NHS
Telford and Wrekin
Clinical Commissioning Group

EMERGENCY PREPAREDNESS RESILIENCE & RESPONSE (EPRR)

INCIDENT RESPONSE PLAN

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Version 1

22 November 2013

Reviewed 5th August 2015

Amendment & Review Record on page 31

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Date	22 November 2013
Audience	CCG on-call (Accountable Officer, Senior Manager On call)
Copy to	Members of local health resilience partnerships (LHRPs) NHS England North Midlands EPRR lead
Description	This is an operational response plan. Please read this document in the context of: the Telford & Wrekin CCG rota and contacts (circulated monthly) the NHS England Sub region Incident Response Plan
Cross reference	http://www.england.nhs.uk/ourwork/eprr/
Action required	This plan has been developed to ensure that all CCG staff are able to carry out their respective functions when responding to major incidents or during emergency situations on behalf of the NHS England Sub Region. It is important staff in the CCG understand this plan and are aware of their specific roles and responsibilities.
Timing	To be used by the CCG on-call in the conjunction with the NHS England Area Team (AT) Incident Response Plan from 1 April 2013.
Contact details	Mrs C Morris – 01952 580334

PART 1 – GENERAL INFORMATION

1.1 AIM

The aim of this plan is the set out how the Clinical Commissioning Groups (CCGs) will support the NHS England Sub Regional Team to mobilise, and where necessary co-ordinate the local NHS in the event of an emergency or major incident.

1.2 OBJECTIVES

The objectives of this plan are to:

Set out roles and responsibilities:

- Define what a major incident is and outline the types of emergency that the local NHS might be expected to respond to;
- Identify the potential hazards faced locally;
- Outline the command, control and co-ordination arrangements both internally within in the local NHS and in the multi-agency context by identifying stakeholders and operational plans, including the decision making process;
- Establish a framework within which the AT's roles and responsibilities can be fulfilled through the CCGs during the response to a major incident;
- Identify the arrangements for communicating information to staff, patients and stakeholders both prior to, during and after a major incident;
- Outline the process for recovery from a major incident.

1.3 LEGAL FRAMEWORK

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

The Health and Social Care Act 2012 provides that the Secretary of State for Health (and thus Public Health England) and NHS England will be Category 1 responders under the Civil Contingencies Act. CCGs will be Category 2 responders. Category 2 responders are co-operating bodies and generically, their roles will be to co-operate and share relevant information with Category 1 responders. They are also required to have business continuity plans in place.

1.4 DEFINING A MAJOR INCIDENT

The CCA defines an emergency as:

> ***An event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK.***

The definition is concerned with consequences rather than the cause or source.

For the purposes of this definition, an event or situation threatens damage to human welfare only if it involves causes or may cause:

Loss of life;

Human illness or injury;

Homelessness;

Damage to property;

Disruption of a supply of money, food, water, energy or fuel;

Disruption of a system of communication;

Disruption of facilities for transport; or

Disruption of services relating to health

For the NHS, major incident is the term in general use. However, the term 'emergency' may be used Instead of incident. For the NHS, a major incident is defined by the Department of Health as:

> ***Any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations[2].***

The NHS is accustomed to normal fluctuations in daily demand for services. Whilst at times this may lead to facilities being fully stretched, such fluctuations are managed without activation of special measures by means of established management procedures and escalation policies. It therefore follows that a major incident is any event where the impact cannot be handled within routine service arrangements.

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

[2] DH Emergency Planning Guidance 2005

A major incident may arise in a variety of ways and the response will be sufficiently flexible to assess and respond appropriately to any of these situations.

	Examples
Big Bang	A sudden incident, such as a major road traffic incident, explosion or series of smaller incidents
Rising Tide	A developing infectious disease epidemic, or capacity/staffing crisis or forecast of severe weather
Cloud on the Horizon	A serious threat such as a major chemical or nuclear release developing elsewhere, needing preparatory actions
Headline News	Public or media alarm about a perceived threat
Internal Incidents	Anything that affects a provider's ability to deliver services such as fire, breakdown of utilities, major equipment failure, hospital acquired infections, violent crime
Deliberate Release	This threat may come from an accident at a chemical or nuclear facility, from a transport incident, from a terrorist or dissident group or disaffected individuals
Mass Casualties	Casualty numbers that are beyond the capacity created by the local implementation of major incident plans – or other major disruptive challenges to the delivery of health care, regardless of their cause
Pre-planned Major Events	Major events that require planning, such as sports fixtures, mass gathering of people, demonstrations etc.

1.5 RISK PROFILE

Major incidents may take many forms.

The potential hazards that may affect communities have been identified, assessed and then ranked according to severity of potential impact and the likelihood of occurrence, and can be found on the West Mercia Prepared website at:

http://www.westmerciaprepared.org/index.php?riskcat=-1

The Risk Register takes into account national and regional hazard assessments mirroring the National Capabilities programme; the multi-agency Risk Assessment Group reviews the Risk Register on a quarterly basis.

This plan is designed as an all risks generic plan to support the mobilisation and co-ordination of local NHS resources on behalf of the AT in the event of a major incident/emergency.

1.6 ROLES AND RESPONSIBILITIES

During the planning phase, CCGs are required to:

- Co-operate and share relevant information with Category 1 responders;
- Engage in discussions (including at the Local Health Resilience Partnership (LHRP)) where this will add value;
- Maintain robust business continuity plans for their own organisations;
- Test and update their own business continuity plans to ensure they are able to maintain business resilience during any disruptive event or incident.
- Support the NHS England in discharging its EPRR functions and duties locally, ensuring representation on the LHRP.
- Provide their commissioned providers with a route of escalation on a 24/7 basis – the CCGs maintain a shared rota of senior managers;
- Include relevant EPRR elements (including business continuity planning) in contracts with provider organisations in order to:
- Ensure that resilience is "commissioned-in" as part of standard provider contracts and to reflect local risks identified through wider, multi-agency planning;
- Reflect the need for providers to respond to routine operational pressures, e.g. winter, failure of providers to continue to deliver high quality patient care, provider trust internal major incidents;
- Enable NHS-funded providers to participate fully in EPRR exercise and testing programmes as part of NHS England EPRR assurance processes.

During the response phase, CCGs will therefore:

- Respond to reasonable requests to assist and co-operate. This will include supporting the NHS England Area Team (AT) should any emergency require local NHS resources to be mobilised;
- Have a mechanism in place to mobilise all applicable providers that support primary care services should the need arise;
- Support providers to maintain service delivery across the local health economy (LHE) to prevent business as usual pressures and minor incidents from becoming significant incidents or emergencies;
- Have systems to manage their provider organisations to effectively coordinate increases in activity across the local health economy;
- At the request of the Area Team, represent the local health economy at any Tactical Co-ordinating Group (TCG) in the event that the incident requires multi-agency command and control arrangements to be instigated on a county level (NB. The AT will represent the NHS at the Strategic Co-ordinating Group when convened);
- Escalate significant incidents and emergencies to the AT.

PART 2 – MANAGEMENT, CONTROL AND CO-ORDINATION

2.1 ROUTINE MANAGEMENT ARRANGEMENTS

The NHS is accustomed to normal fluctuations in daily workload. Whilst at times this may lead to services and facilities being stretched, such fluctuations are managed through established management procedures and the LHE's surge management plans. This plan is not intended to deal specifically with these situations; however, this plan may be activated when LHE reaches Level 4 – Extreme Pressure across the whole system.

Local NHS provider organisations have 24/7 management arrangements in place through on-call systems. The CCGs also have an on-call system in place to provide their commissioned providers with a route of escalation on a 24/7 basis, whether the issue relates to capacity or is incident related. This on-call system will be the single point of contact during a major incident.

2.2 LEADERSHIP OF THE RESPONSE TO PUBLIC HEALTH INCIDENTS

Most public health incidents are contained locally and do not require activation of LRF or NHSE Sub regional level plans. All incidents have the potential to require NHS resources. The route of escalation in public health incidents will be from Public Health England to the NHSE Sub Regional Director on-call who will sanction any expenditure required; the NHSE Sub Regional Incident Manager (first on-call) may contact the CCG on-call to mobilise and coordinate the local NHS response. The NHSE Sub Regional Director will determine at what point command of the incident passes to the NHS.

2.3 ESCALATION TO THE CCG ON-CALL BY PROVIDERS

Typically, provider organisations will contact the CCG on-call when:

- There is intelligence to suggest severe disruption to NHS services is likely, or where significant problems are being experienced by commissioned providers within the county that threaten the provider's ability to provide essential and critical care;
- Business continuity arrangements have been activated in support of a critical service;
- Estate related matters including theft, fire and vandalism concerning CCG owned/occupied estate have been alerted to the provider ;
- Serious clinical incidents and SUIs affecting public or patients;

  Serious performance issues;
- Where the provider has been made aware that a major incident or emergency has been declared by any Category 1 responder or NHS organisation in West Mercia;
- The incident requires the mobilisation of NHS resources;
- Any incident or occurrence likely to focus media attention on NHS funded care within the county;
- The provider has been asked to provide a service which is not funded under an existing contract, and for which they require authorisation.

2.4 ROLE OF THE CCG ON-CALL

The CCG on-call will:

On notification of a serious incident, make an **INITIAL RISK ASSESSMENT** of the situation to determine what action needs to be taken informing provider organisations accordingly;

Questions to consider	Information Collected?*
What is the size and nature of the incident?	
Area and population likely to be affected - restricted or widespread	
Level and immediacy of potential danger - to public and response personnel	
Timing - has the incident already occurred or is it likely to happen?	
What is the status of the incident?	
Under control	
Contained but possibility of escalation	
Out of control and threatening	
Unknown and undetermined	
What is the likely impact?	
On people involved, the surrounding area	
On property, the environment, transport, communications	
On external interests - media, relatives, adjacent areas and partner organisations	
What specific assistance is being requested from the NHS?	
Increased capacity - hospital, primary care, community	
Treatment - serious casualties, minor casualties, worried well	
Public information	
Support for rest centres, evacuees	
Expert advice, environmental sampling, laboratory testing, disease control	
Social/psychological care	
How urgently is assistance required?	
Immediate Within a few hours Standby situation	
***Key √ = Yes X = no ? = Information awaited N/A = Not applicable**	

In making this assessment, it is important to distinguish between:

- Events that can be dealt with using normal day to day arrangements;
- Events that can be dealt with within the resources and emergency planning arrangements of the
- CCGs and local NHS provider organisations;
- Events that require a joint co-ordinated response from the organisations across the area;
- Events that require a strategic level co-ordinated multi-agency response

across the Local Resilience Forum or wider health community, which will become the responsibility of the NHSE Sub Regional Director

The CCG on-call will then:

Inform the NHSE Sub Regional Director on-call using the **INITIAL RISK ASSESSMENT** and **determine the chain of command for the incident** (for a local incident, the NHSE Sub Regional Director on-call is likely to determine that command and control will rest with the CCG on-call).

If an incident is declared the CCG will;

- Ensure that the strategic aims and objectives are in line with NHS England direction, and are reviewed regularly;
- Ensure appropriate documents and records are being kept and all organisations are aware of the need to capture accurate financial information of any expenditure incurred as a result of the incident;
- Ensure where possible that the response can be maintained within the LHE; additional resources should be requested through the NHSE Sub Regional Director on-call where required;
- Ensure the CCGs critical services are maintained;
- Attend the multi-agency Tactical Co-ordinating Group if requested to do so and ensure that the NHSE Sub Regional Director on-call is aware of any SCG arrangements;
- Ensure that the risk assessment is re-visited regularly and that any significant issues are escalated to the NHSE Sub Regional Director on-call immediately (see **ESCALATION CRITERIA** below);
- Decide when the incident is over and stand down the local NHS response;
- Ensure that all CCG staff who have been involved in the response to the incident are debriefed;
- Ensure that any lessons learned are incorporated into future incident response arrangements and an incident report (where appropriate) is written.
- Ensure that the Chief Operating Officers and CCG Clinical Leads are informed in a timely manner.

Escalation or de-escalation of the incident does not necessarily occur sequentially. It can be driven by the nature and scale of the incident and the appropriate response. Reasons for escalation / de-escalation can include:

Criteria for Escalation to the NHSE Sub Region	Criteria for De-escalation

Increase in geographic area or population affected (pandemic, flooding etc.) The need for additional internal resources Increased severity of the incident Increased demands from government departments, the service or from partner agencies or other responders Heightened public or media interest	Reduction in internal resource requirements Reduced severity of the incident Reduced demands from partner agencies or government departments Reduced public or media interest Decrease in geographic area or population affected

2.5 INCIDENT MANAGEMENT TEAM

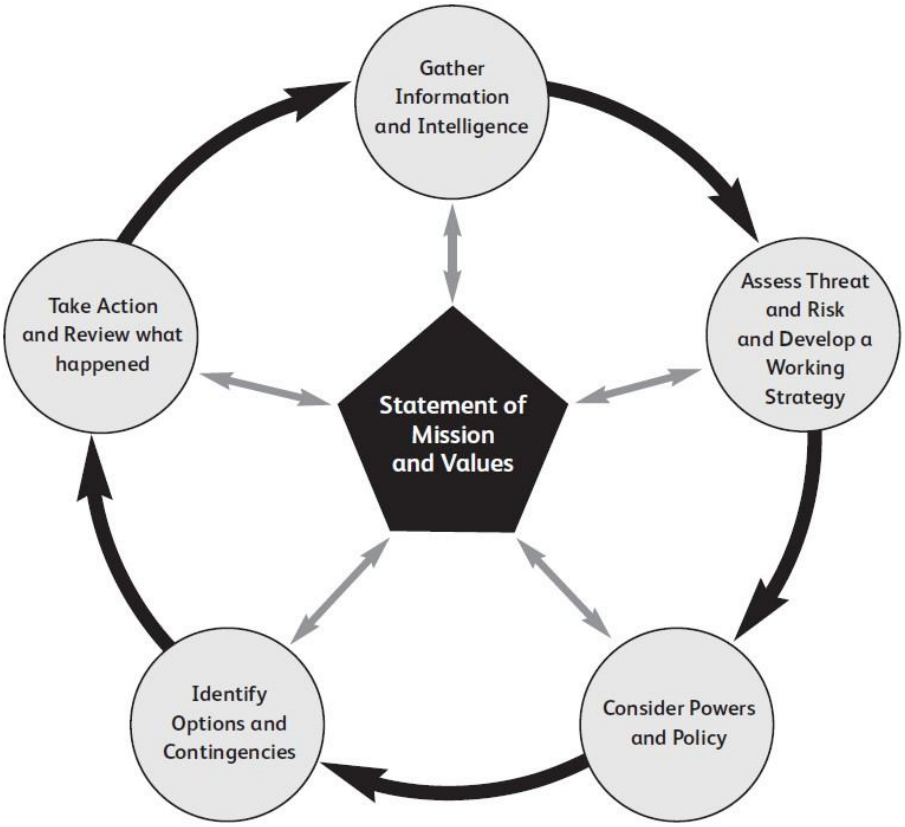
The primary function of the CCG Incident Management Team is to collate information regarding the operational/tactical response across the local NHS, gather intelligence from wider sources relating to the incident and ensure the efficient flow of information between the chain of command and partner agencies.

2.6 INCIDENT COORDINATION CENTRE (ICC)

The ICC serves as a focal point for all liaison with NHS and partner agencies regarding the incident, and is likely to be established in either CCG HQ. Alternatively, it could be co-located within a provider organisation Control Room. The ICC will be staffed by the Incident Management Team, and other relevant personnel. The NHSE Sub Regional Lead will provide you with your ICC plan.

2.7 DECISION MAKING

The ACPO National Decision Making model can be used as a framework for decision making throughout the course of an incident. The model is cyclical where each step logically follows another and allows for continued reassessment of the situation or incident enabling steps to be revisited.



2.8 MULTI-AGENCY COMMAND AND CONTROL PRINCIPLES

Further details on the multi-agency command and control structure and roles and responsibilities of other responders are contained in the following documents held \\xscpcttwpct.nhs.uk\sctw-dfs\TW CCG Policies\Emergency Planning and Business Continuity Plan

- *West Mercia Local Resilience Forum Joint Emergency Response Arrangements (JERA);*
- *Shropshire Multi-Agency Tactical Silver Plan;*
- *WMLRF Guide for Gold Commanders attending Strategic Co-ordinating Group (SCG)*

The management of the multi-agency response and recovery effort is undertaken at one or more of three ascending levels:

2.8.1 Operational (Bronze)

Refers to those who provide the immediate 'hands on' response to the incident, carrying out specific operational tasks either at the scene or at a supporting location such as hospital or rest centre.

2.8.2 Tactical (Silver)

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

2.8.3 Strategic (Gold)

Responsible for determining the overall management, policy, and strategy for the incident whilst maintaining normal services at an appropriate level. They should ensure appropriate resources are made available to enable and manage communications with the public and media. Additionally they will identify the longer term implications and determine plans for the return to normality once the incident is brought under control or is deemed to be over.

Not all these command levels are necessarily activated - depending on the scale of incident and response. The general approach is to escalate the levels with the increasing size and complexity of the response required.

In complex, large scale incidents, there is a need to co-ordinate and integrate the strategic, tactical and operational response of each responder. The **STRATEGIC CO-ORDINATING GROUP** (SCG), which is usually chaired by the Chief Constable, will meet at the Strategic Co-ordinating Centre (SCC) which will normally be established at Halesfield 6, Telford. The local NHS will be represented by the NHSE Sub Regional Director on-call.

The **MULTI-AGENCY TACTICAL CO-ORDINATING GROUP** will be convened to determine the tactical response to an emergency/major incident through examination of the circumstances prevailing, identifying priorities and making tactical decisions. If the SCG is sitting it may make policy directions to the TCG. CCGs might be requested by the NHSE Sub Regional Director on call to attend and represent the LHE.

Multi-agency command and control structures exist in passive form, a Strategic Assessment Meeting (SAM) may be convened as such during a slow burn/cloud on the horizon event to enable multi-agency partners to make preparations.

PART 3: TRIGGERS, ALERTING PROCESS & ACTIVATION

3.1 TRIGGERS

This plan can be triggered in several ways to a potential or actual incident:

In response to internal pressure within the NHS (an **internal** decision) in response to a local incident;

External alert that a multi-agency Tactical Co-ordinating Group is being convened;

External alert that a Strategic Co-ordinating Group is being convened;

External alert that an agency has called a major incident "Stand By";

External alert that a major incident has been "Declared"/"Implemented"; and

In response to a national or regional NHS England direction.

3.2 ALERTING PROCESS

Internal alerts will usually be routed via Directors on-call from provider organisations.

The CCG on-call will be the single point of contact for the NHS Provider Services in the event of major incident stand-by or a major incident being declared in the county. Multi-agency and external alerts are most likely to come via the Area Team, and will include any incident triggering the establishment of the Area Team ICC, such as:

Major Incidents (including road, rail or aircraft accidents);

Explosions;

Evacuations involving a number of people or where additional medical support may be required;

Large fires in residential areas;

Fires in residential areas where asbestos is suspected or confirmed;

Flooding with potential for evacuation;

Flooding causing significant transport disruption;

Burning of non-natural wastes at agricultural premises with potential exposure to large numbers of people;

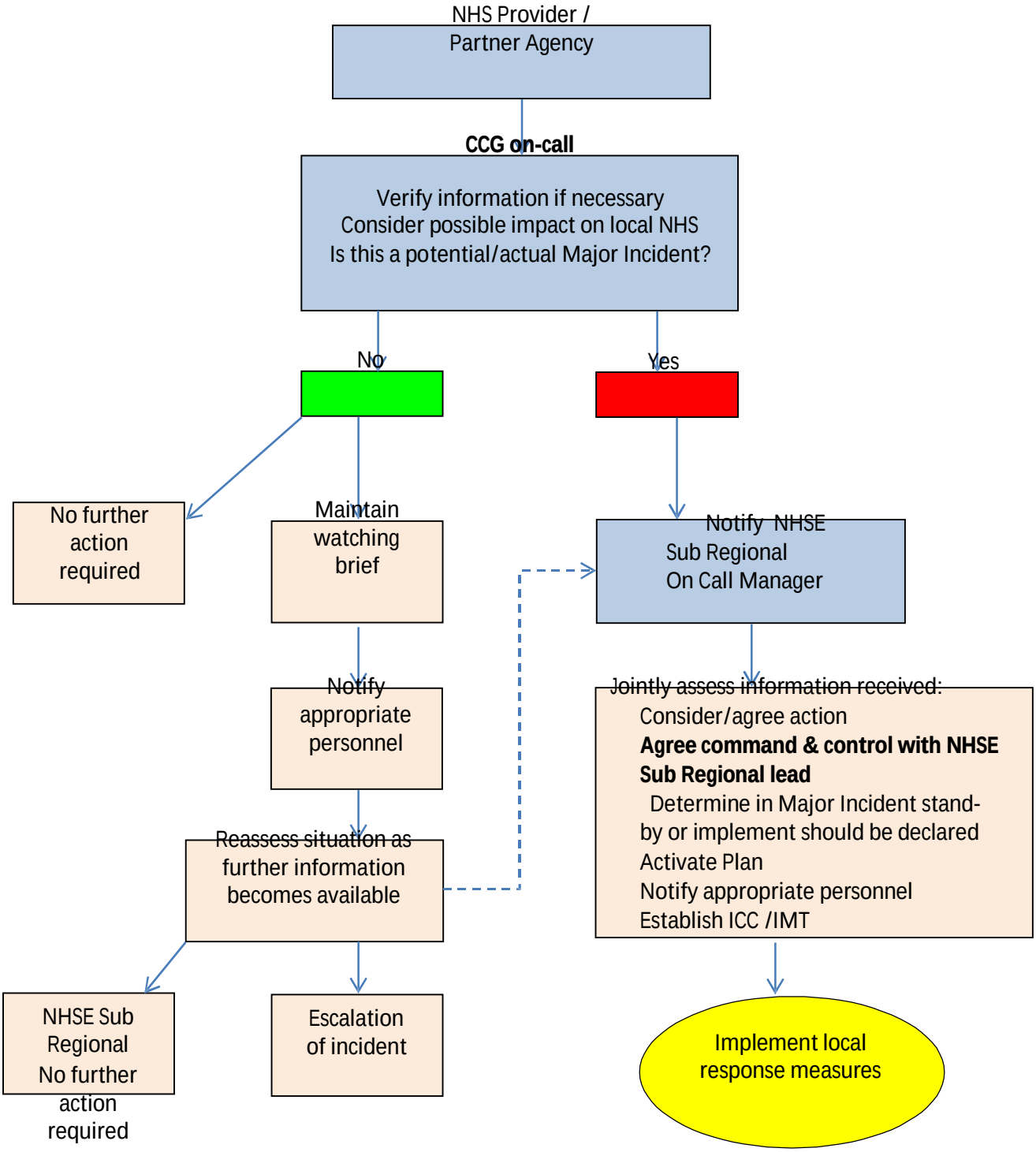
Toxic chemical release with the potential of affecting the population.

3.3 ONWARD ALERTING

The CCG on-call will be responsible for ensuring internal staff, provider organisations and the AT Director on-call are alerted in line with the **ACTION CARD**.

3.4 ACTIVATION

ACTION on receipt of an alert: Activation algorithm



PART 4: ACTION

4.1 Records management

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

4.2 Shift arrangements

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

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

PART 5: STAND-DOWN

In consultation with the AT Director on-call, the CCG on-call will decide when an emergency or major incident stand down should be declared for the LHE, which may be long after the emergency services response is over. This could be either a full or partial stand down with one or more individuals monitoring the situation.

5.1 INITIAL "STAND DOWN"

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

5.2 ADMINISTRATION

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

5.3 RECORDS MANAGEMENT

All logs, records and other details from the incident will be collected and secured from all personnel involved and kept safe.

5.4 DEBRIEFS AND REPORTS (Co-ordinated by NHSE Sub Regional Director)

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

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

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

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

5.5 LESSONS IDENTIFIED PROCESS

This process is the responsibility of the NHSE Sub Regional Lead , if they are involved; if they are not involved it is the responsibility of the CCG:

A separate Lesson Identified report will focus on areas where response improvements can be made in future. This report will include the following sections:

Introduction

Observations

Action Plan (detailing recommendations, actions, timescales and owner).

Throughout the incident at whatever level, there will need to be an agreed process in place to evaluate the response and recovery effort and identify lessons. The Incident Director is responsible for activating the lessons identified process and may delegate the responsibility for lessons identified to the Emergency Planning Manager. The lessons identified process will be implemented at the start of the response and continue during and after the incident until all actions are completed.

Re 5.4 and 5.5 – In cases where the NHSE Sub Regional Lead assumes command and control, CCGs will be required to contribute to the process.

ACTION CARD	INCIDENT DIRECTOR "STAND BY"	
Accountable to	NHSE Sub Regional Incident Director	
Responsible for: assessing the initial information received in respect of a potential or actual major incident and escalating to the NHSE Sub Regional On Call Manager		
Number	**Action**	**Time Completed**
1.	In the event of a potential or actual significant / major incident, the 1st on call will usually be notified by: West Midlands Ambulance Service (WMAS) Provider organisations Public Health England (PHE) NHSE North Midlands Team Notification may also come from other partner agencies.	
2.	Start a personal log detailing information received and actions taken. Copies of the log book can be found in the on call pack. Ensure formal logging of your actions/decisions is in place as soon as possible.	
3.	If necessary, verify the information received by contacting the initial caller, the police, the local authority or other appropriate partner agency.	
4.	Obtain as much information about the incident as possible (METHANE) and begin to complete the log held in the on call pack, including any specific or urgent actions required from the NHS.	
5.	Advise the NHSE Sub Regional On Call Manager immediately.	
6.	Determine the severity of the situation and consider the potential impact of the incident on the local health economy.	
7.	If it is a potential or actual incident for the NHS, or if incident standby or a major incident has been declared by a partner agency, notify the NHSE Sub Regional On Call Manager.	
8.	In liaison with the AT On Call Manager, assess the information received and consider action to be taken.	
9.	On **activation** of the Incident Response Plan notify relevant personnel. Contact numbers for these can be found in the on call pack. These may include: Relevant personnel within the CCGs NHSE Sub Regional On Call Manager WMAS Directors on-call Providers The on call manager for the appropriate Network(s) – Critical Care, Trauma, Burns Public Health England on-call Local Authority(ies) if required **SEE ACTION CARD ACTIVATE THE PLAN- INCIDENT MANAGER**	
10.	Provide further support to the NHSE Sub Regional team as required.	
11.	**If it is NOT a potential or actual major incident:** If no further action is required, complete the log If it can be dealt with using normal resources, notify the appropriate personnel and maintain a watching brief Continue to reassess the situation as further information becomes available and determine if any additional action is required In the event of any increase in the scale / impact of the incident reassess the risk and re escalate as needed.	

AREA TEAM WILL ASSUME COMMAND AND CONTROL IN THIS INSTANCE

ACTION CARD	**INCIDENT DIRECTOR "ACTIVATE THE PLAN"**
Accountable to	**NHSE Sub Regional Incident Director**

Responsible for: Managing the incident as tasked by the NHSE Sub Regional Incident Director (when activated). If aTCG is called the CCG Incident Director will attend on behalf of the local NHS. NHSE Sub Regional Director (NHS Gold) attends the SCG.

Number	**Action**	**Time Completed**
1.	Establish liaison with the appropriate personnel from PHE, NHS Trusts and partner agencies.	
2.	Confirm that the relevant command and control structures have been implemented across the local health economy.	
3.	Confirm that all relevant personnel internally, at the AT and externally have been informed.	
4.	Confirm with the AT Incident Director the NHSE Sub Regional teams's aim and objectives for	
	The following actions are incident dependent: A meeting will be set up ASAP with key involved NHS organisations (plus PHE as indicated) (teleconference/face to face) Briefing out to local NHS trusts, clinical networks Situation Report to the NHSE Sub Regional team.	
5.	Identify battle rhythm dependant on: TCG and SCG meetings (if called) NHS external teleconferences/meetings Reporting requirements.	
6.	Establish an **Incident Management Team (IMT)** and brief the membership. This will depend on the incident but, as a minimum, should include: Emergency Planning Manager Communications lead Administrator Loggist In some incidents the IMT may include a Public Health England (PHE) liaison and a representative from the Public Health team.	
7.	Establish an **Incident Coordination Centre (ICC)** if indicated, tasking specific staff.	
8.	Ensure that all members of the IMT are working from the current Incident Response Plan, ensuring all required roles are undertaken	
9.	Where indicated by the type of incident, establish broader membership consisting of all responding organisations. Request attendance of a liaison person (by teleconference or in person) from each responding organisation including the appropriate network (Critical Care, Trauma, Burns). If this is not possible, confirm a single contact name and contact details.	
10.	As directed by the NHSE Sub Regional team, implement a media strategy and identify anappropriate person to represent the (a NHSE Sub Regional team and other NHS organisations if required) at any press conferences /	
11.	Ensure close communication and full two way briefings before and after each TCG meeting.	
12.	Ensure response to all TCG determined actions.	
13.	In consultation with the NHSE Sub Regional team , determine when the stand down should be declared (taking advice from partners as necessary) and inform the appropriate personnel / agencies of this.	

NHSE Sub Regional Team WILL ASSUME COMMAND AND CONTROL IN THIS INSTANCE

ACTION CARD	INCIDENT DIRECTOR "STAND DOWN"	
Accountable to	NHSE Sub Regional Incident Director	
When the 'Stand Down' command is given by the AT, the Incident Director will:		
Number	**Action**	**Time Completed**
1.	Ensure a process is in place for an appropriate return to business as usual internally and externally across the local NHS.	
2.	Support the multi-agency recovery phase if required.	
3.	Agree when staff involved in the incident should return to their normal duties.	
4.	Debrief the staff working in the incident room ("hot debrief").	
5.	Complete and sign off the incident log and ensure all relevant documentation is secured.	
6.	Ensure a formal report is prepared, highlighting any good practice or issues identified.	

ACTION CARD	STAFF OFFICER TO INCIDENT DIRECTOR (AT TCG)	
Accountable to	**2nd on call / Incident Director**	
Responsible for: Providing support to the Incident Director at the TCG, providing immediate liaison with the AT. If no TCG is called, this role becomes an operations officer in the ICC (see action card)		
Number	**Action**	**Time Completed**
1.	Attend TCG as directed by Incident Director.	
2.	Familiarise yourself with surroundings and ensure arrangements in place for the Incident Director and loggist including telecoms and Wi fi access. Liaise with other agencies as required.	
3.	Establish communication with Incident Director/ICC.	
4.	Support required information flows between Incident Director and Incident Manager.	
5.	Ensure that all briefing material is available to the Incident Director before each TCG meeting.	
6.	Ensure all actions are communicated from the TCG to the ICC.	
7.	Support the loggist who will be maintaining the decision-action log for the Incident Director.	
8.	Ensure resilience for your role and the loggist's role.	

ACTION CARD	LOGGIST
Accountable to	The person for whom they are logging: either Incident Director or Incident Manager
Responsible for: recording and documenting all issues/actions/decisions made by the Incident Director. If the Incident Director attends the TCG they will be accompanied by a loggist if possible. Within the ICC, a loggist will always be present working direct to either the Incident Director.	

Number	Action	Time Completed
1.	The loggist must use the log book provided.	
2.	On arrival all staff must wear Identification Badges. If the badges are unclear the loggist must ask for clarification of who is present within the room and their title.	
3.	The log must be clearly written, dated and initialled by the loggist at start of shift and include the location.	
4.	All persons in attendance to be recorded in the log.	
5.	The log must be a complete and continuous record of all issues/ decisions /actions as directed by the Incident Director/Incident Manager.	
6.	Timings have to be accurate and recorded each time information is received or transmitted. If individuals are tasked with a function or role this must be documented and when the task is completed this must also be documented.	
7.	If notes or maps are utilised these must be noted within the log.	
8.	At the end of each session in the log a score and signature to be added underneath the documentation so no alterations can be made at a later date.	
9.	All documentation is to be kept safe and retained for evidence for any future proceedings.	
10.	Where something is written in error changes must be made by a single line scored through the word and the amendment made.	

The loggist MUST NOT:

Take minutes
Record for more than one decision maker
Keep a separate chronological log
Have responsibility for the decision/action

The log and all paper work becomes legal documentation and could be used at a later date in a public enquiry or other legal proceedings.

ACTION CARD	COMMUNICATIONS LEAD	
Accountable to	**Incident Director**	
Responsible for: Providing communication co-ordination, advice and support to the Incident Director		
Number	**Action**	**Time Completed**
1.	Confirm with Incident Director that an incident is taking place.	
2.	Contact the NHSE Sub Regional team communications and agree who will be leading on	
3.	Commence personal log.	
4.	Issue pre-arranged public health / safety messages in conjunction with Public Health England within the first hour of becoming aware of the incident.	
5.	If requested to do so by the NHSE Sub Regional communications lead, assume responsibility for managing all public information and media communications. Note that if a SC/TCG are established all media responses are controlled and coordinated by them so communications input/feedback should be fed upwards into the SCG/TCG.	
6.	Rapidly formulate and implement an integrated media handling strategy on behalf of the local NHS response. Agree health spokespeople. If no SCG/TCG established, advise media (and stakeholders) on the regularity and timing of future media updates	
7.	Alert communications network of incident and advise of media handling strategy. Brief 111 on the information / advice to be given to the public.	
8.	Deal with all media enquiries/draft statements/organise press conferences and interviews as agreed in media handling strategy.	
9.	If a TCG or SCG are established, they will control messages about the overall incident and its health impact, to the media. Therefore it is vital that communications leads from local health organisations act as one to advise the TCG and SCG.	
10.	Identify communications officer/ admin support to log media calls and develop rolling question and answer brief.	
11.	Identify communications officer/ admin support to liaise with local NHS communications network to ensure urgent cascade of information / coordinated internal communications/messages for staff. This should continue as appropriate throughout the incident.	
12.	Provide regular updates to the NHSE Sub Regional communications lead and stakeholders'communications teams on the NHS response and key health messages. This should continue as appropriate throughout the incident.	
13.	On stand down, ensure that all original documentation (including notes, flip charts, e-mails etc.) are kept. Close personal log.	
14.	Attend Hot and Formal debriefs.	
15.	Manage any on-going media interest in the NHS response, including social media.	

ACTION CARD	OPERATIONS OFFICER (s)	
Accountable to	**Incident Director**	
Responsible for: Supporting the Incident Director to undertake tasks as determined by the Incident Manager which may include any/all the following:		
Number	**Action**	**Time Completed**
1.	Set up and maintain the Incident Coordination Centre if required.	
2.	Establish document control.	
3.	Establish rotas and call in staff as indicated.	
4.	Ensure handover arrangements.	
5.	Ensure staff supported with beverages and food and appropriate breaks.	
6.	Gather information and assess relevance.	
7.	Action decisions and processes as requested.	
8.	Assist in preparation of time critical documents.	

ACTION CARD	ICC ADMINISTRATOR	
Accountable to	**Incident Director (Operations Officer if present)**	
Responsible for: Providing comprehensive administration support to the AT Incident Coordination Centre.		
Number	**Action**	**Time Completed**
1.	Assist with setting up Incident Coordination Centre as directed by the Incident Director (or Operations Officer if present).	
2.	Maintain the record of who is in the Incident Centre at all times.	
3.	Maintain a record of queries/documents and responses.	
4.	Minute any meetings or teleconferences.	
5.	Work with the Operations Officers to ensure robust rotas are in place and appropriate rest breaks are scheduled.	

APPENDIX B:

INCIDENT MANAGEMENT TEAM AGENDA

Time/Date

Venue/Telecon details

1. **Current situation report**
2. **Impact on the NHS**
3. **Current multi-agency command arrangements**
4. **Communications**

    Reporting arrangements (NHS England; DH; SCG)

    Public information and media strategy

    Internal NHS communications and staff briefings
5. **Staff and other resources required**
6. **Authorisation of expenditure**
7. **Horizon scanning**
8. **AGREED**

    NHS command arrangements

    NHS Strategy and/or objectives (depending on level of incident)

    NHS Actions

    NHS Battle Rhythm (linked to SCG/TCG/national rhythm if established)

9. **Next meeting**

Ensure an attendance sheet is completed for every meeting detailing who was present and which role they performed.

APPENDIX C:

NHS INCIDENT SITUATION REPORT (SITREP)

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

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

Exact location of Incident							
Type of Incident (Name)							
Resources Deployed[1] (e.g. Ambulance, Air Ambulance, HART)							
Incident Casualties[2]	Location	**P1:**	**P2:**	**P3**	**P4:**	**Disch'd**	**Dead**
Pre-Hospital							
List Receiving Hospitals	Location	**P1:**	**P2:**	**P3**		**Disch'd**	**Dead**[3]
Hospital # 1							
Hospital # 2							
Hospital # 3							
Hospital # 4							
Total at Receiving Hospitals							
Impact on Critical Functions[4]							
Capacity Issues[5a]							
Capability Issues[5b] (e.g. major trauma, burns)							
Impact on business as normal[6]							
Mutual Aid Request Made (Y/N)[7]							
Current / Potential Media Messages[8]							

Notes to aid completion of SITREP

1. **Resources Deployed:**

   Resources deployed at scene of incident.

2. **Incident Casualties:**

   P1: Casualties requiring immediate life-saving resuscitation and/or surgery.
   P2: Stabilised casualties needing early surgery but delay acceptable.
   P3: Casualties requiring treatment but a longer delay is acceptable.
   P4: Expectant category – confirm if invoked.

3. **Fatalities in hospital:**

   Number of patients arriving at hospital and subsequently dying at/or in hospital.

4. **Impact on critical functions:**

   Implications on Category "A" Ambulance response times.
   Critical Care capacity.

5. **Capacity/capability issues:**

   This section provides a forward look for the NHS and the Department of Health.

6. **Impact on business as normal:**

   Cancellation of elective activity should be covered here.
   Any other service reduction as consequence of incident.

7. **Mutual aid request:**

   Confirm details of mutual aid requested, and from whom requested.

8. **Media:**

   Indicated media interest shown/reported.
   Provide key messages for media, also provide details of lead media contact.

APPENDIX D:

NHS England MAJOR INCIDENT SITUATION REPORT - SITREP

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

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

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

Impact of business continuity arrangements	
Media interest expected/received	
Mutual Aid Request Made (Y/N) and agreed with?	
Additional comments	
Other issues	
NHS England Regional Incident Coordination Centre contact details: **Name:** **Telephone number:** **Email:**	

APPENDIX E:

Amendment and Review Record

Version	Date	Pages	Details of amendments	By
1.1	24.04.13	1; 3		
		32		
2.0	05.08.15	all	All references to AT changed to NHSE Sub Regional Team	CM

APPENDIX F:

Plan Holder record

		Log book number
1	Chief Officer,	
2	Chief Operating Officer,	
3	CCG on-call:	
4	CCG on-call:	
5	CCG on-call:	
6	CCG on-call:	
7	CCG on-call:	
8	CCG on-call:	
9	CCG on-call:	
10	CCG on-call:	
11	CCG on-call:	
12	CCG on-call:	
13	CCG on-call:	
14	CCG on-call:	
15	CCG on-call:	
16	CCG on-call:	
17	CCG on-call	
18	Urgent Care Lead:	
19	CCG HQ:	
20	CCG HQ:	
21	Head of EPRR:	
22	Emergency Planning Manager	