the Chief Executive is the On Call Director for the SHA ERMA then he will need to assign this role to another Director of the Trust.

As the incident progresses the workload may increase, and there may be increased interest from the media, who will turn their attention from the scene of the incident to the receiving hospital for news stories. The nominated Press Liaison Officer should be called to handle press enquiries. The SHA employ the services of LTA who will assist with press liaison, but this is primarily on behalf of the SHA. The Press Centre will be located in the Wolverhampton Medical Institute (WMI) and will be opened by Security. The Press Officer will be located in the Press Centre.

The other emergency services will have set up their strategic commands; liaison will take place at the scene between the emergency services. It is expected that the Hospital Ambulance Liaison Officer (HALO) will keep the A&E Department informed of events and any special circumstances.

All communications and interactions must be logged and the time noted for future reference. This will form an essential part of the debrief [See Section 12] and act as information to feed decision making. Proformas are available in the Gold Control Room for this purpose. Flip charts, interactive white board and wipe boards are also available. Patient tracking will be co-ordinated by the Silver Control Team, and information passed through to the Gold Control Room giving numbers of patients, the type of injuries and any information that may be noteworthy for the press. The telephone numbers for the room are 5993 [also fax] 5994, 5995 and 5996.

Silver Control will provide 30 minute updates on the status of the Hospital, giving information on capacity and capability of all departments involved and responding to the incident.

The length of time for the Gold Control Room to be open will be directly related to the needs of the response to the incident. This may extend into several days and consideration needs to be given to rotation of staff and arrangements to keep communication lines open. Press interest will be a significant factor in this.

The activation of the Gold Control Room can also be made by an internal major incident to the Trust, this is covered by a separate plan and examples of this are: a fire in a Hospital Department, or a utilities failure.

Gold Control will make arrangements for any visiting dignitaries to talk to staff (and patients, if acceptable to the patient).

If the incident continues over an extended period (8 hours), arrangements should be made to call in additional support from the on call rotas.

The control room facilities and paperwork will be kept up to date by the Emergency Planning Office, a check being made at regular intervals of information held in the respective control rooms, Gold and Silver.

3.6 - Record Keeping

The immediate demands of an incident can easily fully occupy staff to the point where no records are kept, and people try to remember what they did "after the event". This is not acceptable as we are required to keep detailed logs / records of our individual actions, communications and instructions, which should be timed, dated and initialled. This is to help following a Major Incident in the event of the Trust being invited or required to provide evidence to an appropriate enforcement agency (e.g. the Health & Safety Executive), a judicial inquiry, a coroner's inquest, the police or a civil court hearing compensation claims. Under no circumstances must any document which relates or may in any way relate (however slight) to the incident, be destroyed, amended, held back or mislaid. Records will also be used to improve the way we respond to emergencies in the future.

Contemporaneous written records will be needed and it is ideal for both the Silver and Gold Control Rooms to have a loggist in each area at all times to record what was said, to whom and what decisions were made. *See Loggist action card.*

Notepads/Incident Log Sheets: A numbered log book will be issued to each control room where a detailed and timed record of all instructions received, actions taken and other events which may enable the Trust to assess the success of the emergency response and provide evidence to any enquiry which may follow. The log book should remain intact; no part should be destroyed or erased because, no matter how trivial notes may appear, the total content may form an important contribution in later assessment of the continuity of response. The log books are to be handed on if the holder is relieved during the incident and following stand-down all log books from both the Gold and Silver Control rooms should be returned to the Legal Services Manager's Office in the Laurels with a receipt being obtained.

Apart from the log books, every scrap of paper must be kept, including notes, post-it notes, audio and video tapes, electronic documents, memos and message pads. A simple box file into which all such scraps can be temporarily stored will be sufficient during the incident. Email messages should be printed out so that a written record of all emails is available. Email is a well utilised communications mechanism, but is, by its nature, ephemeral and messages could be accidentally erased.

3.7. Financial Arrangements

All costs incurred by actions and decisions of both the Gold and Silver the Control Room as a result of the incident should be accurately recorded and forwarded post incident to the Emergency Planning office based in Hollybush House.

3.8. Emergency and Resilience Management Arrangements (ERMA)

The Emergency and Resilience Management Arrangements or ERMA is region-wide system arrangements to support the NHS in the West Midlands to plan, prepare and respond to major incidents. ERMA has a designated control room at 1st Floor, Triplex House, Eckersall Road, Birmingham. ERMA is designed to work at all levels from a local incident right up to Regional Command (i.e. the SHA being in charge). This approach takes account of the Department of Health Emergency Planning Guidance the statutory responsibilities of NHS organizations as category 1 and category 2 responders (as described in the Civil Contingencies Act (CCA) and the make-up of the region.

A copy of the West Midlands Emergency Response and Management Arrangements can be obtained here http://intranet/pdf/major_incident_plan/ERMA.pdf, and in both the Silver and Gold Control Rooms.

ERMA levels

ERMA is divided into 3 levels of response as indicated by the table below and is capable of a fluid (rather than stepped) escalation or de-escalation of its activities in support of a PCT or NHS Trust. This requires that ERMA would always be part of the information loop for any major incident involving an NHS response but that its level of activity would always be matched to the need to respond rather than the desire. In other words ERMA should be capable of varying its response from passive, to active support, to active control as the situation warrants.

Incident Level	Command NHS STRATEGIC: "GOLD"
ERMA Level 1	Local – A single Trust or Local Health Economy where a PCT and Acute Trust work in Partnership. Local Command Trust Lead Local Incident Control Room
ERMA Level 2	Sub Regional More than one Trust or more than one localised health economy within a LHRF Economy. ERMA 2 command ERMA 2 incident control room
ERMA Level 3	Regional More than one LHRF economy ERMA 3 Command ERMA 3 Incident control room

Escalation of ERMA Levels

In essence an incident can escalate for three broad reasons:

- Management (command)
- Resources
- Politics

Management

Escalation through management can be for several reasons;

- The person in charge and or the level 1 incident team recognises that they can no longer cope
- The incident becomes more complex and therefore the management arrangements sit at a higher level (e.g. political and media involvement may drive this)

Resources

The resources available cannot meet the demand for the incident response and therefore requires escalation to bring more on line, seeking mutual aid support. This may happen for the following reasons.

- The incident grows (e.g. magnitude, geographically, politically)
- The incident response needs to be sustained for a longer period of time
- To meet partner expectations/requirements of the NHS response (e.g. Scientific Technical Advisory Cell (STAC) advice, mutual aid, specialist beds, equipment)
- Scale and magnitude of the incident (e.g. significant or immediate NHS Operational/Public health impact – for instance a Mass Casualty Incident, deliberate chemical release or a single case of confirmed smallpox)

Politics

- Increasing involvement of senior command and control tiers, political involvement or excessive media coverage.
- Assure public confidence
- Risks associated with reputational damage

Level 1 (NHS/PCT)

The responsibility of managing a level 1 incident rests with the Chief Executive of the organisation involved. It is expected that all those on the on call rota for the trust will be trained to be competent to deal with such incidents. The responsibility for ensuring this lies with the Chief Executive of the organisation.

Level 2 (PCT) Commander

Levels 2 and 3 of ERMA operate an on call of commanders.
In the event of a level 2 incident, the 'on call director' will be the commander of the NHS for that incident and will be responsible for the leading the NHS ***strategic*** response to the incident, this in fact could be an Acute Trust or PCT lead response. They will be in command and responsible for directing the resources and response strategy for the whole health economy within the LRF boundary.

Level 3 (SHA) Commander

Like the level 2 commander the SHA will manage its response by drawing on commanders from the SHA and other parts of the NHS West Midlands who will lead the SHA (regional) response to the incident for the NHS. They will be in command and directing the resources of the NHS West Midlands.

ERMA is not intended to be activated sequentially (although this may happen), it has been developed to ensure the management and response to incidents is dealt with at the most appropriate level, whilst being very clear about who is in charge.

Activation and Escalation when in response

Level 1

An incident which is locally contained and only involves one NHS Trust (e.g. Acute, PCT, and Mental Health) will be dealt with as a level 1 incident. The ERMA 1 commander (CE or Director on Call) must contact the Level 2 ERMA Commander and discuss the need for escalation and agree the level at which the incident should continue to be managed ie at a local level or escalated to level 2. If it is then deemed necessary to escalate the level for management or resource reasons, this will need to be done in conjunction with the Level 2 ERMA commander.

It is the responsibility of the (Trust) Gold Commander at level 1 to provide ERMA 2 commander/representatives with situational reports which include operational issues, pressures, assessment of ability to maintain business as usual or request for mutual aid. If the incident escalates beyond level 1 to level 2 then strategic COMMAND passes to ERMA level 2.

Level 2

A level 2 incident is defined as more than one Trust within a Health Economy affected by the incident. ERMA 2 will assume responsibility for all Trusts and health economies within one Local Health Resilience Forum Area – this is a sub regional response.

ERMA 2 commander must ensure they are in regular contact with the ERMA 1 Commander (the Trust) and discuss the need for escalation or de-escalating the level of response needed. ERMA 2 will make the decision as to whether the incident needs to be escalated to level 3. Requests for establishment of a Scientific and Technical Advice Cell (STAC) are through ERMA 3, Regional Director of Public Health or the Regional Director Health Protection Agency.

Level 3

This is a regional level of response with the SHA in command (ERMA 3). The SHA cadre commander will be responsible for notifying all of the NHS West Midlands Chief Executives that an incident has happened and what level of response is being managed. They are also responsible for providing the Department of Health with initial notification of significant incidents and DH and significant regional partners including disruption, pressures, business continuity issues and resource shortfalls and mutual aid requests. This will be established in the event of either a major incident affecting more than one trust or where mass casualties are involved or in the case of catastrophic events.

Activation Summary

Activation of the ERMA system does not need to be sequential. Some incidents will be immediately obvious in terms of what level they need to be dealt with (i.e. Flu Pandemic or a Terrorist Act would go straight to level 3), however some incidents may not be so obvious and will therefore require judgement, discussion and agreement between the ERMA commanders on call.

The On Call Director will lead for the Trust in communicating with ERMA

ERMA is activated through First

Response Agency on

01384 215 621

Ask for the West Midlands Conurbation On Call ERMA 2

3.9 SCIENTIFIC AND TECHNICAL ADVICE CELL (STAC)

A Scientific & Technical Advice Cell (STAC) is an important part of the health & environmental protection responses to serious or major incidents at the strategic level. It provides a collective route for the generation of authoritative advice to multi-agency Command and Control structures on the health & environmental consequences of an incident and guides tactical and strategic policy making as well as providing tactical advice to the operational response.

A STAC comprises of senior expert professional trained to provide an incident commander with information to support policy making at a strategic level.

A STAC can comprise of a number of specialists drawn from across the region or national specialists of the Health Protection Agency, Environment Agency, Animal Health, food Standards Agency and others. It should be recognised that a STAC will compromise of those specialists appropriate to the incident type and that the precise make up will vary between incidents.

The nature and role of the STAC has been detailed in The Department of Health document "Provision of Scientific and Technical Advice in the Strategic Co-ordination Centre" (April 2007)

A copy of West Midlands Region – Scientific & Technical Advice cell Arrangements are available on http://intranet/pdf/major_incident_plan/STAC.pdf, and in both the Silver and Gold Control rooms.

3.10. Volunteers

All Matrons and Managers should ensure that anyone volunteering their services to help the Trust during the time of an incident must be verified as an up to date employee, i.e. registration to be current, and having been through a CRB check. Anyone who is unknown to the Department or Trust will not be given permission to care for or treat patients on behalf of the Trust. A record should be kept of anyone coming forward as a volunteer, where they have been asked to work, and if their offer of work has been declined.

3.11. VIPs (Very Important People)

As the incident progresses, it is possible that politicians or local dignitaries will want to visit the hospital to speak to the staff and the injured. Reports from the London Bombings stated that staff were uplifted by visits and felt rewarded by the comments they received. Although these visits might be at a difficult time for the organisation they are therefore to be welcomed. Any approaches made should be directed the Gold Control Room, who will arrange for someone to accompany the dignitary. Gold Control should authorise all proposed VIP visits in consultation with the Silver Control Team.

Section 4 - A&E Response

4.1 Existing Patients

Patients who are already being treated in the A&E Department will be informed that a major incident has been declared. Those who are able to walk and those with non life threatening conditions for whom treatment has not started will be informed that they may wish to attend another Hospital or that their wait will be lengthy. The Phoenix Centre Walk in service will be notified by the A&E department that a major incident has been declared with a view to the Phoenix Centre receiving non MIP minor injuries from the A&E department. Pre-incident ambulant patients who are not seriously ill will be issued with an information leaflet advising of long delays and alternative health care advice. Patients who are awaiting medical admission will be sent directly to the Emergency Assessment Unit for further treatment or to be admitted; those awaiting orthopaedic, ENT or Maxillo Facial admission will be sent directly to D3. [NOT D1].

4.2 Flow of Incident Patients

Incident patients will be received directly by the A&E Department.

The pedestrian entrance to the Emergency Department will be locked down; all patients will be received and triaged at the ambulance entrance, and access will be controlled by the A/E Consultant and triage nurse, supported by security officers and possibly police.

Patients will be triaged and treated as necessary, using the usual services available to A&E. Patients from the incident requiring admission will be sent to Ward D1, where they will be assessed by the Consultant Surgeon and considered for surgery. Some patients may be sent directly to Theatre or ICCU dependant upon their injuries. Children requiring admission from the incident should be sent to children's ward

Where language difficulties exist the usual methods of interpreting service shall be used. Details of callout for these services are available in wards and Departments.

4.3 Paediatrics

All children will be assessed and treated in the designated paediatric area within A&E, unless their injuries require Resuscitation facilities.

Whenever possible, paediatric trained staff should be made available to assess and manage the children.

4.4 Consultants

The A&E Consultant on duty will lead the clinical departmental response. If appropriate [s]he will alert clinical departments upon the type of injuries, e.g. trauma, general surgical or respiratory, etc., so that they can make the most effective arrangements for patient care. The Silver Control Team should be given general information of the same nature. The Consultant Paediatrician on call will be available to give advice if children are involved. Birmingham Children's Hospital may have been involved at the scene if the Ambulance Service requests it.

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

In certain circumstances clinical images of incident patients may be required for evidence. Consenting issues will still apply during a major incident response, in these cases the Medical Illustration Department can be contacted. They are available by contacting the Department direct during office hours, and through the Hospital Switchboard out of hours.

4.5 A/E Nursing in Charge

The Nurse in Charge announces the major incident across the A&E intercom system, calling all staff to the nursing station to be assigned duties and tasks. The department will be cleared in a timely professional manner to prepare for incident patients arriving.

Action cards will be issued appropriately to all staff working in the department.

The Nurse in Charge will contact the charge hand porter [bleep 7373, or mobile *3234] who will dispatch 4 porters to A&E to assist with transferring of patients.

4.6 - Patients arriving by Helicopter

Refer to A&E Departments Helicopter Operations Procedure.

4.7 A&E Health Records

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

The clerks will obtain as much detail as possible from the patients and / or ambulance crews and enter this onto the main A&E record system (MSS) as well as updating the paper copy.

If any patients are admitted the patient administration system (PAS) must be used to enter the patient as an admission noting that they are part of a major incident.

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

A status report should be issued every 30 minutes to the Silver Control Team giving detail of the number of casualties, staffing availability and capacity of the department. This is faxed, emailed or taken to the Silver Control Room.

The passing of data and information has a very important part to play in the command and control of a major incident. Patient data and numbers must be kept accurately to ensure that any reports to external agencies are precise and well managed. By using the MSS system the A&E Department can capture data and it can be read directly by the Silver Control Team who can then transmit the information to the Gold Control Room. The computers in the A&E Registrars' Office are available for this purpose. It will be set up by the A&E Reception Team or IT technician, and then available for checking the number and status of patients in the Department. *Any "patient identifying" data MUST NOT be transmitted or verified to any external agency or person not authorised to receive it.*

4.8 A&E Radiology

The on duty radiographer in A&E X-ray will be notified by the Cascade Nurse in A&E.

On duty radiographer will contact Head of Radiology Services and A&E Superintendent/ Deputy so that Radiology Major Incident Plan (Normal Working Hours/ Out of Hours) will be activated.

The A&E X-ray Department will act as the primary service for incident patients attending A&E Department. The satellite department in Fracture Clinic will be prepared as a stand by facility to work in conjunction with A&E X-ray/CT. The Main Radiology Department will be used as co-ordination base for all other radiology services including CT/MRI and Ultrasound.

Co-ordinator based in Main Radiology will assess and prioritise current workload, available staffing and resources and implement necessary actions to make capacity for incident patients.

4.9 Police Incident Information Centre/Casualty Bureau

The Casualty Bureau (CB) is the single point of contact for receiving and assessing information about people believed to be involved in an incident. This will include them maintaining a list of casualties resulting from the incident, including casualties dealt with at the site without referral to hospital. Casualty Bureau will receive initial enquires and the Police will usually co-ordinate media bulletins. CB is located at Police Headquarters, Lloyd House, Birmingham with a fall back site at another location within the West Midlands area. The national telephone numbers for CB will be publicized via various media sources. The public will instructed to use this number and not contact the hospital direct. Any enquirers ringing the hospital for information concerning casualties should be referred to the national CB contact numbers.

4.9.1. Police - Major Incident Documentation Team (MIDT)

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

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

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

The MIDT attend A&E Department to interview people involved at the scene. It is possible that the perpetrator[s] might attend for treatment and so this is an important source of information to them, safety of staff is an essential element of this work. The police may need to be allocated an office in the A&E department or come to cubicles to interview

patients. The Trust makes provision for an external telephone line for them to use, use of fax facilities located in the A&E reception supervisor's office, they may also bring a wireless encrypted laptops and a vehicle onto site for satellite transmission of data. Security should be contacted to arrange for parking of this vehicle.

It is another aspect of a team response and there is an obligation to assist the Police in their work. There is no reason to disclose clinical information but we may need to allow the Police access to unidentified patients, to enable them to build up a description of that individual for identification purposes. Obviously, this must not interfere with the clinical management of the patient.

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

4.10 WMAS Hospital Ambulance Liaison Officer (HALO)

As part of their response to a major incident the Ambulance Service will dispatch a Hospital Ambulance Liaison Officer (HALO) to all Acute Hospital A&E Departments taking part in the incident, i.e. whether the Trust is a "receiving hospital" or "support hospital". The HALO will report to the Nurse in Charge in the A&E Department; and thereafter liaise with the A&E Consultant and Triage Nurse at the ambulance entrance.

- The HALO acts as a communications link to the scene of the incident and with other emergency agencies, i.e. Police and Fire Service. (S)he is the Hospital point of contact giving information about the scene, nature of injuries (if known), and any special circumstances to note, e.g. chemical, biological, nuclear or radiation incidents or contact. [S]he will be able to assist with co-ordination and transfer of patients, should the A&E Department be overwhelmed with casualties or by a response requiring greater specialist involvement than the hospital can respond to. This will be particularly relevant for supra regional specialties such as Burns or Specialist Children's Units.
- The HALO will ensure the quick turn around of ambulances bringing casualties to the hospital and return to the incident if required.
- The HALO, in co-operation with the scene ambulance silver commander will co-ordinate requests for, and the transport of, bulk medical supplies as necessary.
- The HALO will provide a communications link with the Silver Control Team situated at the rear of the A&E department in the A&E Registrars' office and ERMA, if established.
- Ensure maximum cooperation with the Silver Control Team in regard to decanting of patients to secondary hospitals.
- The HALO will remain at the hospital subsequent to Major Incident Stand Down in order to manage continuing demands on resources for discharges/transfers.

Section 5 – Emergency Assessment Unit [EAU] and Medicine

5.1 Role

The Emergency Assessment Unit will be the admissions area for non incident patients who are awaiting admission from A&E. They will take immediate reception of patients, making space as appropriate. The Ward area of EAU will discharge patients as speedily as possible, utilising the Admissions and Discharge Unit as appropriate.

5.2 Nursing Staff

The Nurse Co-ordinator for the Emergency Assessment ward will contact RCMT to provide support for discharging patients. Patients will be transferred from A&E by the Porters who have been allocated for this task (4 to A&E and 2 to

EAU) and brought to the EAU, where space will have been made available to receive them. The capacity team will then be contacted to request bed availability.

5.3 Medical Staff

The Acute Physician or Consultant Physician on call will be alerted and will be responsible for identifying patients for discharge and treating those patients who are already in the system and awaiting decisions on admission / discharge. Only those patients who would be unsafe to discharge should be admitted.

The level of discharges required will depend upon the expected number of patients from the incident requiring admission and the types of beds required e.g. medical, surgical, trauma etc.

It may be necessary to arrange early discharge for patients who are awaiting packages of care and placements in nursing homes, to temporary alternative facilities. This should be addressed through the Silver Control Team, the Community On Call Manager, who will liaise with the community services and Social services. Wards should ensure relatives are informed of patients being discharged early along with the reason for this.

As the Senior Doctor for the Silver Control Team is the Renal Physician on call, this may result in a clash of duties. For those circumstances when the on call Renal Physician is also named as the General Physician on call then the On Call Gastroenterologist would be called to act as EAU physician.

5.4 Status Reporting

In order to keep the Silver Control Team fully briefed EAU is required to submit a status report every 30 minutes. This should be faxed each hour giving information on available capacity, staffing issues, and any other pertinent data.

5.5 Bed Bureau

Bed Bureau will be contacted by the Nurse Co-ordinator for the Emergency Assessment ward to notify them of the incident; as and when GPs call into the Hospital with potential admissions, the Bed Bureau will inform the GP of the major incident and request that another Hospital be contacted to take the admission. Any problems should be directed to the Silver Control Team.

5.6 RWHT Capacity Management Team (RCMT)

Its general role in the major incident will be to assist the medical wards in discharging patients to make capacity for the non-incident patients from A&E to come to the EAU; and creating additional capacity for incident patients.

The aim is to match the capacity of the hospital with the anticipated demand proactively and to ensure the efficient utilisation of beds within the Trust.

The RCMT are responsible for maintaining an up-to-date capacity situation report throughout the 24 hour period. This provision will be by the Capacity Manager, Patient Flow Co-ordinators and Patient Flow assistants from 07.00am until 20.30 and by the Clinical Night Nurse Managers from 20.30 until 07.00. A 24/7 service is in place.

The RCMT are responsible for the allocation of beds for all categories of admissions, with the aim to maintain and optimise patient flow.

The RCMT are responsible for maintaining the EMS (Escalation Management System) to support communications externally and to provide the status of the Trust in terms of its capability and viewing the wider conurbation status.

The specific responsibilities of RCMT are set out in *Capacity Management Policy OP65*.

5.7 Medical Wards

Medical Wards play a part in major incident response in a supporting role to allow non-incident patients to be taken out of A&E and cared for / treated in EAU. EAU may be able to respond to this with no support, equally they may need to transfer patients to the rest of the medical zone to create capacity. In order for them to be able to discharge safely and effective they will be supported by the RWHT Capacity Management Team and Out of Hours Practitioners. Patients can be accommodated in the Discharge Lounge or the Admissions area (Appleby suite). The Team will assist with this and any other issues that will need resolving to create capacity. Wards should notify patients' relatives of any ward transfers or early discharge arrangements. The ward should also make the necessary follow up arrangements to ensure safe discharge. A record of all patients discharged early as a result of the incident should be forwarded to the Silver Control Team.

Section 6 – Surgical Zone -

6.1 Surgical and Orthopaedic

The main admitting ward for incident patients will be D1. Identification of patients for discharge will take place without delay; patients should be accommodated in the Admissions ward (Appleby) or the Discharge Lounge (during normal working hours). The Nurse in Charge will cascade the callout to the Consultant Surgeon, Ward D2, the Vascular Ward, Matron for Surgery (who may be in Silver Control Room), and Junior Doctors.

The Matron for Surgery or Nurse in Charge of D1 will liaise with A&E to transfer incident patients to the surgical ward D1. She will also maintain control over the movements of patients between the surgical wards, ensuring that the location of incident patients is known at all times.

Wards should notify patients' relatives of any ward transfers or early discharge arrangements. The ward should also make the necessary follow up arrangements to ensure safe discharge. A record of all patients discharged early as a result of the incident should be forwarded to the Silver Control Room.

In order to keep the Silver Control Team fully briefed the Matron for Surgery is required to submit a status report every 30 minutes, giving information on available capacity, staffing issues, and any other pertinent data. This should be faxed, emailed every 30 minutes.

The on call Consultant General Surgeon will be expected to attend ward D1 making decisions on cases for theatre and / or Critical Care. [S]he may be required in A&E for opinion and the A&E Consultant will make contact if necessary.

The on call Consultant Trauma Orthopaedic Surgeon is called by switchboard, and is expected to attend the hospital to give advice on trauma cases. All Orthopaedic cases are expected to be accommodated on D1, but may be accommodated elsewhere if deemed clinically appropriate.

6.2 Integrated Critical Care Unit

The Integrated Critical Care Unit [ICCU] are notified by D1, and give the alert to the Clinical Director, Nurse Manager, and General Intensivist on Call. It is the responsibility of ICCU to make provision for cases that may require the services of an ICCU, either directly from A&E or post theatre attendance. A minimum of one bed space will be made available immediately with at least 4 further level 3 beds. The Nurse in Charge will ask for cases to be reviewed, particularly for level 2 patients, who may be well enough to return to wards and therefore create capacity. This will be managed utilising the RWHT Capacity Management Team. [See 5.6]

A 30 minute status report on capacity, staffing and other issues will be made to the Silver Control Room by fax, email or runner.

6.3 Theatres

The Practitioner in Charge for Theatres, upon receiving the major incident call from D1, will determine the next available operating theatre and make arrangements to cancel forthcoming cases. [S]he will ensure that the staffing for each theatre is adequate and prepare for potential surgical cases. A strong liaison will exist between General Theatres, Cardiothoracic theatre team, Surgical Consultant, Orthopaedic Consultant and Surgical wards to follow up on the number of cases that will require theatre to ensure that ensure that resources are used appropriately; cardiothoracic may be directly involved in treating the incident cases if the injuries require this.

In order to keep the Silver Control Team fully briefed Theatres is required to submit a status report every 30 minutes. This should be faxed, emailed or a runner giving information on available capacity, staffing issues, and any other pertinent data.

6.4 Cardiothoracic Support

The Cardiothoracic Service, housed in the Heart and Lung Centre can support the Hospital in two ways, firstly, it can offer its specialist skills should the incident require the services of cardiothoracic expertise. Secondly, its bed capacity and theatres can all provide back up capacity for the main departments dealing with a major incident.

The service is triggered from the surgical zone response by the Integrated Critical Care Unit. The Cardiothoracic Team will provide support to the ICCU through assessing patients to return to routine wards, and to prepare for incident patients to arrive.

The theatre manager or designated daily theatre co-ordinator liaises with Nucleus Theatres to allocate appropriately skilled staff to support main theatres. Elective work is cancelled to free up theatres in case they are needed for incident patients.

All wards in the Heart and Lung Centre will identify patients who can be discharged and the bed state will be communicated to the Silver Control Team.

Out of hours the on call lead theatre practitioner must be contacted in the first instance. This contact number is kept with ICCU.

6.5 Paediatrics

The A&E Consultant will notify the Consultant Paediatrician direct if [s]he requires the opinion or support from the specialty. Paediatrics will also be notified, however, by the ward notification from the bed bureau.

Should the incident involve children the Nurse in Charge will implement the children's bed management policy. The Children's Outpatients Department will close to clinic appointments; and the area will be utilised as a discharge facility.

The Community Paediatric service will instigate its own major incident plan actions to provide support to the hospital's paediatric service in relation to triaging and discharge support for non major incident children.

Capacity may further be increased by the addition of cots and chair beds should this be necessary.

Due to the nature of an event which predominantly involves child casualties' special arrangements need to be made.

Where ever possible, severely injured children will be sent by WMAS to the most appropriate centre to deal with their injuries. In most cases this will be Birmingham Children's Hospital, however in large scale events such as mass casualty or catastrophic events the Trust may have to deal with large numbers of children.

The ICU anaesthetist should be called for any critically injured child that requires supported airway management.

6.6. ENT / Maxillo Facial

The skills and expertise of the speciality of ENT / Maxillo Facial may be requested by A&E

6.7. Maternity Unit

The skills and expertise of the Obstetric/Gynaecology department may be requested by A&E dependant on the incident and nature of injuries.

6.8. Eye Infirmary

The skills and expertise of the Ophthalmology department may be requested by A&E dependant on the incident and nature of injuries.

6.9 Admissions and Discharge Lounge

The Admissions and Discharge Lounge are 2 separate facilities with the aim to provide support for those patients being admitted and for those who are ready to be discharged, but are waiting for transport, drugs, etc. The facilities will be used to assist discharges from any of the wards in the plan and will support the communication for transport and pharmacy. However it is not available 24 / 7 and so the Silver Control Team, in conjunction with the Surgical Matron, will decide if the Hospital will benefit from the opening of the facilities.

Section 7 – Clinical Support Departments

7.1 Out Patients Department (OPD)

The main Out Patients Department [OPD1] is responsible for accepting patients for discharge who have been involved in the incident and treated in the A&E Department. The Nurse in Charge will stop outpatient clinics [if in working hours] or will be called in by the Silver Control Team [if out of working hours]. Relatives are also sent to OPD to be reunited with their loved ones.

OPD will contact the PALS team for support to patients and their relatives if necessary. Four suites will be identified for patients and relatives to use for privacy if needed; support will be given by the Hospital Chaplains.

Catering will be provided by the Hotel Services Department, who will send staff to OPD as soon as they are notified.

OPD1 will also act as the staff check point. Any extra staff who have been called to provide support in the event of an incident by their ward/department, will be required to undertake a checking in process in order to ensure that there is a central point for staff to report to and then to the respective areas requiring support. All members of staff will require their ID cards to gain admission to the hospital.

7.2 Pharmacy

The On-call Pharmacist will be called by the Hospital Switchboard on major incident declaration, and will report to the Main Pharmacy Department. The role is to ensure that appropriate medicines are available as required and that hospital discharges can occur promptly.

The most senior pharmacist on site will assume the role of Pharmacist in Charge and will gain information of the nature of the incident and assess whether additional staff need to be brought in. They will make judgements as necessary as to the requirements for medicines, re-allocating levels, internally or ordering from wholesalers or other hospitals as necessary.

Medical, Surgical, Cardiothoracic and Paediatric wards will also require assistance with urgent discharge of patients to create capacity. The Pharmacy Department will make timely provision of discharge medication to facilitate rapid and safe discharge of patients.

7.3 Haematology

The Haematology Department will respond to the Hospital Switchboard alert to a declared major incident. The available blood stock held will be ascertained and any requests from A&E or Theatres will be noted. The Blood Transfusion Service is then contacted to place an order. If no indication of blood requirement is available, then the department will ensure that minimum products are available as per departmental guidelines in their major incident folder. The Consultant will be available to give advice and support to A&E and Theatres on the suitability and availability of blood products.

7.4 Clinical Chemistry

The Clinical Chemistry Department is alerted by Switchboard at declaration. A departmental cascade callout then ensues, which staffs the service to the necessary levels to respond to any testing required as part of the major incident. Blood gas analysers are already used in critical areas such as the A&E Department, Heart and Lung Centre and EAU, it is expected that these machines would continue be used during a major incident for casualties.

The Clinical Chemistry Department is available to provide urgent and routine testing of blood and urine samples. It will respond to requests made by A&E as clinical needs dictate.

7.5 Medical Equipment Library

Additional medical equipment may be required to treat incident patients and the Medical Physics and Clinical Engineering Department provide a storage and maintenance service to all inpatient wards. The department responds on a 24 hour basis to requests.

Section 8 – Non Clinical Support Departments

8.1 General Health Records (Admissions/Outpatients)

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

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

8.2 IT

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

8.3 Hotel Services

8.3.1 Catering

Additional catering facilities will be required for patients and relatives in the form of snacks, sandwiches and beverages. This is provided from the Discharge and Relatives Centre in OPD1. The Hospital is also likely to attract a greater number of visitors, including the press and so additional provisions will be made available from the Café Royal. During normal working hours Independent providers will also be alerted to possible increased trade, namely: Escape, Greggs, WRVS, and Food For Thought [WMI]. (Note these services are not open out of hours). Vending machines will be kept stocked throughout the incident.

Two employees will be sent to man the Café Royal providing snacks and beverages for staff and patients as required. The emergency services can obtain beverages from the snack bar with no charge. Normal charges will apply to visitors and staff.

One member of staff will liaise with A&E staff, control room staff, and OPD1 to arrange for snacks and beverages to be provided accordingly.

The need for additional catering provision will be monitored and all RWHT outlets stepped to provide for additional visitors. The independent providers will be also be alerted and invited to review opening times, etc.

8.3.2 Housekeeping

The Housekeeping Department are called upon to assist with general duties to facilitate discharges, to make drinks for patients and relatives and to run errands.

One employee is dispatched to the EAU and 2 to D1 to assist nursing staff with bed making and to run errand as required, they will also be available to make and serve drinks for patients and staff.

Three members of staff will go to OPD1 to assist with the support of discharged patients and relatives, giving support, making drinks for patients, relatives and staff, and running errands as required.

8.3.3 Portering

The A&E Department will call the Charge hand Porter upon standby or declaration to request assistance in the immediate movement of patients to EAU and D1. The Charge hand porter will dispatch 4 porters to A&E. A call will also be instigated by Switchboard as part of their cascade list in the event of a major incident.

Upon a full declaration of major incident, porters will be dispatched as follows:

4 to A&E

2 to EAU

2 to D1

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

8.4 Security & Lockdown

8.4.1. Security

The role of security in a Major Incident can be wide reaching, dependent upon the circumstances, the number of people involved and the press interest. Primarily, the Trust contract security company APOCA will be responsible for the locking and unlocking of doors and buildings, and assisting with traffic flow and car parking.

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

Increased interest by the media and general public may place great demands on the Hospital, and Departments may require support in controlling visitors, etc. Departments will report to the Silver Control Team on any difficulties of limiting access to wards and departments and Security will be instructed to support these areas, through Silver Command. Security may still be called directly for urgent issues, which will be prioritised and dealt with accordingly by Security Control/LSMS.

8.4.2. Lockdown

The lockdown procedure will be implemented by the security department on the instruction of Gold command. Available on the Emergency Preparedness intranet site http://intranet/pdf/major_incident_plan/Hospital_Lockdown_Protocol.pdf.

8.5 Engineer

The on call Engineer and Building on call Manager ensures that the appropriate temporary signs are erected to direct people appropriately around the site. The Press Centre (WMI) and Discharge and Relatives Centre (OPD1) will have signposting for traffic and to indicate the relevant buildings.

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

8.6 Patient Advisory Liaison Services (PALS)

PALS will be used to provide information, support and advice to relatives and discharged patients from the incident.

8.7 Wolverhampton Medical Institute (WMI)

Representatives of the press will gathered in the WMI. They will be briefed at regular intervals by the Trust Communications Manager or appointed Press Liaison Officer.

8.8 Medical Illustrations

During an incident Medical Illustration will play a key supporting role to A&E, Gold and Silver Command as required. They will support the 'taking of photographs' etc if required and will act as an independent source to support record keeping of an incident.

8.9 Chaplains

Pastoral support and counselling is offered to incident patients and relatives who have been discharged from A&E. The Chaplain on call will determine whether the multi-faith community needs to be contacted to give appropriate support. [S]he will be based in OPD1 but will attend wards and department as necessary.

The needs of multi-faith communities have been recognised and specific awareness will be made for catering provision, death and dying rituals, and any other special requests of the faith.

8.10 Mortuary

Regrettably many Major Incidents result in fatalities amongst the casualties. It is the role of the H.M Coroner to take overall responsibility for the deceased and to ascertain the cause of death. The role of the Police is to investigate the incident and also to act as Coroner's Officers.
In the event of a Major Incident, the Mortuary will provide storage facilities for deceased patients, continuity of documentation; assistance to the police in identification procedures.

Casualties who have died at the scene will remain there, as the incident site may be regarded by the police as a crime scene. Casualties who die on the way to hospital or who cannot be resuscitated once they have arrived at hospital will be certified and taken to the mortuary in the usual way.

If, however, our resources become overwhelmed, the demand for mortuary space exceeding capacity plan will be activated,(FT.003.HIS in hours/FT.002N.HIS out of hours).

The bodies of those patients dying as a result of a major incident are the property of the coroner and will be kept in our mortuary only until the police can make arrangements to transfer them.

Section 9 – Integration with Plans of Other Services

An effective response to a major Incident will be a "Team Event". A large–scale Major Incident will require resources over and above the normal day-to-day provision. There may be many casualties, many evacuees, many people affected by the trauma of such an incident.

It will require the co-operation of the Emergency services, NHS, Local Authorities, Government Agencies and the Voluntary Agencies.

The many responders must be able to work together at the scene and in the overall co-ordination of the response. There is no place for surprises on the day.

This means that multi-agency Major Incident Planning has to be joined up and plans and responses truly integrated. In the field of emergency planning and response the Trust plays an active role in the Wolverhampton Resilience Forum; sharing knowledge and resources and a joint approach will assist in the overall management of a Major Incident. For this to happen in practice requires an understanding by all services and agencies of their own and each other's roles and responsibilities at such time. When dealing with a Major Incident is not the time to learn the roles and responsibilities of partner agencies.

9.1 Ambulance

The ambulance service is responsible for the management at the scene of live casualties at an external incident and will ensure an appropriate medical assessment, triage casualties, treat at the scene where practically possible and transport to an appropriate designated hospital.

In an external event where the Trust is designated to receive casualties, the ambulance service will send a Hospital Ambulance Liaison Officer (HALO) to provide a communication link to the Receiving Hospital from Ambulance Control and the scene, giving vital information to the A&E Department on the type, number and severity of casualties. The HALO works alongside the A&E Department and liaises with the Silver Control Team in providing clear information at timely intervals regarding the progression of the incident, impact, duration and casualty numbers as well as up dating the ambulance service with the Trust's response and capabilities.

9.2 Fire Service

The primary role of the Fire service in a major incident is the rescue of people trapped by fire, wreckage or debris. They will prevent further escalation of an incident by controlling or extinguishing fires, by rescuing people and by undertaking other protective measures. They will deal with released chemicals or other contaminants in order to render the incident site safe or recommend exclusion zones. They will also assist the ambulance service with casualty handling, and the police service with recovery of bodies.

The primary areas of the Fire service's responsibility at a major incident are:

- Life, saving through search and rescue
- Fire fighting and fire prevention
- Rendering humanitarian services
- Management of hazardous material and protecting the environment.
- Provision of qualified scientific advice in relation to HAZMAT incidents via their scientific advisers
- Salvage and damage control
- Safety management within the inner cordon, and

- Maintaining emergency service cover throughout the brigade area and returning to a state of normal functioning at the earliest time.

West Midlands Fire Service (WMFS) will often be involved at the scene of a Major Incident, but also provides valuable advice to the A&E Department with regard to CBRN and decontamination. Upon request, and if they are not needed at the scene, they will provide a Fire Appliance to provide decontamination assistance at the Hospital, bringing the full equipment to decontaminate self-presenting casualties.

WMFS will also assist the trust in certain internal incidents such as fire on hospital property, hospital evacuation etc.

9.3 Police

The Police will normally coordinate all the activities of those responding at and around the scene of a land based emergency.

The primary areas of police responsibility at a major incident are:

- The saving of life, together with the other emergency services
- The coordination of the emergency services, local authorities and other organisations acting in support at the scene of the incident.
- To secure, protect and preserve the scene and to control sightseers and traffic through the use of cordons.
- The investigation of the incident and the obtaining and securing of evidence in conjunction with other investigative bodies where applicable.
- The collection and distribution of casualty information
- The identification of the dead on behalf of Her Majesty's (HM) Coroner.
- The prevention of crime
- Family liaison, and
- Short term measures to restore usual daily functioning after all necessary actions have been taken.

During a Major Incident the Police Service will handle enquiries from the general public, about the incident and those involved.

Major Incidents may be caused by criminal acts and are likely to be subject to subsequent investigation.

All potential evidence relating to the Major Incident should be retained in a sealed and appropriately labelled property bags. Police documentation teams are routinely sent to receiving hospitals as part of the police role in collating information to be used by the police casualty bureau in communicating with relatives. They collate information from the scene and Hospitals to ascertain the number of casualties and are then able to give information to relatives. A room is made available to them in the A&E Department to gather details from those patients who are able to help with this work.

The preservation of life and clinical necessity will always take precedence over the gathering of evidence and the maintenance of the chain of evidence. As far as possible, staff should assist in the collection of evidence and should not deliberately obstruct or tamper with evidence.

9.4 Local Authority

Wolverhampton City Council can assist with providing Humanitarian Assistant Centres should they be needed across the Borough. This may be useful in providing support during an internal incident where the trust is required to evacuate personnel or patients into a rest centre. They are also responsible for Temporary Mortuary arrangements should these exceed the capacity of the local mortuary.

They are an important link and their Emergency Plan is held in the Silver Control Room for reference.

9.5 Primary Care Trust [PCT]

With the changes in the White Paper and the many reforms taking place the PCT is still classed as a category 1 responder and as such continues to hold the responsibility of central co-ordination and operational management for the provision of some health care services and the protection of public health within their geographical area. Wolverhampton City PCT in a Major Incident will generally be associated with public health issues or where the health of a locality is compromised. They are usually alerted by the City Council, if large numbers of the population need public health support, etc. An incident affecting premises, e.g. GP surgeries or health centres, would also involve their emergency plan.

The roles and responsibilities identified in the The NHS Emergency Planning Guidance 2005: underpinning materials for Primary Care Organisations (PCOs) are listed below:-

In response to an incident PCOs will:

Co-ordinate, the NHS response to a major incident at PCO level

- Provide a 24 hour emergency management response
- Co-ordinate the primary care and mental health response provide appropriate clinical settings for the treatment of people with minor injuries and conditions such as reception centres, GP walk in centres and general practice
- Provide care and advice to evacuees, survivors and relatives, including replacement medication
- Liaise with local authorities
- Assess the effects of an incident on vulnerable care groups, such as children, dialysis patients, elderly, medically dependent, or physically or mentally disabled
- Establish with local authority facilities for mass distribution of counter-measures; for example, vaccinations and antibiotics
- Provide support, advice and leadership to the local community on health aspects of an incident
- Support screening, epidemiology and long term assessment and management of the effects of an incident
- Provide psychological and mental health support to staff, patients and relatives in conjunction with the appropriate provider
- Continue to provide core business services
- Maintain liaison with and co-ordinate the response with the Strategic Health Authority or equivalent
- Work with the local authority and community to support the recovery phase
- Assess the medium term impact on the community and priorities for the restoration of normality
- Consider the need for long term monitoring
- Preserve all plans and documentation used or produced during the course of the emergency response
- Prepare a post-incident report for consolidation in the NHS report to be forwarded to the PCT Board, the SHA or equivalent and other interested organisations

During normal working hours the PCT can be contacted via Coniston House Switchboard – for out of hours Penn Hospital switchboard.

9.6 Strategic Health Authority [SHA]

Emergency Response Management Arrangements [ERMA] have already been described in Section 3. Communication with the SHA is made through this system keeping them up-to-date with the incident and whether it is likely to escalate.

9.7 Mental Health Trust

The local mental health trust may be utilised in post incident psychological support of staff and patients.

9.8 Other Agencies

The trust may seek advice and support from a range of organisations during an incident these include:

- Travel West Midlands
- St John Ambulance
- British Red Cross
- Health Protection Agency

Section 10 – Communications

10.1 Internal

In order to give resilience to the plan, all types of communication have been built in as a contingency against IT failure. Electronic methods have been employed for patient data capture and for communication with ERMA, normal landline telephones are available as well as fax machines, email and mobile phones are held by the command and control teams. In addition to this, two way radios are identified for communication between the Silver Control Room and Gold Control Room. If all systems fail then support staff are used as runners to gather information between departments and report back.

Status Reports will be sent into the Silver Control Room every 30 minutes or if difficulties arise, these will be noted and kept for use in the Debriefing arrangements [see Section 12]. The main departments to do this are: A&E, EAU, Surgical Matron, CCU and Theatres, all other departments will send in exception reports only.

All communication will be noted and retained for later reference.

10.2 External

Communications with the press and external agencies are the responsibility of the Gold Control Room. All calls from outside agencies will be directed to the Gold Control Room, with press enquiries being directed to the nominated Press Liaison Officer referring to the Royal Wolverhampton Hospitals NHS Trust communication plan (available on the Emergency Preparedness intranet site). Liaison with other agencies will take place at strategic and operational levels, with ERMA relating to Gold Command [see 3.5] and A&E liaising with the HALO and Police Documentation Team [See 4.10]. The Silver Control Room will liaise with the Local Authority and PCT if needed.

Calls received from the general public wanting to know if relatives have been brought to the Hospital will be directed to call the Casualty Bureau; the number is given out on radio and TV broadcasts.

10.3 Press

In the early stages of an incident it is highly likely that the reporters and photographers will be in attendance very quickly. The reporters have a job to do and they have a right to talk to people and take photographs; however they must not be permitted to access clinical areas unless escorted by members of staff and pre-approved by the Press Liaison Officer; this would be dependent on the incident. The early identification of a Press Liaison Officer will help to build a workable relationship.

It is important that we work with the media and recognise that the media can assist us to manage the response, and provide an excellent means of rapid communications with the public and off duty staff.

Information should be provided from a single, nominated, authorised, informed source. All requests for media statements should be directed to the Press Liaison Officer.

The Press Centre will be located in the Wolverhampton Medical Institute, and the media will be directed to use this area to gain information and press releases from the Press Liaison Officer. All calls received by switchboard for press enquiries shall be handled by the nominated Press Liaison Officer.

10.4 Other Agencies:

10.4.1 - Police

Communication with the Police will take place at local level in the A&E Department to deal with operational issues. At the strategic level [Gold command] ERMA will liaise on the overall direction of the incident and ongoing issues. Any tactical queries from the Hospital should be escalated through ERMA.

10.4.2 - Fire

The Fire Service will usually be at the scene of an incident and not normally contacted by the Hospital. They will assist with the disrobing of patients during a decontamination process, if they have a vehicle available. They are contacted by the Nurse in Charge in A&E.

10.4.3 - Ambulance

West Midlands Ambulance Service [WMAS] use a Hospital Ambulance Liaison Officer [HALO] who will be stationed in the A&E Department of the Receiving Hospital to keep in direct contact with Ambulance Control and through them to the scene of the incident.

10.4.4 - Local Authority

The Local Authority will be contacted by the Silver / Gold Control Room for assistance with Social Services, Temporary Mortuary arrangements or mutual aid support.

Section 11 – Special Incidents

There are some specific incidents which Trusts are required to plan for. These include incidents involving patients suffering Burns injuries, as well as Chemical, Biological, Radiological or Nuclear (CBRN) and HAZMAT incidents.

11.1 Burns Injuries

The Trust will treat burn-injured patients primarily by early stabilisation, airway management and fluid replacement. Initially burns will require paraffin gauze dressings until senior burns triage begins. This will be carried out by medical staff from the regional burns service in conjunction with Trust medical teams. These plans are detailed in the national burns plan and can be viewed in full by using this link: http://www.specialisedservices.nhs.uk/safe_sustainable/burn-major-incident-plan .

Guidance can also be sort from NHS Emergency Planning Guidance 2005: Planning for the Management of Burn Injured patients in the event of a Major Incident. This guidance can be viewed in full by using this link:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081281

11.2 Chemical, Biological, Radiological or Nuclear (CBRN) / Hazmat Incidents

In the event of a Chemical, Biological, Radiological, Nuclear (CBRN) or Hazmat incident the CBRN Plan will be activated.

Further Guidance relating to the above type of incidents can be located in the “CBRN Incidents: Clinical Management and Health Protection 2005”.

http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1158934607980

Chemical, biological, radiological or nuclear (CBRN) plans and arrangements are not designed to be activated solely in response to a deliberate release incident: they can and should be utilised for any incident that involves chemical, biological, radiological or nuclear agents or materials.

NOTE:- The Department of Health guidance on the management of casualties potentially contaminated with radioactive materials differs from the advice where chemical or biological contaminants may be involved.

Each incident should be assessed and the following considered:

Is this a deliberate overt (clearly identifiable release, although the precise content of the release may not be known) or covert (a concealed release of a biological or chemical agent) release (CBRN incident).

Or

Is this an accidental discharge of a chemical or hazardous substance (HAZMAT incident)

In the event of a suspected Radiological event RAM-GENE 1 detection equipment (2 units are located in the NAIR cupboard located in the A/E department) should be used to confirm contamination of patients and Medical Physics contacted for assistance / guidance.

11.3 - Chemical Incidents

Many chemical incidents occur every year. The Chemical Hazards and Poisons Division is part of the Health Protection Agency's centre for Radiological, Environmental and Chemical Hazards and records over 1,000 incidents a year in England and Wales.

Refer to the HPA CBRN Incidents: Clinical Management and Health Protection 2005 Guidance on Chemical Incidents for further information. http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194947382859

In the event of a Chemical, or Hazmat incident the Chemical Incident Plan will be activated.

A national stockpile of drugs and equipment for use in chemical and biological incidents are available, they have been packed into "pods" and distributed to strategic sites around the United Kingdom. Emergency pods of supplies are held at West Midlands Ambulance Service HQ at Dudley. (Appendix B)

Incidents may involve additional exposure to chemicals, biological, radiological or nuclear [CBRN] hazards. In these cases, the Fire Service and Ambulance Service will set up a decontamination process at the scene, and casualties known or suspected to be contaminated will be cleaned before transfer to Hospital. Some casualties make their own way to Hospital and so a small decontamination facility is available in each type 1 A&E Department for chemical decontamination only.

The CBRN plan is available on the Intranet http://intranet/pdf/major_incident_plan/Chemical_Incident_Plan.pdf

11.4 - Biological Incidents

Because, there is an incubation period between exposure and development of symptoms, the release of a biological agent may not be apparent until people become ill.

Early recognition of a covert release of a biological agent will be achieved only if clinicians remain aware of the possibility, and are willing to alert and consult with the microbiologist and HPA on suspicion, and before a definitive diagnosis has been reached.

Be alert to the unusual, the unexpected, and the case that just doesn't fit.

Refer to the HPA CBRN Incidents: Clinical Management and Health Protection 2005 Guidance on Biological Incidents for further information. http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194947395481

A Reserve National stockpile of drugs and equipment for use in chemical and biological incidents are available, they have been packed into "pods" and distributed to strategic sites around the United Kingdom. Emergency pods of supplies are held at West Midlands Ambulance Service Headquarters at Dudley and can be activated by contacting WMAS refer to Appendix B.

Reference can also be made to The Department of Health have produced guidance on "How to Access stock".

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081038

11.5 - Radiological and Nuclear Incidents

On a worldwide basis, both nuclear and radiological accidents and incidents are relatively infrequent when compared with events involving other potentially hazardous materials such as chemicals.

Refer to the HPA CBRN Incidents: Clinical Management and Health Protection 2005 Guidance on Radiation Incidents for further information. http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194947392290

Radiation cannot be sensed by humans. Exposure to a radioactive source may not be immediately apparent unless large doses of radiation have been received.

Exposure to radiation can produce one or more of the following effects: tissue reactions at high doses of radiation, potentially carcinogenic effects at low doses, and psychological effects even where little or no radiation exposure occurred.

The exposed population may fall into one of three categories:

- Irradiated (casualties have received a large dose of radiation but who have no radioactivity on them)
- Contaminated (those who still have radioactivity on them or in them)
- Irradiated and contaminated

Decontamination is not an automatic or inevitable response to a CBRN incident involving nuclear or radioactive materials. The need for decontamination depends on the type and scale of the incident.

It is important that help and support is obtained early on from the Medical Physics department – but do not wait for them to arrive before admitting the patient and beginning to treat them. It is important that the approved guidance is adhered to help prevent wide spread contamination within the department, http://intranet/pdf/major_incident_plan/NAIR_Plan.pdf. In the event of a radioactive incident, Appendix D outlines a number of contact numbers for medical physics radiation advice in the West Midlands.

Effective communication with the public and media is critical in the event of any incident that involves radiation or radioactive materials, even where the level of radiation dose and risk to public health exposure is low. This will be achieved through information being passed to Silver Control up to Gold control.

11.6. Vulnerable Persons

Within the Civil Contingencies Act 2004, the particular needs of vulnerable persons should also be recognised. The general definition of vulnerable persons is: people present or resident within an area known to local responders who, because of dependency or disability, need particular attention during emergencies.

(The NHS Emergency Planning Guidance 2005, DoH)

In terms of the Act, vulnerable persons are defined as those:

- Under the age of 16.

- Inhibited in physical movement, whether by reason of age, illness (including mental illness), disability, pregnancy or other reason.
- Deaf, blind and visually impaired or hearing impaired.

Children – children may be involved in a major incident, either as casualties or as members of families or groups caught up in the event. 6.5 of the plan refers to the dealing of children from an incident. Specific guidance on dealing with children in the context of emergency preparedness is currently being developed by the department of health.

Non-English-speaking Communities and Faith Groups – at the scene of an incident simple language guides will generally be available to assist with incident management. Existing arrangements within a trust may be sufficient for dealing with usual numbers of people from the non-English speaking communities and faith groups; however, the scale of an incident may require assistance being sought from other sources.

(refer to RWHT Interpreting Services – provided by Big Word)

People with Learning Difficulties and Mentally Ill People – The Trust's existing facilities and procedures may be sufficient to assist people with learning difficulties and mentally ill people during the course of a major incident; however, there may be small numbers for whom additional and/or specialist assistance may be required.

11.7.1 Mass Casualty Incidents

NHS organisations have previously demonstrated their ability to deal with major incidents, but now need to demonstrate their ability to prepare for, and respond to, events that may result in patient numbers well in excess of those used in past planning assumptions.

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" (Emergency Preparedness Division - Mass Casualties Incidents – A Framework for Planning, DH, March 2007)

The NHS has defined 3 levels of incidents:

Level 1 - Major

Level 2 - Mass

Level 3 – Catastrophic

These are referred to in section 1.2 of the plan

The basic operational principles for dealing with an incident which results in mass casualties are the same as for a major incident.

The Command and Control arrangements and operational procedures for dealing with any of the 3 levels described are the same. The impact of a genuine mass casualty incident has the potential to rapidly overwhelm – or threaten to exceed – the local capacity available to respond. The Trust will need to create additional capacity to deal with an increased number of casualties. This could be achieved by cancelling all elective work, transferring patients temporarily to non acute facilities in liaison with the local PCT and Social Service Departments.

A mass casualty incident is likely to have a longer duration than other major incidents, so the Trusts control teams will be required to ensure the response can be sustained over a long period of time.

Section 12 – Debrief and Post Event

At the conclusion of any incident consideration should be given to identifying the strengths and weaknesses of the response through incident debrief. Initially post incident debriefing (Hot debriefing) should be conducted by Team Leaders.

12.1 Hospital and Departmental debrief

At the command "Major Incident Stand down" each department will be required to hold a short debrief meeting drawing out issues that presented problems or where improvements can be made to the process and response.

A representative from each of the departments listed at Appendix E will attend the Hospital Debrief meeting which will be called by the Director leading the Gold Control Team. The usual venue will be the Conference Room unless otherwise stated at a time determined by the Director, but no later than a few hours after the incident. Any documentation from the incident may be used to assist in the discussions.

This is an opportunity for everyone involved in an exercise / incident to comment on the organisational response. The purpose of the debrief is to capture the lessons learned for subsequent analysis. A debriefing session after a Major Incident or exercise will help to:

- Inform future training
- Improve procedures
- Collect evidence for any enquiry
- Identify and respond to the need of the shift
- Identify staff support required

A sample agenda is attached as Appendix F but this can be adapted to suit the specific circumstances of the incident.

12.2 Participation in ERMA debrief

Participation may be required in the Strategic Debrief if ERMA is activated, the date will be notified to the Director. If no approach is made then the Director must check to see if attendance is required.

12.3 Staff Support and Wellbeing Following the Event

The welfare and wellbeing of all staff during a Major Incident is highly important. Major Incidents can be traumatic events, and staff will probably need some additional support in the time following the incident. Many members of staff could find the experience of dealing with an incident extremely stressful. An incident is managed as a team and all members of the team maybe affected and have the right to be considered equally. The first step in dealing with a stressful situation is to talk through it with someone you trust and who can listen. In the first instance this is likely to be a work colleague. But no-one has to talk about how they feel, some will choose not to disclose or express personal feelings. If you have concerns about a colleague you should consider sharing your concerns with your line manager.

Managers are asked to note any particular needs of staff and in extreme cases to refer to Occupational Health for help with stress related issues.

The Chaplaincy Department can also be a valuable source of support following an incident.

National Reference Documents

The Major Incident Plan has been prepared in accordance with the following guidance.

Cabinet Office (2004) Civil Contingencies Act 2004.*Cabinet Office (2003)* Dealing with Disaster: Revised 3rd Edition

Cabinet Office (2005) Emergency Preparedness

Department of Health (2000) Deliberate Release of Biological and Chemical Agents: Guidance to help plan the Health Service Response.

Department of Health (2002) Emergency Planning and Response to Major Incident: Summary of roles and Responsibilities

Department of Health (May 2004) Handling Major Incidents: An Operational Doctrine

Department of Health (2005) Emergency Preparedness Division. The NHS Emergency Planning Guidance 2005.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121072

Department of Health (2005) Emergency Preparedness Division. The NHS Emergency Planning Guidance 2005. Planning for the management of Blast Injured Patients

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081506

Department of Health (2005) Emergency Planning Guidance 2005:underpinning materials

Critical care Contingency Planning in the event of an emergency where the numbers of patients substantially exceeds normal critical care capacity.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081282

Department of Health (2007) Emergency Preparedness Division. Strategic Command Arrangements for the NHS During a Major Incident.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081507

Department of Health (2007) Emergency Preparedness Division. Mass Casualties Incidents – A Framework for Planning.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073395

Department of Health (2007) NHS Emergency Planning Guidance 2005.

Planning for the management of Burn Injured Patients in the Event of a Major Incident.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081281

Department of Health (2008) NHS Resilience and Business Continuity Management Guidance. *Interim Strategic National Guidance for NHS Organisations*

Health Protection Agency (2005) CBRN incidents: Clinical Management and Health Protection.

Home Office (2004) The Decontamination of People Exposed to Chemical, Biological, Radioactive and Nuclear substances or Materials – Strategic National Guidance.

National Audit Office (2002) Facing the Challenge: NHS Emergency Planning in England

The Corporate Manslaughter and Corporate Homicide Act 2007

http://www.hse.gov.uk/corpmanslaughter/

National Major Incident Plan for Burn Injury

http://www.specialisedservices.nhs.uk/safe_sustainable/burn-major-incident-plan

STAC

http://intranet/pdf/major_incident_plan/STAC.pdf

Local Reference Documents

Business Continuity Strategy
http://intranet/pdf/major_incident_plan/Business_Continuity_Strategy.pdf

Capacity Management Policy OP 65
http://intranet/pdf/policies/OP_65_Policy.pdf

Chemical Incident Plan
http://intranet/pdf/major_incident_plan/Chemical_Incident_Plan.pdf

Emergency Preparedness Strategy
http://intranet/pdf/policies/ST_Emergency_Preparedness_Strategy.pdf

Health & Safety Policy HS 01
http://intranet/pdf/policies/HS_01_Policy.pdf

Helicopter Landing Procedure (Available in the A&E Department)

Infection Prevention Policies
http://intranet/policies_and_strategies/infection_prevention_and_contr.aspx

Lockdown Protocol
http://intranet/pdf/major_incident_plan/Hospital_Lockdown_Protocol.pdf

Major Incident Action Cards/Procedures
http://intranet/emergencypreparedness/major_incident_cards.html

Major Incident Communication Plan
http://intranet/pdf/major_incident_plan/Major_Incident_Communications_Plan.pdf

Nair Plan
http://intranet/pdf/major_incident_plan/NAIR_Plan.pdf

Pandemic Influenza Plan
http://intranet/pdf/major_incident_plan/pandemic_influenza_plan.pdf

DISTRIBUTION LIST

In order to comply with the requirements of being a Category 1 responder under the terms of the Civil Contingencies Act 2004 the Trust has a responsibility to share its plans with partner agencies and the public. This list will identify those partner agencies that the plan is share with.

External Distribution List

Lead PCT for Emergency Planning:	Health Emergency Preparedness for the West Midlands Conurbation
NHS Acute Trust:	Walsall NHS Trust Dudley Group of Hospitals NHS Trust
Primary Care Trusts:	Wolverhampton PCT South Birmingham PCT
Emergency Services:	West Midlands Ambulance Service Wolverhampton Police Wolverhampton Fire Service Staffordshire Police & Fire Service
Local Authorities:	Wolverhampton City Council
Other	Wolverhampton Resilience Forum (WRF)

Internal Distribution List

Printed Copies

Chief Executives Office (one copy)
Emergency Planning Officer (one copy)
Emergency Department (one copy)
Emergency Assessment Unit (one copy)
Ward D3 (one copy)
Heart and Lung Centre (one copy)
Security Office (one copy)
Silver Control Room (two copies)
Gold Control Room (two copies)
Emergency, Medical and Community Service Division (Three copies)
Surgical Division (Two copies)
Switchboard (one copy)
Divisional Manager Facilities and Estates (one copy)
Divisional Manager IT (one copy)
Capacity Management Office (one copy)

An electronic version of this plan will be made available via the intranet for all members of staff and an electronic version of the non-confidential sections of the plan will be published on the Trust website to comply with our requirements to warn and inform the general Public.

EMERGENCY RESPONDERS

Category 1 Responders ["core responders"]	Category 2 Responders ["co-operating responders"]
Emergency Services • Police forces • British Transport Police • Fire authorities • Ambulance services • Maritime and Coastguard Agency Local Authorities • All principal local authorities [i.e. metropolitan districts, shire counties, shire districts, shire unitaries] • Port health authorities Health bodies • Primary Care Trusts • Acute Trusts • Foundation Trusts • Local Health Boards [in Wales] • Any Welsh NHS Trust that provides public health services • Health Protection Agency Government agencies • Environment Agency	Utilities • Electricity distributors and transmitters • Gas distributors • Water and sewerage undertakers • Telephone service providers [fixed and mobile] Transport • Network Rail • Train operating companies [passenger and freight] • London Underground • Transport for London • Airport operators • Harbour authorities • Highways Agency Health bodies • Strategic Health Authorities Government agencies • Health and Safety Executive

Emergency Pod Supplies

A national stockpile of drugs and equipment for use in chemical and biological incidents are available through the National Mass Casualty Vehicles, they have been packed into "pods" and distributed to strategic sites around the United Kingdom.

These pods are for use by all acute hospitals and ambulance services, if required.

Pod Number	*Pod Description*	*Location*
1	Modesty Pod	These are held by 14 nominated Ambulance services. Access is via local ambulance service. (West Midland Ambulance Service 01384 451665)
2	Nerve Agent Pod	These are held by the National Blood Service in England. Access is via local ambulance service. (01384 451665)
3	Equipment Pod	These are held by 14 nominated Ambulance services. Access is via local ambulance service. (01384 451665)
4	Biological Ciprofloxacin Pod	These are held by the NHS Logistics Authority. Access is via the UK Reserve Stock Hotline for Major Incidents. (01384 451665) 01245-442211
5	Biological Doxycycline Pod	These are held by the NHS Logistics Authority. Access is via the UK Reserve Stock Hotline for Major Incidents. (01384 451665) 01245-442211

Should you require:

1. Obidoxime to treat nerve agent poisoning in patients failing to respond to pralidoxime chloride.

or

2. Botulinum Antitoxin contact Blood Bank who will then ring the local National Blood service Issue Department to request the above.

Appendix C

Major Incident Record Sheet (METHANE)

ALERT A&E via RED PHONE then FAX 2 Copies URGENTLY TO A&E
A&E - Fax - 695661

Name of Caller:	
Originating Organisation: If other please state who	Police / Fire / Ambulance / Other
Date & Time of Call:	
Contact Number:	

Major Incident:	STANDBY / DECLARED
Exact location of Incident:	
Type of Incident: Give Brief Description:	RTC, Fire, Rail, Explosion, Chemical, Radiation, Terrorist, (CBRN) etc
Hazards: (Either present or potential)	
Arrival Time:	
Number of casualties involved or likely to be affected: Adults/Children etc Types of Injuries:-burns, trauma	
Emergency services activated and responding	Ambulance / Fire / Police / Helicopter

Completed By (Signature):	
Completed By (Name):	
Completion Date:	
Completion Time:	

Appendix D

Contact Details for Radiation Advice

Point of First Contact of the Casualty with the NHS	Primary Care Trusts	Health Protection Unit	Local Medical Physics Support
Hospitals with A&E Department Russells Hall Hospital (DGH) TEL: 01384 456111 New Cross Hospital (RWH) TEL: 01902 307999 Manor Hospital Walsall TEL: 01922 721172 **Minor Injuries Units** **Walk in Centres** Walsall NHS Walk in Centre, Market Square, Digbeth, WS1 1QZ. TEL: 01922 858550 The Mailing Centre, Parsonage St, West Brom, B71 4DL TEL: 0121 612 3575 Dudley Borough Walk in Centre, Holly Hall Clinic, 174 Stourbridge Road, Dudley, DY1 2ER. TEL: 0330 123 9225	Dudley Walsall Wolverhampton	**HPA West Midlands West** Elgar House Green St Kiddermister DY10 1JF Tel: 01562 756300 Fax: 01562 756302	Medical Physics New Cross Hospital, Wolverhampton **Office Hours** Tel: 01902 307999 (switch) Malcolm Foley **01902 695 522** (x6191) **Out of Hours** Tel: **01902 307999** (via hospital switchboard, ask for NAIR responder)

Appendix E

Post Incident Debrief

Debrief Attendees	
	* Gold Commander
	* Silver Commander
	* A&E Nurse in Charge/Consultant/Reception lead/HALO
	Switchboard representative
	* EAU Nurse in Charge/Consultant
	* Ward D1 Nurse in Charge
	OPD1 Nurse in charge
	Hotel Services Lead
	Chaplain
	Haematology/Clinical Chemistry Duty Managers
	Pharmacy Lead
	Stores Lead
	* Matron – Surgical
	* ICCU representative – Nurse in Charge/Consultant
	* Theatres Practitioner in charge
	Medical Physics/Medical Library
	* Community Services On Call Manager
	Engineer/Security Lead
	* Local Security Management Specialist (LSMS)
	Therapy Services
	Health Records Lead
	Patient Transport Lead

*Required attendees – All others may send a deputy

Appendix F

Sample Agenda for Debrief Meeting
To be chaired by Gold Commander
Date Venue

A G E N D A

1. Overview of Incident

2. Number of Casualties treated

3. Number of Casualties admitted

4. Report from A&E

5. Report from EAU and Medicine

6. Report from Surgical/Orthopaedic Zone

7. Report from ICCU

8. Report from Theatres

9. Other Departmental Reports

10. Identify Lessons Learned
    - 3 Weaknesses of the response
    - 3 Strengths of the response
    - Identify any immediate changes to the plan

11. Thanks to participants