MAJOR INCIDENT & EMERGENCY RESPONSE PLAN

Review Date: See Policy Sheet

Document Owner: See Policy Sheet

For ‘OFF SITE’ Emergencies go to Action Card Bravo

November 2013

www.cddft.nhs.uk
Darlington Memorial Hospital, Hollyhurst Road,
Darlington, County Durham DL3 6HX  Tel: 01325 74  Fax: 01325 74
# County Durham & Darlington NHS Foundation Trust Incident Response & Recovery Plan 2013

<table>
<thead>
<tr>
<th>Date</th>
<th>November 2013 – updated to reflect changes with regard to Health &amp; Social Care Act 2012, EPRR arrangements and Annual Review</th>
</tr>
</thead>
</table>
| Audience | • NHS Foundation Trust Chief Executive, Trust Board and Staff  
• All Stakeholders |
| Copy to | • Members of the local health resilience partnerships (LHRPs)  
• Members of Local Resilience Forum (LRF)  
• PFI Partners |
| Description | This is an operational response plan. Please read this document in the context of:  
• NHS Commissioning Board Core Standards for Emergency Planning, Resilience & Recovery 2013  
• NHS Commissioning Board Emergency Preparedness Framework 2013  
• The Role of the Accountable Emergency officer's for EPRR  
• NHS Commission Board Business Continuity Management Framework (Service resilience) |
| Action required | This plan has been developed to ensure key participants carry out their respective functions when responding to major incidents or during emergency situations. It is important that all strategic, tactical and operational staff of the Trust understand this plan and are aware of their specific roles and responsibilities. |
| Timing | To be used by the Trust Incident response staff in the conjunction with the NHS CB Incident Response & multi-agency response plans as part of the implementation of the new EPRR arrangements from 1 April 2013 |
| Contact details | Gary Siddle, Trust Resilience Lead, gsiddle@cddft.nhs.uk 07825722597 |
Major Incident & Emergency Response Plan

Version number 5.0
Document Type Policy
Original Policy Date July 2010
Review and Approval Committee Quality & Healthcare Governance Committee
Approval Date 12 November 2013
Next Review Date 12 September 2014
Originating Directorate & Group Nursing & Service Transformation
(where applicable)
Document Owner Trust Resilience Lead
Lead Director or Associate Director Executive Director of Nursing
Scope Trust-wide
Equality Impact Assessment completed on July 2010
Status Ratified
Confidentiality Unrestricted
Keywords Business Continuity, resilience, emergency planning

Ratification

Executive Chairman or Executive Sponsor Signature

Date Ratified 12 November 2013
Executive Chairman or Executive Sponsor Mike Wright - Executive Director Of Nursing
Ratifying Committee Quality & Healthcare Governance Committee
Signed master copy held at: Corporate Records Office, Darlington Memorial Hospital
# Table of Revisions

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Section</th>
<th>Revision</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 2010</td>
<td>1.0</td>
<td>New provisional plan</td>
<td>G Siddle</td>
<td></td>
</tr>
<tr>
<td>July 2010</td>
<td>2.0</td>
<td>Final Plan</td>
<td>G Siddle</td>
<td></td>
</tr>
<tr>
<td>Jan 2012</td>
<td>3.0</td>
<td>Various</td>
<td>Post restructure</td>
<td>G Siddle</td>
</tr>
<tr>
<td>Nov 2013</td>
<td>4.0</td>
<td>All</td>
<td>Plan review</td>
<td>G Siddle</td>
</tr>
<tr>
<td>Jan 2014</td>
<td>5.0</td>
<td>Action cards</td>
<td>Amend cards 19, 20 &amp; 21</td>
<td>G Siddle</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Insert cards 43 &amp; 44</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Remove Amendment History</td>
<td></td>
</tr>
</tbody>
</table>
IF A MAJOR INCIDENT HAS BEEN DECLARED GO STRAIGHT TO THE HOSPITAL INFORMATION CENTRE AND REFER TO YOUR ACTION CARD

ALL ACTION CARDS WILL BE AVAILABLE FROM THE HOSPITAL INFORMATION CENTRE SITUATED AT:

DMH: MAIN RECEPTION

UHND: FIRST FLOOR MAIN OUT PATIENTS

If you are reading a printed copy of the Major Incident and Emergency Response Plan, ensure you are reading the latest version.

The current version of the Major Incident and Emergency Response Plan is held on the Trust Home page, go to

⇒ Popular Links
⇒ Sites
⇒ Emergency Preparedness
⇒ Major Incident plans
Table of Contents

1. Foreword .................................................. 7
2. Acknowledgements ........................................ 8
3. Introduction .............................................. 9
4. Roles & Responsibilities .................................. 10
5. Trust Command .......................................... 11
6. Incident Control Team .................................... 13
7. Hospital Information Centre .............................. 14
8. Hospital Capacity ......................................... 15
9. Alerts ....................................................... 17
10. Alerting Process .......................................... 17
11. Onward Alert ............................................ 18
12. Activation ............................................... 20
13. Switchboard ............................................ 21
14. Triage .................................................... 22
15. Sort ....................................................... 24
16. Imaging ................................................... 25
17. Triage For Blood Products ............................... 26
18. Reconfiguration of services ............................. 26
19. Rapid Response Community Nursing Team ........ 30
20. Special types of Major Incident ........................ 31
21. Incidents involving Children ............................ 33
22. Mass Casualty Incidents ................................ 34
23. Casualties Suffering Thermal Burns .................. 35
24. Casualties exposed to CBRN ............................ 36
25. Vulnerable people ........................................ 36
26. Support from Partner Agencies ....................... 36
27. Business continuity ...................................... 37
28. Risk Registers ........................................... 38
29. Record Management ..................................... 38
30. Plan Ownership .......................................... 38
31. Plan Administration ...................................... 39
32. Review, Maintenance, Training & Exercising ....... 40
33. Audit and Monitoring .................................... 42
34. Equity and Diversity ..................................... 43
35. Acronyms and terms used in the plan ............... 44
   Annex One - Action Cards .............................. 45
   Annex Two – Required-Useful documentation .......... 97
   Annex Three – Communication & Media ............... 102
   Annex Three (2) Media Messages ..................... 105
   Annex Four Equity & Diversity ....................... 110
   Annex Five Manager on Call Contact list ............. 117
   Annex Six Rail Incident Care Teams ................... 119
   Annex Seven Red Phone List ......................... 120
   Annex Eight Emergency Communication Methods .... 122
   Annex Nine Health System ERPP Operating Model – Response 123
1. FOREWORD

This plan has been developed to ensure key participants carry out their respective functions when responding to major incidents or during emergency situations. It is important that all strategic, tactical and operational staff of the County Durham & Darlington NHS Foundation Trust understand this plan and are aware of their specific roles and responsibilities.

We are satisfied this plan ensures that the County Durham & Darlington NHS Foundation Trust has effective arrangements in place to respond to a major incident/emergency within our own health community and/ or to offer support to neighbouring communities.

Sue Jacques
Chief Executive

Tony Waites
Chairman
2. ACKNOWLEDGEMENTS

This Major Incident & Emergency Response Plan has been prepared in accordance with the following guidance:

**The NHS Emergency Planning Guidance 2013: Emergency Preparedness Division.**
Including underpinning material:
- Immediate medical care at the scene of a Major Incident
- Acute Trust and Foundation Trusts
- Critical Care Contingency Planning
- (2007) Planning for the management of blast Injured casualties
- (2007) Critical care contingency planning in the event of an emergency where the numbers of casualties substantially exceeds normal critical care capacity


Cabinet Office (2004) **Civil Contingencies Act 2004**

Department of Health (2000) **Deliberate Release of Biological and Chemical Agents.**

**County Durham & Darlington Local Resilience Forum (LRF) Generic Plan**

**North East Escalation Plan (NEEP) Frameworks**

**Health System Pandemic Influenza Plan**

**North East Regional Radiation Framework,**

**North East Framework for Mass Vaccination,**

Framework for health services resilience PAS2015:2010

**North East Framework for terrorist incident resulting in mass casualties Engaging the capacity and capabilities of faith communities in Civil Resilience- 2008**

**NHS Commissioning Board Core Standards for Emergency Planning, Resilience & Recovery 2013**

**NHS Commissioning Board Emergency Preparedness Framework 2013**

The Role of the Accountable Emergency officer’s for EPRR
3.0 INTRODUCTION

Who is the plan for?

3.1 The plan is primarily for County Durham & Darlington NHS Trust staff. It sets out the trust response to a significant health related incident / emergency and describes the command and control arrangements therein.

3.2 The plan describes what needs to happen, and who needs to do what, should a significant health related incident/emergency occur. Directors/Managers must ensure that they are sufficiently familiar with the plan and that they are ready and able to mount an immediate (24/7) response in accordance with the plan.

3.3 It is important that all relevant officers of the organisations in the Local Health Resilience Partnership (LHRP) and the Local Resilience Forums (LRFs) are aware that the plan exists and understand fully their contribution if required to be involved in the implementation of the plan.

3.4 During a health related major incident / emergency, the Trust will operate an Incident Management Team (IMT). This will be located at an Incident Coordination Centre (ICC) either at the Woodlands suite at Darlington or the board room at the Old Trust Headquarters site at Durham.
4.0 ROLES & RESPONSIBILITIES

This section describes the roles and responsibilities required to deliver the response to a significant health related incident/emergency. For full details of the responsibilities and associated actions, please refer to the action cards in Annex One.

Levels of command

- The **Operational (Bronze)** level of command refers to those who provide the immediate ‘hands on’ response to the incident, carrying out specific operational tasks either at the scene or at a supporting location such as a hospital or rest centre.

- **Tactical (Silver)** personnel are those who are in charge of managing the incident on behalf of their agency. They are responsible for making tactical decisions, determining operational priorities, allocating staff and physical resources and developing a tactical plan to implement the agreed strategy.

- The **Strategic (Gold) command** level is 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.

The Trust has adopted this structure, in keeping with partner agencies and thereby affords contact with the appropriate level of command in partner agencies.

Within the Trust these levels will be known as:

**Trust Command – (Gold) aka Incident Response Co-ordination team**

**Incident Control Team - (Silver)**

**Hospital Information Centre - (Bronze)**
5.0 Trust Command

Trust command will deal with:

- Strategic issues (essentially liaison with other agencies to reallocate resources or demand – sometimes referred to as “mutual aid”).
- Reallocation of resources *between* different sites.
- Leading recovery [this is likely to be the most taxing role for Trust Command].

The Trust commander will usually be the Chief Executive (in their absence the acting Chief Operating Officer or the Director on call); they will require administrative staff to assist them including a loggist. Trust command is responsible for the whole CDDFT Trust. Trust command will be located in either DMH or UHND *whichever is nearer to the Trust commander when they are informed of the incident* (i.e. it need not be in the initial receiving hospital). Roles of Trust command include:

- Liaison with Local Health Resilience Partnership’s Area Team
- Liaison with Strategic Coordination Group (SCG). Multi agency gold group situated at Police Headquarters, Akley Heads, Durham
- Advise the Hospital’s Incident Control Team (s) on any issues arising from the above and seek regular updates from them.
- Monitor use of resources (including the reallocation between Trust sites) and ensure resupply (Finance Director)
- Accompany any VIP or VVIP who visit the Trust
- Give media interviews on behalf of the Trust
- Ensure that members of Hospital’s Incident Control Teams are replaced if/when necessary

Command will be located at the discretion of the commander when they are advised of the incident: They will not embed with the INCIDENT CONTROL TEAM on that site but locate themself in their identified office.

Trust Command will **not** become involved in any tactical issues and will leave the Incident Control Teams to make these decisions during the Major Incident.
The Trust Commander will call in additional staff to assist in this role, but not by depleting control teams or leaderships.

- **Loggist** to record decisions made and the rationale for such action, but not keep minutes
- **Accountable Emergency Officer**
- **Finance** function is part of Trust command. The Finance Officer (Director of Finance or senior deputy) will track use of resources and will be required to approve the acquisition of additional resources (and maintain records of these resources and their cost).
- **Director of Estates & Facilities**
- The **press/media officer** will be part of Trust command.
- Where there are issues relating to infrastructure *that will affect the Trust’s capacity for recovery or service continuity*, the **Executive Director for Facilities** (or senior) will be needed in Trust command.
- **Admin/clerical staff** will be needed in Trust command.

**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 Commander.

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 SCG) 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.
6.0 INCIDENT CONTROL TEAM (Formerly Hospital Control Team)

The Incident Control Team will manage the tactical response to the incident and be led by the Incident Commander.

This team will comprise clinical and managerial staff. The INCIDENT CONTROL TEAM is responsible for task allocation and prioritisation, acquisition of expert advice, liaison with staff/emergency services on scene, and the overall deployment of staff within the Trust.

The INCIDENT CONTROL TEAM will be situated as follows:

DMH Woodlands Meeting Room, DMH (ext. 44539)
UHND Old Trust HQ Boardroom (ext. 32540/32541/32542/32543)

The Incident Control Team will focus on four main functions:

- Operations
- Planning
- Logistics
- Safety

**Operations**
This function is to ensure that all operational staff including clinicians have been given direction and to monitor the progress in achieving these objectives.

**Planning**
This function is to ensure that accurate and up to date information is available about:

- Casualties awaiting treatment
- Resources available
- Any anticipated resource deficits

**Logistics**
This function is to acquire and/or allocate resources (identified by the planning function) so that the actions tasked by operations functions can be carried out. If logistics identify a need to acquire additional resource, this should be approved by the Finance Officer (with Trust command), but they will be able to allocate existing resources without requiring approval.

The Incident Control Team will comprise:

- A manager (Incident Commander)
- A nurse
- A doctor
- A 'loggist' and administrative support
- Communications Officer

The INCIDENT CONTROL TEAM will wear designated tabards and be supported by Trust Resilience Lead and Accountable Emergency Officer.

*Whenever possible the INCIDENT CONTROL TEAM at DMH and at UHND will have the support of a member of staff familiar with telecommunications facilities at that site. (IT on call OUT of Hours)*
7.0 HOSPITAL INFORMATION CENTRE

This Operational (Bronze) team will co-ordinate the initial trust response out of hours led by the Senior Nurse Patient Flow. Then following establishment of the Hospital Control team, will revert to its in hours task of administration and an information gathering unit in support of the Hospital Control Team.

This will enable the Hospital Control team the freedom to operate without interruption.

The Hospital Information Centre will be managed by an Administrator Manager/Supervisor and have a team of administration staff in support.

The Hospital Information Centre will:-

- Issue Action Cards against a register
- Receive Staff ‘on-site’ registers from the wards/units
- Receive Ward / Unit bed status sheets
- Record and issue temporary ID cards to bona fide visitors
- Act as Information Centre
- Provide Initial call handling facility
- Provide casualty tracking function
- Act as portal for information from bronze to silver and vice versa.

CONTACT DETAILS

Contact details for the Hospital Information Centre can be found in the footer margins of the action cards. Operational staff/units must contact the Hospital Information Centre in the first instance.

Hospital Information Centre DMH 43017

Hospital Information Centre UHND 32517
8.0 ASSESSMENT OF TRUST CAPACITY

The prime responsibility for assessment of the state of the hospitals within the Trust falls to the INCIDENT CONTROL TEAM; they will require information from clinical staff in order to carry this out. The exact nature of the assessment will depend on the nature of the incident and the expected number and severity of casualties. It is likely, though, to include the following:

- number of functional operating theatres available
- the number of staffed ITU beds available
- the number of other acute admissions
- overall bed availability
- the number of staffed functional x-ray rooms
- Blood Bank status

On declaration of a Major Incident every effort will be made to discharge casualties home, cancel elective surgery and clear out-patient departments. It is envisaged that all departments will provide a list of staff currently on duty and a bed occupancy statement to the HOSPITAL INFORMATION CENTRE within thirty minutes of plan activation.

Incident Control will relay this information to NEAS as this allows for an assessment to be made of the hospitals current and potential capacity to receive casualties.

The trust should have received a situation report (SITREP) from the scene in the form of a ‘METHANE’ or ‘CHALETS’ mnemonic.

<table>
<thead>
<tr>
<th>METHANE</th>
<th>CHALETS</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Major incident</td>
</tr>
<tr>
<td>E</td>
<td>Exact location</td>
</tr>
<tr>
<td>T</td>
<td>Type of incident</td>
</tr>
<tr>
<td>H</td>
<td>Hazards</td>
</tr>
<tr>
<td>A</td>
<td>Access</td>
</tr>
<tr>
<td>N</td>
<td>Number of casualties</td>
</tr>
<tr>
<td>E</td>
<td>Emergency Services</td>
</tr>
<tr>
<td></td>
<td>Casualties</td>
</tr>
<tr>
<td></td>
<td>Hazards</td>
</tr>
<tr>
<td></td>
<td>Access</td>
</tr>
<tr>
<td></td>
<td>Location</td>
</tr>
<tr>
<td></td>
<td>Emergency Services</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
</tr>
</tbody>
</table>
Some anticipatory planning should be made and consideration given to the following:

- Is this an event that can be dealt with using normal day to day arrangements?
- Is this an event that can be dealt with within the resources and emergency planning arrangements of the Trust?
- Is this an event that requires support beyond the capabilities of the Trust?

**Decision Making**

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

*Source: Association of Chief Police Officers*

http://www.acpo.police.uk/documents/president/201201PBANDM.pdf
9.0 ALERTS

TRIGGERS

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

- In response to internal pressure within the NHS (an **internal** decision) in response to a local incident
- **External** alert that an agency has called a major incident “Stand By”
- **External** alert that a major incident has been “Declared”/”Implemented”
- In response to a national or regional NHS CB direction.

10.0 ALERTING PROCESS

External alerts will usually be routed via North East Ambulance Service (NEAS) who will follow the agreed early alerting protocol. The call will usually be received by the respondent Hospital Switchboard who will follow the activation algorithm (section four).

**Agreed early alerting criteria North East Ambulance Service**

- **Major Incidents** (including road, rail or aircraft accidents)
- Explosions
- Evacuations involving a number of people or where additional medical support may be required
- **Surge Escalation** (out-with normal surge arrangements through the Clinical Commissioning Groups - CCGs)
- 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
- Radiation release confirmed
11.0 ONWARD ALERTING

If an emergency service declares a Major Incident, ambulance control will ring switchboard so the call-out cascade can be commenced and the call then be passed through to the Emergency Department (ED), so that clinical information can be relayed.

If ED receive a call from an external agency concerning a major incident this should be immediately forwarded to switchboard.

A ‘Major Incident – Radiation’ will be declared by NEAS if a radiation incident is confirmed, irrespective of number or presence of causalties. Senior Manager / Nurse Patient flow will contact the Radiation Protection/Emergency Response Advisor. Contact details in Hospital Information Centre box

Any emergency service can declare a Major Incident – though notification to the Trust would be via Ambulance Control (NEAS) - or the ED consultant or senior nurse may also declare a Major Incident.

Note: Senior staff from any other hospital department can only declare a Trust Emergency in line with the escalation of their Business Continuity Plan

If the ED ‘declares’ a Major Incident they need to qualify what the nature of the incident is and likely effect on partner agencies.

OFF SITE EMERGENCY

The Trust is responsible for many ‘off site’ estates. In order to effectively manage an incident on these sites that are without a senior management presence, an ‘off- site’ adaptation of the Major Incident and Emergency Recovery Plan is required.

An Off- site trust emergency will not necessarily require a full clinical major incident response therefore an adapted callout contact cascade has been developed for use by the switchboard staff.

Those administrative staff required to respond have been highlighted on the cascade call out matrix in red.
For a Major Incident the contact cascade will be called in full.

For a Trust Emergency; only those staff highlighted in red will be called.

The cascade will be followed by a group text message informing staff that a Major Incident or Trust Emergency has been invoked.
12.0 ACTIVATION

Activating the Major Incident & Emergency Response

Standard Messages Used by NHS Organisations
To avoid confusion about when to implement plans, it is essential to use these Standard messages:

1. Major Incident – Standby

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

2. Major Incident Declared – Implement Plan

This alerts NHS organisations that they need to activate their plan and mobilise additional resources.

3. Major Incident – Cancelled

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

4. Major Incident Stand Down

All receiving hospitals are alerted as soon as all live casualties have been removed from the site. Where possible, the Ambulance Incident Commander will make it clear whether any casualties are still en-route. While Ambulance Services will notify the receiving hospitals(s) that the scene is clear of live casualties, it is the responsibility of each NHS organisation to assess when it is appropriate for them to ‘Stand down’.

- 20 -
13.0 SWITCHBOARD RESPONSE & CALL OUT CASCADE

On receipt of the alert the switchboard operator will record the message on the following form.

<table>
<thead>
<tr>
<th>Identity of Caller</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Caller’s Telephone Number</td>
<td></td>
</tr>
<tr>
<td>2. Major Incident Standby / Declared</td>
<td></td>
</tr>
<tr>
<td>3. Trust Emergency</td>
<td></td>
</tr>
<tr>
<td>If yes activate Red Cascade</td>
<td></td>
</tr>
<tr>
<td>4. Location of Incident</td>
<td></td>
</tr>
<tr>
<td>5. Time of Incident</td>
<td></td>
</tr>
<tr>
<td>6. Type of Incident</td>
<td></td>
</tr>
<tr>
<td>7. Estimated number and Type of Casualties</td>
<td></td>
</tr>
<tr>
<td>8. Expected Time of Arrival</td>
<td></td>
</tr>
<tr>
<td>9. Is the Trust the <strong>Receiving</strong> Hospital</td>
<td></td>
</tr>
<tr>
<td>10. Date/time Call Received</td>
<td></td>
</tr>
<tr>
<td><strong>Receiving</strong></td>
<td></td>
</tr>
<tr>
<td>11. Is a Medical Incident Commander (MIC) Requested</td>
<td></td>
</tr>
<tr>
<td>Yes/No</td>
<td></td>
</tr>
<tr>
<td>(if so inform ED Consultant on call)</td>
<td></td>
</tr>
<tr>
<td>12. If a MIC is required when will the Transport</td>
<td></td>
</tr>
<tr>
<td>Arrive?</td>
<td></td>
</tr>
</tbody>
</table>

Check the information by reading it back carefully to the caller. After taking the message the telephonist will ring the Ambulance Officer on **0191 4143144** to check authenticity (dedicated major incident line).

The telephonist will then initiate the call out procedure following cascade system attached to action card according to situation at the time.

Once a verified call declaring Major Incident has been received, switchboard will call the required personnel via their contact list which are site specific and updated daily. On this list they will note if the member of staff has confirmed his/her intention to respond and their likely arrival time.
14.0 TRIAGE

TRAUMA TRIAGE

Trauma triage is the use of trauma assessment for prioritising of patients for treatment or transport according to their severity of injury. Primary triage is carried out at the scene of an accident and secondary triage at the casualty clearing station at the site of a major incident. Triage is repeated prior to transport away from the scene and again at the receiving hospital.

The primary survey aims to identify and immediately treat life-threatening injuries and is based on the 'ABCDE' resuscitation system. (Advanced Trauma Life Support) This includes:

- Airway control with stabilisation of the cervical spine.
- Breathing.
- Circulation (including the control of external haemorrhage)
- Disability or neurological status.
- Exposure or undressing of the patient while also protecting the patient from hypothermia

Priority is then given to patients most likely to deteriorate clinically and triage takes account of vital signs, pre-hospital clinical course, mechanism of injury and other medical conditions. Triage is a dynamic process and patients should be reassessed frequently. In the UK, the 'P system' is conventionally used at a major incident:

- Immediate priority (P1): require immediate life-saving intervention (Red).
- Urgent priority (P2): require significant intervention within two to four hours (Yellow).
- Delayed priority (P3): require intervention, but not within four hours (Green).
- Expectant priority (P4): treatment at an early stage would divert resources from potentially beneficial casualties, with no significant chance of a successful outcome (Black).

Triage systems are most often used following trauma incidents but may be required in other situations, such as an influenza epidemic.

**NB:** Maritime agencies (HM Coastguard) use the prefix ‘T’ as opposed to ‘P’

The coloured categories reflect those used by the ‘Cruciform’ triage labelling system currently used by NEAS which has national recognition.

To triage children, a triage tape should be used if the child is of primary school age or less (height of 140cms and then use adult triage parameters)
**TRIAGE SIEVE**

The triage sieve can be used at the scene of major trauma and involves a rapid assessment:

Can the patient walk?

**Yes**: Priority 3 (Green - see above).

**No**: Is the patient breathing?

**No**, even after opening airway: Dead. Priority 4 (Black)

**Yes**, after opening airway: Priority 1 (Red).

**Yes**, without resuscitation:

What is the respiratory rate?

**Above 30/minute or less than 10/minute**: Priority 1 (Red).

**10-30/minute**: What is the pulse rate (or capillary refill time)?

**Less than 40 or more than 120 (or capillary refill time greater than 2 seconds)**: Priority 1 (Red).

**Between 40 and 120** (or capillary refill time less than 2 seconds): **Priority 2** (Yellow).

Modified sieve systems are available for use in children.
**15.0 THE TRIAGE SORT**

The triage sort is one method used for triage at a casualty clearing station or on arrival at the Emergency Department.

<table>
<thead>
<tr>
<th>Physiological variable</th>
<th>Value</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory rate</td>
<td>10-29</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>&gt;29</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>6-9</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1-5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Systolic Blood Pressure</td>
<td>&gt;90</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>76-89</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>50-75</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1-49</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Glasgow Coma Score (GCS)</td>
<td>13-15</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>9-12</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>6-8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4-5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

Respiratory Rate + Systolic BP + GCS = Total Score

A total score of 1-10 indicates priority P1, a score of 11 indicates P2, and 12 indicate P3, 0 indicates death P4.

P1 will be directed to Resuscitation bay
P2 will be directed to Majors area
P3 will be directed to Minors (UCC/Day ward)
Casualties triaged as P4 should be held at the incident site or removed to a temporary mortuary, however if death occurs en route to hospital, the casualty should be admitted to the emergency department for verification. Certification / confirmation of death must not take place in the ambulance.

**Triage** is needed, when resources are limited to ensure that the best possible use is made of the available resources. Triage of casualties will occur when they arrive at ED but also at a number of other points.

Triage is needed for
- Arrival at the ED – action card should say they should call in extra people in, if the rate of arrivals is too great
- For radiology and blood bank requirements
16.0 TRIAGE FOR IMAGING

Radiology facilities may quickly become overwhelmed if imaging requests are not limited in the initial phase of the response. Some investigations may be needed immediately (to rule out immediately life-threatening problems), others are required while the patient is in the ED (urgent) and others can wait until all life-threatening and limb-threatening problems have been treated and all live casualties from the incident have reached hospital:

**Immediate (these requests will take priority over all others)**
- Chest (if Haemothorax, Aortic Dissection or other immediately life-threatening condition suspected)
- Pelvis (if unstable fracture suspected)
- Major joint dislocation or fracture with distal neurovascular compromise

**Urgent (these requests take priority over other requests except those in the immediate category)**
- Abdominal scan – needs triage by senior general surgical or ED clinician
- Brain scan – needs triage by senior ED clinician
- Major joint dislocation or fracture without distal neurovascular compromise
- Cervical spine - needs triage by senior ED clinician
- Long bones if shaft # suspected

**Delayed (all other requests take priority over these)**
- Other regions of spine
- Other limb examination
- Other areas of body

If staffing permits location of a senior radiologist in ED to triage requests and interpret images for ED casualties. They could also triage requests for scans.
17.0 TRIAGE FOR BLOOD PRODUCTS

Initially requests will be for type specific blood (though O negative will be available in the normal way, though it should be reserved for casualties with class IV shock – the use of O negative blood should be approved, whenever possible, by the consultant responsible for the casualty)

Requests will be limited initially to the following:

- Chest injury
- Abdominal injury
- Pelvic fracture
- Femoral shaft fracture
- Significant external haemorrhage

Blood will be requested only if there is (or has been) clinical evidence of shock. If not, Group and Save will be requested.

The Haematology Laboratory has a direct line to the NHS Blood Transfusion Service and will monitor and manage our transfusion needs accordingly.

18.0 RECONFIGURATION OF SERVICES

In order to maximise our service response to meet the anticipated surge of activity, determined by the emergency. Departments will be reconfigured in the following manner:

**EMERGENCY DEPARTMENTS**

Emergency Departments will clear their department as far as is possible by the direct admission to the specialties or referral of casualties to alternative health care provision e.g. Urgent care centres or their General Practitioner

The Emergency Department will only receive P1 and P2 casualties; P3 casualties will be directed to the Urgent care centre or Orthopaedic Out-patients or the Surgical Day Unit dependant on the nature of their injuries.
The Trust should not receive the dead (P4) from the scene but those casualties who die from their injuries in transit must be admitted to the Emergency department for confirmation / certification of death. This process must not take place in the ambulance.

There is no requirement for the hospital to provide such temporary mortuary facilities on site.

**CASUALTY REGISTRATION**

All casualties will be registered on the hospital's data base upon arrival or as soon as is practicable in the emergency department.

There are 50 pre designated patient numbers and administration packs available.

**ALL CASUALTIES MUST HAVE IDENTITY LABEL AFFIXED**

*Unknown casualties* will be given in addition to their pre-registered hospital number a generic forename and surname unique to that number e.g. the patient’s arriving at DMH would accrue the name ‘Delta Alpha’ the next patient becoming ‘Delta Bravo’ and so forth.

UHND would use the prefix ‘Uniform’. Thus Uniform Alpha, Uniform Bravo etc

Such casualties would have their personal information updated as and when their details became available.

This 3 point identification system has been found to be very useful in ‘live’ incidents such as the London Bombings of July 2007.

**NON INCIDENT CASUALTIES**

Non Incident casualties who normally present to DMH/UHND as emergencies should wherever possible be conveyed by NEAS to supporting hospitals. This will be managed by NEAS.

If this is not practicable the non-incident casualty should be treated as an incident victim. There will be no discussion over such presentations equally medical emergencies such as a cardiac arrest will be treated in the Emergency Department.

For administrative purpose these non-incident casualties will be treated as Major Incident victims until they are admitted or discharged. Only the Police documentation team may remove a person from their lists.
If the Incident is county / region wide and no supporting hospitals are available or the patient has self-presented and requires admission, the Acute Medical Unit or Surgical Assessment Unit will take direct admissions.

Emergency nursing and medical staff will wear Tabards for identification purposes.

The Police Documentation Team will occupy a designated area within the emergency department.

- DMH the Emergency department’s reception office
- UHND the ED consultants secretaries office

Supporting documentation for the police is held in the Emergency Departments

**ORTHOPAEDIC OUTPATIENTS / URGENT CARE CENTRES (HOSPITAL BASED)**

Orthopaedic out-patients / UCC will accommodate P3 Minor Injuries (walking wounded). If during normal working hours they will be required to suspend /cancel their clinics and discharge their patients accordingly.

Orthopaedic Nursing Staff/HCAs will assist in the treatment and care of this casualty group under the direction of an Emergency Nurse Practitioner and/or an Emergency Department Staff Grade. This will occur at both DMH and UHND.

Casualties who are able, will be discharged via the Main Out-patients Department providing clearance has been obtained from the Police Documentation Team

**SURGICAL DAY WARD**

The Surgical Day Ward will see category P3 casualties who are unable to walk as a result of lower limb injuries or wrist injuries requiring mobilisation or minor burns. If during normal working hours the Day ward will be required to suspend / cancel operative procedures and discharge their patients accordingly.

The day ward will also hold casualties preoperatively or casualties who have severe burns, head or spinal Injuries and are awaiting transfer for definitive care ay a regional centre. The Day ward staff will require specialist medical & nursing support if required to care for these patients.
HOSPITAL INFORMATION CENTRE

The Main reception desk of DMH will become the Hospital Information Centre.

The first floor Main Outpatients department at UHND will serve as its Hospital Information Centre. Signage will need to be placed on the ground floor reception desk to inform those attending of location of HIC

Staffed by nominated Service Manager or Matron, they will be responsible for supervising the registration of staff and visitors, issuing temporary identification badges and providing advice for other hospital users and visitors.

The manager will be supported by reception staff and communicate directly with the Hospital Control Team.

PATIENT DISCHARGE & REUNION AREA

Main Outpatients DMH / ENT Outpatients UHND
These areas are planned to accommodate casualties awaiting discharge, transport and being reunited with family and friends. It also provides for a relative reception point.

Relatives enquiring about next of kin should have their contact details recorded and forwarded to the Police Information bureau. If it is known there relative is on site they may be directed to the patient relative reunion area or they may be advised to return home and contact the Police Casualty Bureau for further information.

Relatives at UHND are accommodated in the Main Out-patients Department.

NON INCIDENT PATIENT DISCHARGE AREAS
Ophthalmology out-patients will provide discharge lounge facilities for non-incident patients at UHND.

DMH will use existing Discharge lounge for inpatient discharges. ED will discharge non incident casualties via the women’s centre.
TRAUMA WARDS
These are the nominated receiving wards for casualties requiring inpatient admission from a major incident. When a major incident is declared the ward should be cleared by discharging patients home or transferring to other wards as soon as possible to free up the beds. As the incident progresses, aim to keep all casualties together and preferentially transfer existing in-patients to other areas.

The designated Trauma Wards are Wards 31 & 34 at DMH and Wards 12 & 16 at UHND. Decanting patients from these wards may prove problematic. The Patient Flow Co-ordinator with the assistance of specialty Matron/Senior Nurse should facilitate this process

AMU ACUTE MEDICAL UNIT
The AMU will continue to take its ‘normal’ admissions, transport permitting and any additional casual self-referrals through the Emergency Department.
It may also take medical emergencies e.g. asthma, diabetes, cardiac failure and the like as direct admissions. Again bed capacity should be maximised through the escalation process

It must be remembered that although much of the focus of the organisation is concerned with the activity generated by the Incident, it remains our responsibility to care for our existing patients and staff must remain vigilant.

All areas that have been identified in this plan are required to have local plans in place that reflect such activity as part of their Business Continuity planning process.

19.0 RAPID RESPONSE COMMUNITY NURSING TEAM
Arrangements are in place to rapidly deploy a community nursing team composed of some 20 community matrons. This professional and mobile resource will be available to be deployed at the behest of the Incident Commander in the Incident Control Centre.

The team will be contacted by the manager or deputy for the Adult Integrated service team. They will be directed to a rendezvous where they can park their vehicles and board designated transport for example. Bulk/Group texting will be the communication tool of choice. See Annex 8
Group Text references are:

CDDFT-MIP-CM-EAST – (East locality)

CDDFT-MIP-CM-SOUTH - (South locality)

CDDFT-MIP-CM-NORTH – (North locality)

The teams may be called individually or collectively dependant on geography and size of incident.

If they are required to man a treatment centre in a store or village hall for example then NEAS will provide basic dressing packs and equipment including PPE and Airwave radio sets.

They may be deployed in any safe structure with power, light, heat and sanitation that has been vetted by the Ambulance service on the trusts behalf.

They are not to be deployed as a Merit (Mobile Emergency Response and Incident Team) or assist at the scene of a non- trust incident.

This has been developed in consultation with the community nursing team and the HART & Resilience Manager, North East Ambulance Service.

20.0 SPECIAL TYPES OF MAJOR INCIDENT

INCIDENT ON A TRUST SITE – TRUST EMERGENCY

Definition: A Trust Emergency is an incident which compromises normal service delivery but does not affect external agencies or partner organisations.

In the event of an incident occurring on a trust site, staff should invoke their Business Continuity plans. If escalation is required to the relevant head or lead for that service, they must decide if further escalation is required. If this is the case then a Trust emergency is declared.

The command and control structure invoked for a major incident should be deployed.

The call out cascade would be modified to reduce notification to areas that are not required to be activated, for example, as specials measures needed to manage multiple casualties would be unlikely.

The Trust has many ‘off site’ estates. In order to effectively manage an incident on these sites that are without senior management presence, an ‘off- site’ adaptation of the Major Incident and Emergency Recovery Plan is required.
Hospital sites experiencing such difficulties must inform allied services such as sister hospital sites, neighbouring Trusts and the Ambulance Service.

A trust emergency may be called by Senior Manager or Senior Nurse. Examples include:

- Power failure
- Loss of or loss of access to building due to flood or fire associated with patient evacuation
- Loss or displacement of staff
- Serious injury or death (staff)
- Capacity issues
- Contamination Incident
- Major loss of IT
- Loss of trust reputation

In a Trust Emergency the INCIDENT CONTROL TEAM would be responsible for informing other relevant agencies (depending on incident), e.g., LHRP and Clinical Commissioning Groups to divert GP admissions.

Ambulance Service and other Local Trusts to divert emergencies

**ESCALATION AND DE-ESCALATION**

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:

<table>
<thead>
<tr>
<th>Criteria for Escalation</th>
<th>Criteria for De-escalation</th>
</tr>
</thead>
<tbody>
<tr>
<td>increase in geographic area or population affected (pandemic, flooding etc.)</td>
<td>reduction in internal resource requirements</td>
</tr>
<tr>
<td>the need for additional internal resources</td>
<td>reduced severity of the incident</td>
</tr>
<tr>
<td>increased severity of the incident</td>
<td>reduced demands from partner agencies or government departments</td>
</tr>
<tr>
<td>increased demands from government departments, the service or from partner agencies or</td>
<td>reduced public or media interest</td>
</tr>
<tr>
<td>other responders</td>
<td>decrease in geographic area or population affected</td>
</tr>
<tr>
<td>heightened public or media interest</td>
<td></td>
</tr>
</tbody>
</table>

Changes in incident level will be authorised by the Incident Director.
21.0 INCIDENTS INVOLVING CHILDREN

It is recognised that children have special needs in any Major Incident. They are different from adults in terms of their size, physiology and psychological needs. This section outlines the additional arrangements to be made and allocates the main responsibilities to be discharged in the event of a Major Incident involving a large number of children.

Triggering Factors
The ED Department Consultant on-call, in conjunction with the Paediatric Consultant on-call, will decide the level of preparation for the hospital, depending upon the number of casualties, their type and severity of injuries.

Children Requiring Intensive Care Facilities
Intensive care for children should, wherever possible, be provided at the Royal Victoria Hospital in Newcastle or the James Cook University Hospital in Middlesbrough. The Consultant Paediatrician or Consultant Anaesthetist will obtain the available regional bed numbers. The Consultant Anaesthetist and/or Paediatrician from the receiving hospital will stabilise children in preparation for theatre or transfer. Each individual child must be discussed with the senior clinician on-call.

If there are predominantly young child casualties Ward 22, DMH and or Treetops, UHND will become the primary receiving ward.

Parents
It is recognised that parents are likely to want to have close contact with their child, no matter how serious their injuries may be. Staff will always try to accommodate parents’ wishes to remain with their children.

Additional Roles and Responsibilities for the Paediatric Response

1. **Manager Member of the Hospital Control Team**
   In addition to roles and responsibilities outlined in the relevant Action Card this person will in the event of an incident involving school children:
   - ensure that the appropriate school and local education authority have been informed
   - liaise with the local education authority who may provide support by contacting parents
2. **Nurse Member of the Hospital Control Team**  
   In addition to roles and responsibilities outlined in the relevant Action Card this person will ensure:
   - additional paediatric nurses are called in to assist
   - sufficient numbers of paediatric/experienced staff are available to respond to the ED to assist
   - additional vital paediatric equipment is available as required
   - the relevant area in the children’s ward has been established and staffed appropriately by paediatric nurses

3. **Medical Member of Hospital Control Team**  
   In addition to roles and responsibilities outlined in the relevant Action Card this person will:
   - Liaise closely with the Consultant Paediatrician on-call, to ensure additional paediatric medical staff have been called in
   - keep the Medical Incident Officer (on scene) informed of paediatric capacity

4. **ED Department Consultant on-call**  
   In addition to roles and responsibilities outlined in the relevant Action Card this person will:
   - liaise closely with the Consultant Paediatrician on-call

---

**22.0 MASS CASUALTY INCIDENTS**

A mass casualty incident is one in which far greater numbers of casualties or fatalities occur than is associated with the hitherto experience of the NHS and the emergency services of Major Incidents. It may be a situation that comprises a series of related incidents either in close proximity or geographically separated.

A mass casualty incident will consequently be defined by the circumstances and apparent nature of the episode, not by the initial assessment of number of casualties. Numeric assessments are not possible in such incidents, often for hours or days. It will generally be recognised by its geographical scale and the fact that usual Major Incident responses are insufficient.

Special considerations and arrangements are therefore required to respond to a mass casualty incident. An example of such planning can be found in ‘The North East framework for terrorist incident resulting in mass casualties June 2011’ had been developed for such an incident.

Copies of this restricted document are held in the secure cabinet in the Operations rooms.
The North East framework for terrorist incident resulting in mass casualties augments the existing plan it does not replace it.

Note: Doing the greatest good for the greatest number of people will require changes to clinical practices and acceptance that it may not be possible to deliver patient care to the same standards, clinical protocols and guidelines that normally apply, this will increase stress and anxiety amongst care deliverers.

The medical coordinator will need to consult with clinical staff to identify the scope for adapting normal clinical practice in response to specific clinical needs, for the treatment, triage and discharge thresholds. In the absence of specific incident related guidance, the following guidance may be implemented where appropriate.

Clinical Guidelines for use in Major Incidents (2011 NHS) copies of which are held in both emergency departments.

23.0 INCIDENTS WITH LARGE NUMBERS OF CASUALTIES SUFFERING THERMAL BURNS

Each hospital with an ED should be able to undertake the initial management of 20 casualties with burns. In some circumstances they may need to care for more than this.

Each department should have access to the following equipment (which need not be stored separately):

- 5 rolls of Clingfilm
- 40 Lund and Browder charts (for all ages)
- Burns Fluid Calculator
- Equipment for escharotomy

Triage of burns casualties (add age and % Body Surface Area (BSA) burned):

- < 35    Manage at non-specialist hospital
- 35-100  Manage at burns unit
- > 100   Manage at non-specialist hospital

If the burns unit is unable to accept all casualties in the middle triage category, the lower end of this range may need to be elevated

Refer to BURNS MAJOR INCIDENTS AND BURNS MASS CASUALTY INCIDENTS PLAN

From the NORTHERN BURN CARE NETWORK held in Incident room cabinet and online.
24.0 CASUALTIES EXPOSED TO CHEMICAL, BIOLOGICAL RADIOLOGICAL OR NUCLEAR AGENTS

Please refer to associated HAZCHEM / CBRN PLAN

25.0 VULNERABLE PEOPLE

Blind or Partially Sighted Persons

If a casualty is blind or partially sighted and has a guide dog the Guide dog Association offer the following advice:

Each Guide Dog owner has an ID card

The ID card carries the number of a nominated emergency contact usually family or friend who will care for the dog in an emergency.

Should the emergency contact be unavailable then an Emergency Boarder can be contacted, these are volunteers registered with the association who will provide care for the dog during the owner’s infirmity.

The emergency contact or boarder will bring the dog in to visit the owner on a daily basis but the association do not recommend that the guide dogs travel in ambulances or stay in hospital.

26.0 SUPPORT FROM PARTNER AGENCIES

AMBULANCE LIAISON OFFICER (ALO)

Supplied by NEAS this officer will base themselves in the Emergency Department or Incident Control Centre and provide the current hospital status to the Ambulance Information Officer at the incident scene.

The ALO will also be advised of incoming casualties

POLICE DOCUMENTATION TEAM

Supplied by County Durham & Darlington Constabulary, these two officers of the Detective inspectorate will provide the administrative aspect of the Police response. They have no remit outside this role and are not responsible for site security.

As previously mentioned their documentation is located in respective emergency departments and they have received appropriate training.

LOCAL AUTHORITY SUPPORT

Support will be provided at the Local Authority’s Emergency Reception Centre, The Emergency Reception centre will be able to provide a range of support to address clothing, shelter,
transport and any financial needs. Should such a centre not be operational then advice may be sought from the Local Authority via the on call manager

Agreed in consultation with the Head of Emergency Planning Civil Contingencies unit Durham County Council.

RAIL EMERGENCIES
The Association of Train Operating Companies have teams of specially selected volunteers who have been trained and equipped to respond to the needs of those affected in the hours and days immediately following a rail emergency. These are referred to as Rail Incident Care Teams. See Annex 5

27.0 BUSINESS CONTINUITY, RECOVERY AND RESUMPTION OF SERVICE

Trust Command Responsibilities

Debriefing of staff

- All departments to instigate service continuity plans
- Give information to all casualties about where they can get advice
- Review clinical notes of all casualties
- Formal audit
- Produce report for Local Health Resilience Partnership

Support for Staff

Arrangements will be made to minimise the risk of psychological ill health amongst staff as a consequence of their involvement in the personally traumatic aspects of the Major Incident.

All members of staff who are involved in the Major Incident will be invited to attend group meetings, 48–72 hours after the end of the incident. Attendance will not be compulsory but is strongly advised. The sessions will include the following:

- Identifying the normality of certain responses and reactions both during and immediately after the incident, including duration times.
- Education regarding symptoms and reactions which may yet occur and warning signs when to seek help.
- Encourage the use of normal individual coping strategies.
- Identifying procedures for obtaining further help if required (an information leaflet will be provided).
This will be co-coordinated by the Occupational Health Department, in liaison with the Department of Psychology.

Formal counselling for all is now thought unnecessary and may prolonged or evoke adverse reactions or delay the normal recovery processes.

**28.0 RISK REGISTERS**

This plan is in place to enable the trust to respond to a range of risks. These risks have been identified nationally and locally and have been incorporated into the community risk register(s) of Durham, Darlington and Tees Local Resilience Forum.

*Copies of current Risk Registers can be found on the Emergency preparedness home page*

**29.0 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.

**30.0 PLAN OWNERSHIP**

This plan is owned by the Executive Director of Nursing designated ‘Accountable Emergency Officer’ (AEO) on behalf of the Trust Board and is maintained and administered by the Trust Resilience Forum in collaboration with Care Group/service leads. Service Managers are responsible for ensuring that the plan and the resources required for testing and exercising are made available.

To report changes or amendments to this document please contact the Trust Resilience Lead
31.0 PLAN ADMINISTRATION

CONSULTATION
This document has been produced by the Nursing and Quality Department on behalf of the Trust Resilience Forum and the Chief Executive.

In preparing the document for official ratification the stakeholders listed below were consulted and their comments added to the document as appropriate.

- Trust Resilience Forum Clinical leads
- Care Group Clinical Leads/Associate Chief Operating Officers
- Department Heads
- General Managers
- Communications Team
- Durham, Darlington & Tees NHS Area Team
- North East Ambulance Service
- Action Card Holders
- Local Resilience Partners

DOCUMENT APPROVAL AND RATIFICATION
The Trust Resilience Forum has carried out a full and proper consultation and has considered the content of the document in relation to; current best practice, legislation, mandatory and statutory requirements.

The plan will be submitted to Patient Quality & Healthcare Governance committee for approval before submission to the Trust Board.

PLAN AVAILABILITY
A full and up-to-date copy of this plan will be held in both the Operations (Incident Control) Rooms, the Hospital Information Centres and each Emergency department.

An electronic version can be found on the Trust’s Intranet site on the ‘Policies and Procedures’ page under ‘Emergency Preparedness’.

As described in the Emergency Preparedness Strategy it is the responsibility of the Associated Chief Operating Officers, Clinical Leads and Service Managers to familiarise themselves with this plan and to raise awareness amongst their staff of its existence.
It is the responsibility of all staff to ensure they are reading the most up-to-date version of the plan – verification can be sought from either the Emergency Planning Intranet page or Trust Resilience Lead.

32.0 REVIEW AND MAINTENANCE, TRAINING & EXERCISING

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

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

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

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

TRAINING

The Emergency Preparedness Training Programme will ensure all staff that may be involved in a major incident are prepared to respond.

Training for the Trust will be generic with specific training focusing on groups and individuals.

The training programme will be designed to ensure staff:

• Understand their roles and those of others, and how these relate to each other;
• Understand the Major Incident & Emergency Response’s systems and procedures;
• Know how accommodation should be used;
• Know where equipment is kept and how to use it;
• Make necessary preparations
• Perform to an agreed standard; and
• Learn from experience

**EXERCISING**

Plans become unreliable if not regularly exercised and tested.

It is important to validate our Major Incident & Emergency Response Plan and the competencies of our staff by exercises at regular intervals as part of the hospital’s quality assurance programme.

Exercises may test the full plan or specific parts of it.

The Trust as a minimum must conduct:

- A Command Post Exercise every six months
- A table top exercise once a year.
- A communication cascade test every six months, involving multi agency partners where possible.
- A live exercise every three years

The principal components of the Major Incident & Emergency Response Plan can be tested using the following methods:

- **Simple familiarisation visits and inspection of equipment.**
- **Table top exercises** - based on an imagined scenario – can, be a useful low-cost means of testing working relationships, the integration of roles and responsibilities and command and control links (minimum of one per year)
- **Live exercises** - a live exercise means simulating the actual response of all resources to a major incident. It will start with a simulated event to which a range of health care and other agencies will be required to respond (minimum of every three years). An ‘Emergo’ exercise qualifies as a live exercise.

Exercises need to be very carefully planned as they are time-consuming, resource intensive and have the potential to disrupt other National Health Service activities.

**LESSON IDENTIFIED PROCESS**

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 Incident 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.

Success depends on support and commitment from senior management.

33.0 AUDIT AND MONITORING

NHS Commissioning Board Core Standards for Emergency Preparedness Resilience & Response states that
‘All NHS Commissioning Board EPRR framework guidance will include relevant extracts from these standards. And EPRR control processes will require evidence that the standards are being met.’

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations and sub-contractors must show that they can deal with these incidents while maintaining services to patients. This work is referred to in the health service as ‘emergency preparation, resilience and response’ (EPRR).

It is the responsibility of individuals, services and departments to ensure that any changes to its service delivery procedures or staffing changes, which may affect the delivery of this plan, are notified to the trust’s resilience lead immediately, in order for amendments to be made.

This plan will be reviewed by the Trust’s Resilience Forum annually or earlier if a change in circumstances takes place.

The Plan will be audited in line with the NHS commissioning boards Core Standards for Emergency Preparedness Resilience & Response annually to ascertain the completeness of this plan.
The minutes from the meetings of the Trust Resilience Forum will also be submitted to the Patient Quality & Healthcare Governance committee for scrutiny.
The methodology described above will be used to ensure the Major Incident & Emergency Response Plan remains relevant in relation to content and legislation. Results from the audit will be published in the annual report to the Board.

34.0 EQUALITY & DIVERSITY

See Annex 5
35.0 ACRONYMS AND TERMS USED IN THE PLAN

AT  Area Team - the local presence of the NHS Commissioning Board
CBRN  Chemical Biological Radiological Nuclear
CCA  Civil Contingencies Act
COBR  Cabinet Office Briefing Rooms
COMAH  Control of Major Accident Hazards
DH  Department of Health
DPH  Director of Public Health
ED  Emergency Department
EPRR  Emergency Preparedness, Resilience and Response (DH)
ICC  Incident Coordination Centre
IMT  Incident Management Team
IRP  Incident Response Plan
LHRP  Local Health Resilience Partnership
LRF  Local Resilience Forum
NHS  National Health Service
NEAS  North East Ambulance Service
NHSCB  NHS Commissioning Board
PHE  Public Health England
SAGE  Scientific Advice to Government in Emergencies
SCG  Strategic Coordinating Group (Multiagency Gold Command)
SITREP  Situation Report
STAC  Scientific and Technical Advice Cell

<table>
<thead>
<tr>
<th>METHANE</th>
<th>CHALETS</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Major incident</td>
</tr>
<tr>
<td>E</td>
<td>Exact location</td>
</tr>
<tr>
<td>T</td>
<td>Type of incident</td>
</tr>
<tr>
<td>H</td>
<td>Hazards</td>
</tr>
<tr>
<td>A</td>
<td>Access</td>
</tr>
<tr>
<td>N</td>
<td>Number of casualties</td>
</tr>
<tr>
<td>E</td>
<td>Emergency Services</td>
</tr>
</tbody>
</table>

C | Casualties |
H | Hazards |
A | Access |
L | Location |
E | Emergency Services |
T | Type of incident |
S | Safety |
## ANNEX ONE – ACTION CARDS

### GENERAL ACTIONS FOR ALL TRUST STAFF

**– TO BE READ PRIOR TO AN INCIDENT**

<table>
<thead>
<tr>
<th>In advance of an incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensure that you are familiar with the incident response plan and understand the role you would take in the event of a Major Incident.</td>
</tr>
<tr>
<td>• Undergo training and participate in exercises as required.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you have a specific role in the plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensure that you understand your role and to whom you report.</td>
</tr>
<tr>
<td>• Find the action card for that role and follow it.</td>
</tr>
<tr>
<td>• Ensure you are adequately briefed.</td>
</tr>
<tr>
<td>• Undertake tasks as directed, meeting all agreed deadlines.</td>
</tr>
<tr>
<td>• Ensure handover arrangements are in place for your role which should include a period of shadowing if possible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When alerted to attend an Incident Coordination Centre (ICC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Maintain a personal log/ notes of the incident if your role requires this.</td>
</tr>
<tr>
<td>• Understand the location of and how to access the ICC out of hours.</td>
</tr>
<tr>
<td>• Set up the ICC if you are requested to do this as part of your role.</td>
</tr>
<tr>
<td>• For other agencies/organisations:</td>
</tr>
<tr>
<td>o Ascertain where the ICC is being established and make your way to the location.</td>
</tr>
<tr>
<td>o Ensure that your organisation/agency continues to provide advice whilst you are in transit to the ICC, e.g. a second member of staff responds to queries raised.</td>
</tr>
<tr>
<td>o Ensure you have a full briefing of your organisation’s actions/decisions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide your personal log/notes and other documents.</td>
</tr>
<tr>
<td>• Contribute to the post-incident debriefing.</td>
</tr>
<tr>
<td>• Contribute to the report of the incident.</td>
</tr>
</tbody>
</table>
**ACTION CARD**

**SENIOR NURSE PATIENT FLOW**

**‘ALPHA’**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Manager On Call</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible for:</strong> Initiating the initial Hospital Response in respect of a potential or actual Major Incident. You will be made aware of a Trust Emergency but will only respond if it is ON SITE or at the request of the Silver Incident Manager</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Time</th>
</tr>
</thead>
</table>
| 1. | In the event of a potential or actual major incident / Trust Emergency, the Senior Nurse Patient Flow will be notified by:  
  - Hospital Switchboard  
  - If External Phone call – Redirect call to switchboard | |
| 2. | Assume Executive Authority for the incident until relieved by the manager on call or an executive officer | |
| 3. | Go to Hospital Information Centre (location is site dependant)  
Commence personal log | |
| 4. | If ‘Standby’ advised, confer with manager on call and emergency department. Await ‘**Stand down**’ or ‘**Activation**’. | |
| 5. | Gain access via key from switchboard DMH (Code for key pad from security UHND). Collect Major Incident Box from reception area and set up Hospital Information Centre, Follow prompt card in box. | |
| 6. | **If Incident confirmed initiate Hospital Information Centre**  
Issue Action Cards and register holders  
Collate Staff on site registers, Bed Status sheets and issue ID and register Bona Fida visitors (Police, NEAS et al)  
Receive Airwaves Handset from Incident Control Centre  
Commence Patient tracking  
Provide general advice to public until call centre established  
Prepare Brief / Situation Report (SITREP) for incoming manager on call / Manager Hospital Control Team | |
| 7. | You will be relieved by the service manager / Supervisor responsible for this area and assume your duties but maintain close contact with the Hospital Information Centre | |
| 8. | In the event of a declaration of **Major Incident – Radiation**  
Contact the Radiation Protection/ Emergency Response adviser immediately  
Contact numbers in HIC box and held in Switchboard. | |
**ACTION CARD**

**‘BRAVO’**

**MANAGER ON CALL**

**Accountable to** Executive Director On Call

**Responsible for:** Initiating the initial Hospital Response in respect of a potential or actual Major Incident / Trust Emergency. (For Trust Emergency Omit Actions No 4 & No 5)

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The Manager on Call will be notified by Hospital Switchboard</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Commute to Site of activation</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>When on site assume Executive Authority for the incident until relieved by an executive or senior manager.</td>
<td></td>
</tr>
<tr>
<td>(4).</td>
<td>Rendezvous in Hospital Information Centre and take Initial brief from Senior Nurse Patient Flow or service manager. Do not enter the Emergency department or any other clinical area.</td>
<td></td>
</tr>
<tr>
<td>(5).</td>
<td>If ‘Standby’ advised, confer with Executive on call and Emergency department consultant on call. Await Stand down or Activation.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Gain access to (Woodlands DMH or Old Trust Boardroom UHND) via key from switchboard (DMH) / Reception (UHND) and establish Incident Control Centre (ICC)</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td><strong>If Incident confirmed initiate</strong> Incident Control Team Set up Control centre in accordance with wall chart Distribute Airwaves Handsets (Bronze, Silver, Gold) Commence Personal Log Call and identify two Loggists (see list in box)</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Initially this role will be occupied by the Manager on Call Subsequently the role will be occupied by a non-clinical Director or Associate Director or Associate Chief Operating Officer.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>When the quorum of the Incident Control Team are assembled (Senior Manager, Medical Director, Senior Nurse and Loggist) Activate the Incident Control Team. Take first situation report (SITREP) from Senior nurse Patient flow or service manager. In hours you may be briefed by the Area Team.</td>
<td></td>
</tr>
</tbody>
</table>
### ACTION CARD
**EXECUTIVE DIRECTOR ON CALL**

**‘CHARLIE’**

**Accountable to:** Chief Executive Officer

**Responsible for:** Implementation of Major Incident and Emergency Response Plan

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Time Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>In the event of a potential or actual major incident / Trust Emergency, you will be notified by the hospital Switchboard</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Commute to Site of activation</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>When on site assume Executive Authority for the incident until relieved by AEO, CEO or Medical Director</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Access Incident Control Centre via Hospital Information Centre (Bronze) at Main Reception. Start a personal log detailing information received and actions taken. Copies of the log book can be found in the Incident Control cabinet. Ensure formal logging of your actions/decisions is in place as soon as possible.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>In the event of plan activation establish that the Incident Control Team (Silver) is active and able to manage the immediate response.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Withdraw to dedicated Directors Incident Response room</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Establish Incident Response Co-ordination Team (Gold) You / CEO / Medical Director Directors of Finance / Estates / Operations AEO (Accountable Emergency Officer) Communication’s officer Loggist &amp; Administrator</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Assume the role of Trust Commander and follow the Trust Commanders Action card (Number 1)</td>
<td></td>
</tr>
</tbody>
</table>

THE INCIDENT CONTROL CENTRE (ICC) IS SITUATED IN THE WOODLANDS ROOM DMH OR OLD TRUST BOARDROOM UHND

THE INCIDENT CONTROL TEAM CONSISTS OF MEDICAL DIRECTOR, A MANAGER, A SENIOR NURSE AND, A LOGGIST AS A MINIMUM

MAY BE ENHANCED WITH COMMUNICATIONS OFFICER, ADMINISTRATOR, RESILIENCE LEAD OR ACCOUNTABLE EMERGENCY OFFICER (AEO) & NEAS AMBULANCE LIAISON OFFICER* (May deploy to Emergency Department)

IF THE INCIDENT REQUIRES STRATEGIC INPUT THEN AS THE EXECUTIVE ON CALL YOU SHOULD LEAD THE GOLD TEAM UNTIL CEO ARRIVES

THE GOLD TEAM SHOULD INCLUDE THE DIRECTORS OF FINANCE / ESTATES & FACILITIES / OPERATIONS & PLANNING / AEO / LOGGIST / COMMS

THE GOLD TEAM MAY ALSO BE KNOWN AS THE INCIDENT RESPONSE CORDINATION GROUP

HIC DMH 43017

- 48 -

HIC UHND32517
**ACTION CARD 1**

**TRUST COMMANDER**

**POST HOLDER** CEO / MEDICAL DIRECTOR

**Chief Executive Officer / Director Area Team**

**Responsible for:** The strategic management of the incident and the recovery and restoration of the service.

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Establish Trust command (either DMH or UHND, whichever you can get to most quickly); do not pass through clinical areas if they can be avoided.</td>
</tr>
<tr>
<td>2.</td>
<td>Establish Incident Response Coordination Team [IRCT] (GOLD) and brief the membership. This will depend on the incident but, as a minimum, should include: You / CEO / Medical Director Directors of Finance / Estates / Operations AEO (Accountable Emergency Officer) Communication’s officer Loggist Administrator</td>
</tr>
<tr>
<td>3.</td>
<td>Confirm that the relevant command and control structures have been implemented across the trust</td>
</tr>
<tr>
<td>4.</td>
<td>Confirm that all relevant personnel internally, at region and externally have been informed.</td>
</tr>
<tr>
<td>5.</td>
<td>Confirm with the Incident Director of the Area Team the trust’s status and its aim and objectives for responding to the incident and the strategy to achieve these.</td>
</tr>
<tr>
<td>6.</td>
<td>Identify battle rhythm dependant on: Area Team’s directive</td>
</tr>
<tr>
<td>7.</td>
<td>Receive briefing’s from Incident Control Team (Silver) &amp; Area Team (Health Gold)</td>
</tr>
<tr>
<td>8.</td>
<td>Ensure that all members of the ICT are working from the current Incident Response Plan, ensuring all required roles are undertaken</td>
</tr>
<tr>
<td>9.</td>
<td>Prepare to receive support/liaison officers from partner agencies and other VIP’s</td>
</tr>
<tr>
<td>10.</td>
<td>Implement the media strategy and identify an appropriate person to represent the Trust at any press conferences/media interviews.</td>
</tr>
<tr>
<td>11.</td>
<td>Finance team to monitor any additional resource requirements. Authorise catering provision in accordance with plan.</td>
</tr>
</tbody>
</table>
| 12.    | All requests for expert advice must be passed through the trust Commander for onward transmission to the SCG if sitting. The Scientific & Technical Advice Cell (STAC) will consider the request and advise accordingly via SCG. Should the SCG not be sitting then advice should be sought via Public Health England (PHE).  
  (In hours) 0844 225 3550  
  (Out of hours) 0191 269 7714 |
<p>| 13.    | Issue Stand down message as appropriate |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>In prolonged scenario’s implement a shift rota</td>
</tr>
<tr>
<td><strong>Post Incident</strong></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Ensure adequate audit trails are in place for strategy, objectives and decisions taken</td>
</tr>
<tr>
<td>16.</td>
<td>Lead the trust recovery, you may wish to adopt the same command &amp; control structure.</td>
</tr>
<tr>
<td>17.</td>
<td>Commission post Incident trust impact analysis</td>
</tr>
<tr>
<td>18.</td>
<td>Commission post impact report and debrief the executive board and trust as a whole.</td>
</tr>
<tr>
<td>19.</td>
<td>Consider arrangements for restocking, recommencing elective lists, outpatient lists and on-going staffing requirements</td>
</tr>
<tr>
<td>20.</td>
<td>Ensure a review of the Trust Emergency Planning procedures and the major incident and business continuity plans takes place</td>
</tr>
</tbody>
</table>
ACTION CARD 2

MEDICAL DIRECTOR

Accountable to

Trust Commander

Responsibilities:
- Overall Control of trust medical resources
- Suspension of elective and outpatient lists
- Liaison with on-site personnel
- Attend press conference as required

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Time Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Liaise with Trust commander to establish location of Incident Response Coordination Centre, (either DMH or UHND, whichever you can get to most quickly); do not pass through clinical areas if they can be avoided.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>On arrival of Ambulance Liaison Officer (ALO) seek clarification of incident scene status</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Liaising with ALO and determining what services are available and viable to victims at the scene utilising supporting hospital services as necessary.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Assist with Trust Commander in determining the ability of the Trust to manage at capacity.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Access requirements for additional medical staffing and arrange appropriate call out.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Liaise with consultant colleagues to ensure adequate numbers of medical staff available throughout the incident and for those shifts immediately following the incident.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Declare ‘Stand down’</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Ensure a review of the Trust Emergency Planning procedures and the major incident and business continuity plans takes place</td>
<td></td>
</tr>
</tbody>
</table>
## ACTION CARD 3

**INCIDENT COMMANDER**  
LEADER OF THE INCIDENT CONTROL TEAM  
POSTHOLDER – SERVICE MANAGER/AD/ACOO

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Trust Commander</th>
</tr>
</thead>
</table>
| **Responsible for:** | Implementation of the Major Incident & Emergency Response plan at the Tactical level. The deployment of all staff within the hospital is the responsibility of this post. This post will liaise with senior member of staff from Balfour Beattie Workforce (BBW) within the Incident Control Team to ensure that staff who are not Trust employees contribute fully to the Major Incident response. **You are the main point of contact between the Trust Command and the Incident Control Team.**  
All non-clinical staff in the hospital report to you via the Facilities and Estates co-ordinator. You work with the Nurse and Doctor member of the Incident Control Team. |

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Time Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Establish the Incident Control Centre at the designated site(either DMH or UHND), do not pass through clinical areas if they can be avoided.</td>
<td></td>
</tr>
</tbody>
</table>
| 2. | Establish/Join the **Incident Control Centre (ICC)** and brief the membership. This will depend on the incident but, as a minimum, should include:  
Senior Nurse  
Senior Doctor  
Senior Manager  
Loggist | |
| 3 | Confirm that the relevant command and control structures have been implemented across the trust | |
| 4 | Obtain briefing or **give** Trust Command initial brief | |
| 5 | Determine tactical response, aims and objectives | |
| 6 | Brief Divisional Teams about the incident and planned response and ensure they understand their role and remind them of the Trust responsibility for staff well-being. | |
| 7 | Assess requirements for additional non-clinical staff and ensure the appropriate call-out has been undertaken. | |
| 8 | Acquire Bed Status, staffing levels, out-patient and theatre lists | |
| 9 | Assess requirements for redeployment of equipment or for additional equipment/resources and inform Trust Command of any additional equipment that will be needed. | |
| 10 | Request the **attendance of chaplain** via switchboard. | |
| 11 | Request the attendance of **Local Authority Hospital Crisis Officer** via dedicated number.  
See Annex 5 | |
<table>
<thead>
<tr>
<th>Action if Standby declared</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Convene Incident Control Team, assess incident and hospital status and implement any parts of the plan thought necessary.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>After an Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Record all your actions and decisions, together with times. After the incident copy your action/decisions log and give a copy to the Manager Member of the Incident Control Team</td>
</tr>
<tr>
<td>2. Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.</td>
</tr>
<tr>
<td>3. Make sure that colleagues are aware that you are leaving – so that staff log is up to date.</td>
</tr>
<tr>
<td>4. Do not make “off the cuff” comments to media.</td>
</tr>
</tbody>
</table>

The Incident Commander will receive and keep safe a copy of the action/decision logs from the following then pass them to the Trust Resilience Lead for Archiving.
- Switchboard
- All members of Trust Command and Incident Command Centre
- All co-ordinators
- Loggists
### ACTION CARD 4

**DOCTOR MEMBER OF THE INCIDENT CONTROL TEAM POST HOLDER – DEPUTY MEDICAL DIRECTOR or DEPUTY**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Medical Director</th>
</tr>
</thead>
</table>

**Responsible for:** Implementation of the Major Incident & Emergency Response plan at the hospital level. The deployment of all doctors within the hospital is the responsibility of this post, though this will be achieved via the medical co-ordinators. You work with the Nurse and Manager member of the Incident Control Team.

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Establish the Incident Control Centre at the designated site (either DMH or UHND), do not pass through clinical areas if they can be avoided.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Establish/Join the <strong>Incident Control Centre (ICC)</strong> and brief the membership. This will depend on the incident but, as a minimum, should include: Senior Nurse Senior Doctor Senior Manager Loggist</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Obtain briefing or assist in giving Trust Command initial brief</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Brief Clinical co-ordinators about the incident and the planned response and ensure that they understand their role and remind them of their responsibility for staff well being</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Assess requirements for redeployment of equipment or for additional equipment/resources and inform Trust Command of any additional equipment that will be needed.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>If necessary suspend routine operating, outpatient clinics and ward work; consider arrangements for patients receiving care elsewhere.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Liaise with Area Team 1st on call 0191 430 2453 regarding GP registrars to assist in hospital</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>If the incident is expected to be prolonged (&gt;12 hours) you should nominate someone to take over as Trust Commander and free them from other duties until then.</td>
<td></td>
</tr>
</tbody>
</table>

**Action if Standby declared**

| 9. | Alert ED senior staff and Executive/Manager on call await stand down or activation. |      |

**After an Incident**

- Record all your actions and decisions, together with times. After the incident copy your action/decisions log and give a copy to the Manager Member of the Incident Control Team.
- Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
- Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
- Do not make “off the cuff” comments to media.
### ACTION CARD 5

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Time Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Establish the Incident Control Centre at the designated site (either DMH or UHND), do not pass through clinical areas if they can be avoided.</td>
<td></td>
</tr>
</tbody>
</table>
| 2.     | Establish/Join the **Incident Control Centre (ICC)** and brief the membership. This will depend on the incident but, as a minimum, should include:  
Senior Nurse  
Senior Doctor  
Senior Manager  
Loggist |                |
| 3.     | Confirm that the relevant command and control structures have been implemented across the trust |                |
| 4.     | Obtain briefing or assist in giving Trust Command initial brief |                |
| 5.     | Determine tactical response, aims and objectives |                |
| 6.     | Brief diagnostic and support specialists about the incident and planned response and ensure they understand their role and remind them of the Trust responsibility for staff well-being. |                |
| 7.     | Assess requirements for additional nursing staff by specialty and arrange appropriate call-out. |                |
| 8.     | Establish that the **Police Documentation Team** status. Remember this team has no normal policing duties |                |
| 9.     | Establish that the Trust has been informed of the number for the **Casualty bureau** and switchboard / wards and departments are informed of this. |                |
| 10.    | Liaise with Area Team 1st on call **0191 430 2453** regarding  
- Alternative admission arrangements  
- Mobilising GPs to GP OOH  
- Establishing advice line (consider 111) |                |
| 11.    | Consider activation **Community Nursing Team via Head of Adult Integrated Services** or deputy via switchboard |                |
| 12.    | Convene Incident Control Team, assess incident and hospital status and implement any parts of the plan thought necessary. |                |

**Action if Standby declared**

- Consider activation **Community Nursing Team via Head of Adult Integrated Services** or deputy via switchboard

**After an Incident**

- Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
- Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
- Do not make “off the cuff” comments to media.

<table>
<thead>
<tr>
<th>The Incident Commander will receive and keep safe a copy of the action/decision logs from the following then pass them to the Trust Resilience Lead for Archiving.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Switchboard</td>
</tr>
<tr>
<td>- All members of Trust Command and Incident Command Centre</td>
</tr>
<tr>
<td>- All co-ordinators</td>
</tr>
<tr>
<td>- Loggists</td>
</tr>
</tbody>
</table>
## ACTION CARD 6

### LOGGIST

**POSTHOLDER – TRAINED LOGGIST**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>The person for whom they are logging: either Incident Director (Trust Commander) or Incident Commander</th>
</tr>
</thead>
</table>

**Responsible for:** Recording and documenting all issues/actions/decisions made by the Incident Director/Incident Manager. Within the Incident Coordination Centre / Incident Management Team, a loggist will always be present working direct to either the Incident Director or the Incident Commander.

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.

### NOTE

THE LOGGIST SHOULD BE RELEASED AFTER EVERY 30 MINUTE PERIOD

(IDEALLY A PAIR WORKING SHIFT AND SHIFT ABOUT)

The loggist is NOT:
- A gopher
- A general administrative support

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 7**

**COMMUNICATIONS LEAD POSTHOLDER – AD MARKETING & COMMUNICATIONS / COMMUNICATION LEAD**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Trust Commander or Incident Commander</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assume responsibility for managing all public information and media communications on behalf of the trust in accordance with the directions of the Area Team (AT) Incident Director / Incident Manager</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Receive own action card from Hospital Information Centre</td>
</tr>
<tr>
<td>2.</td>
<td>Locate and support Trust Commander</td>
</tr>
<tr>
<td>3.</td>
<td>Commence personal log</td>
</tr>
<tr>
<td>4.</td>
<td>Issue pre-arranged public health / safety messages in conjunction with Public Health England within the first hour of becoming aware of the incident.</td>
</tr>
<tr>
<td>5.</td>
<td>Assume responsibility for managing all public information and media communications on behalf of the trust in accordance with the directions of the AT Incident Director/Incident Manager and the SCG communication cell if established. Note that if a SCG is established all media responses are controlled and coordinated by the SCG so AT communications input/feedback should be fed upwards into the SCG. AT media statements / communications should focus solely on the NHS response / system issues. If issued proactively, statements should be notified to the SCG.</td>
</tr>
<tr>
<td>6.</td>
<td>Rapidly formulate and implement an integrated media handling strategy on behalf of the NHS response. Agree health spokespeople. If no SCG established, advise media (and stakeholders) on the regularity and timing of future media updates</td>
</tr>
<tr>
<td>7.</td>
<td>Alert communications network of incident and advice of media handling strategy.</td>
</tr>
<tr>
<td>8.</td>
<td>Identify communications officer/ admin support to log media calls and develop rolling question and answer brief.</td>
</tr>
<tr>
<td>9.</td>
<td>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.</td>
</tr>
<tr>
<td>10.</td>
<td>Deal with all media enquiries / draft statements organise press conferences and interviews as per media handling strategy.</td>
</tr>
<tr>
<td>11.</td>
<td>Once a strategic coordinating group (SCG) has been established, it 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 SCG. <strong>This will be via an NHS communications lead identified to be present at SCG</strong> and the Public Health England Communication lead who will be present at the science and technical advice cell.</td>
</tr>
<tr>
<td>12.</td>
<td>Provide regular updates to the NHS Commissioning Board regional office communications team and stakeholders’ communications teams on the NHS response and key health messages. This should continue as appropriate throughout the incident.</td>
</tr>
<tr>
<td>13.</td>
<td>On stand down, ensure that all original documentation (including notes, flip charts, e-mails etc.) are kept. Close personal log.</td>
</tr>
<tr>
<td>15.</td>
<td>Manage any on-going media interest in the NHS response, including social media.</td>
</tr>
</tbody>
</table>
### ACTION CARD 8

**ASSOCIATE DIRECTOR OF PLANNING / PATIENT BOOKING MANAGER**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Incident Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible for:</strong> Co-ordination of out-patient areas and suspension of out-patient service in liaison with Medical Director. Coordinate patient discharge management with consideration for transport needs, and provide additional support for the hospital information centres and Patient &amp; Relative Reunion areas.</td>
<td></td>
</tr>
</tbody>
</table>

| 1. | Receive Action card from Hospital Information Centre |
| 2. | Join Incident Control Team |
| 3. | Establish current outpatient activity and note suspensions |
| 4. | Establish active operative lists |
| 5. | Plan for and initiate clinic / list closures in consultation with Medical Director |
| 6. | Co-ordinate transport to take outpatients home |
| 7. | Co-ordinate cancellation of operating lists and outpatients for the next 24 hours or longer if applicable |
| 8. | Co-ordinate setting up Call Centres, liaising with the Communications Officer |
| 9. | Allocate additional resources to assist with Call Centres / administration |
| 10. | Allocate resource to support administration in Patients & Relative reception areas |
| 11. | Plan for Restoration and Recovery of operative and outpatient services |
| 12. **After an Incident** |

- Record all your actions and decisions, together with times.
- After the incident copy your action decisions log and give a copy to the Manager Member of the Incident Control Team
- Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
- Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
- Do not make “off the cuff” comments to media.
### ACTION CARD 9

**MANAGER - HOSPITAL INFORMATION CENTRE**

**POSTHOLDER – MANAGER/ SUPERVISOR**

**Accountable to:** Incident Manager

**Role:** This card is for the first service manager who arrives but is not required to establish the Hospital Control Team. During working hours the service manager will assume control and direct the reception staff accordingly. Out of hours the Senior Nurse Patient Flow will initiate set up of the Hospital Information Centre until superseded by a service manager.

**Responsibilities:** Establish Hospital Information Centre (Main reception desk or alternative dependant on situation) Key OOH in Switchboard DMH/Access? UHND

**Initiate the immediate hospital response**

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>In the event of a potential or actual major incident, the post holder will be notified by Hospital Switchboard</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Relocate to designated Main Reception Area Commence personal log</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>If ‘Standby’ advised, confer with manager on call and emergency department. Await ‘Stand down’ or ‘Activation’.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Gain access via key from switchboard (DMH) or through keypad at UHND (Code from security staff) Obtain Major Incident Box and set up area. (UHND access?) Follow prompt card in box.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td><strong>If Incident confirmed initiate Hospital Information Centre</strong> Issue Action Cards and register holders Collate Staff on site registers, Bed Status sheets and issue ID and register Bona Fida visitors (Police, NEAS et al) Access Airwaves Handset (I hand set available from Incident Control Centre) Commence Patient tracking Provide general advice to public until call centre established Prepare Brief / Situation Report (SITREP) for incoming manager on call / Manager Hospital Control Team Maintain Hospital Information Centre function until ‘Stood down’.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>In the event of a declaration of Major Incident – Radiation contact Radiation Protection/ Emergency Response adviser immediately Contact numbers in HIC box and held in Switchboard.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>After an Incident</td>
<td></td>
</tr>
</tbody>
</table>

- Record all your actions and decisions, together with times.
- After the incident copy your action decisions log and give a copy to the Manager Member of the Incident Control Team
- Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
- Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
- Do not make “off the cuff” comments to media.
**ACTION CARD 10**

| Accountable to | NURSE CO-ORDINATOR  
| EMERGENCY DEPARTMENT  
| POSTHOLDER – MATRON / SENIOR NURSE |
| Senior Nurse Incident Control Team |

**Responsible for:** Effective management of the emergency department (ED) in response to a major incident ensuring a timely and appropriate patient journey maximising use of the nursing compliment and health care resources.

**Actions if Stand by declared:**
Determine if any current or planned activities should be cancelled or postponed. Consider keeping staff if a shift is about to end (until more information is available).

**Actions if Incident is declared:**
On receipt of the call identify the ED capacity to cope with numbers of:
- Immediate casualties
- Urgent casualties
- Delayed casualties

Arrange one or more members of staff to address patients already in the department so that those that can be treated elsewhere/later/vacate the department.

1. Open up Major Incident store cupboard, bring additional equipment to department and issue ED staff tabards
2. Allocate a member of staff to inform all waiting patients of the situation, asking those non-urgent patients to seek alternative health care provision or return at a later date.
3. Expedite the treatments and transfer of all other ED patients.
4. Those patients awaiting transport home should be directed or escorted to the designated discharge area. (Women’s Centre DMH) (Location UHND)
5. Ensure patient disposal is documented on the ED card
6. Deploy nursing staff within the department as they become available:  
    - One ED nurse to each resuscitation bed and trauma room  
    - One member of ED staff to staff base to keep tracking up-to-date  
    - Nurse Practitioner and SHO to Surgical Day Unit  
    - One non ED nurse to each cubicle as they become available  
    - One ED nurse to triage (ambulance only entrance)
7. Consider keeping staff if the shift is about to end. Arrange for additional nursing staff to be called in – remember to ensure staffing for the next 24 hours will be adequate.
8. A further challenge will be the restoration of the usual services provided by the ED after the incident. Towards the end of the incident, you should consider calling in another senior nurse to manage this recovery phase.
### ACTION CARD 11
### MEDICAL CO-ORDINATOR
#### EMERGENCY DEPARTMENT
#### POSTHOLDER – CONSULTANT / REGISTRAR

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Doctor Member Incident Control Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible for:</strong></td>
<td>Effective management of the emergency department (ED) in response to a major incident ensuring a timely and appropriate patient journey maximising use of the medical compliment and health care resources.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Actions if Stand by declared:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine if any current or planned activities should be cancelled or postponed. Consider keeping staff if a shift is about to end (until more information is available).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Actions if Incident is declared:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocate staff to specific areas (including triage). Medical staff should be deployed in descending order of seniority as follows:</td>
</tr>
<tr>
<td>1. ED Senior Doctor</td>
</tr>
<tr>
<td>2. MIC (if requested) – only a MIMMS qualified doctor should undertake this role.</td>
</tr>
<tr>
<td>3. Triage Officer.</td>
</tr>
<tr>
<td>4. Doctor in Resuscitation (i.e. immediate area) (P1)</td>
</tr>
<tr>
<td>5. Doctor in Urgent area (P2)</td>
</tr>
<tr>
<td>6. Doctor for “normal” ED emergency and urgent care</td>
</tr>
<tr>
<td>7. Doctor in delayed area (P3)</td>
</tr>
<tr>
<td>Communicate frequently with doctors 3 to 7 to find out what capacity remains and where additional staff are needed.</td>
</tr>
<tr>
<td>Arrange for additional medical staff to be called in – remember to ensure staffing for the next 24 hours will be adequate.</td>
</tr>
<tr>
<td>2. In liaison with the ED nursing co-ordinator, Manage the ED response to the incident.</td>
</tr>
<tr>
<td>3. Communicate with the Hospital Control Team so they can manage the hospital’s response (you lead on this by communicating with the doctor member of the HOSPITAL CONTROL TEAM):</td>
</tr>
<tr>
<td>- Provide them with information about the status of ED and the casualties therein.</td>
</tr>
<tr>
<td>- Let them know, in advance if possible, of additional resources required in ED.</td>
</tr>
<tr>
<td><strong>Note.</strong> Communication between ED and areas/agencies inside or outside the hospital should be minimal.</td>
</tr>
<tr>
<td>4. A further challenge will be the restoration of the usual services provided by the ED after the incident. Towards the end of the incident, you should consider calling in another senior clinician to manage this recovery phase</td>
</tr>
<tr>
<td>5. Record all your actions and decisions, together with times.</td>
</tr>
<tr>
<td>- After the incident copy your action decisions log and give a copy to the Manager Member of the Incident Control Team</td>
</tr>
<tr>
<td>- Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.</td>
</tr>
<tr>
<td>- Make sure that colleagues are aware that you are leaving – so that staff log is up to date.</td>
</tr>
<tr>
<td>- Do not make “off the cuff” comments to media.</td>
</tr>
</tbody>
</table>
### ACTION CARD 12

**TRIAGE OFFICER**

**EMERGENCY DEPARTMENT POSTHOLDER – CONSULTANT / REGISTRAR**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Doctor Member Incident Control Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible for:</strong></td>
<td>Allocation of an appropriate treatment priority for all casualties attending from the Major Incident.</td>
</tr>
</tbody>
</table>

The triage system is use is known as the 'Cruciform' triage labelling system currently used by NEAS and emergency care providers nationally.

The Cruciform card is folded in such a way as to display the relevant Triage Category thus

<table>
<thead>
<tr>
<th>Color</th>
<th>Category</th>
<th>(P1)</th>
<th>(P2)</th>
<th>(P3)</th>
<th>(P4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Immediate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yellow</td>
<td>Urgent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Green</td>
<td>Delay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>Deceased</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Must be a medical officer of sufficient seniority to perform Triage

**Action**

1. Receive own action card
2. Set up a triage point at the ambulance only entrance
3. Clarify roles with triage nurse and triage receptionist
4. As casualties arrive record triage category, allocated at incident scene, on ED record
5. Reassess patients, allocate and record new triage category if appropriate.
6. Direct casualty to treatment destination.
7. Maintain communication with medical coordinator
8. • Record all your actions and decisions, together with times.
   • After the incident copy your action decisions log and give a copy to the Manager Member of the Incident Control Team
   • Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
   • Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
   • Do not make “off the cuff” comments to media.

**NB** the triage officer must not become involved in direct patient care.
### ACTION CARD 13

**MINORS TREATMENT AREA**

**ORTHOPEDIC OUTPATIENTS**

**POSTHOLDER – F2 / NURSE PRACTITIONER**

**Accountable to**: Medical Co-ordinator ED

**Responsible for**: ensuring care and appropriate support for those casualties considered to have minor injuries. Nominally Category P3 casualties

#### Actions if Stand by declared:

Determine if any current or planned activities should be cancelled or postponed. Consider keeping staff if a shift is about to end (until more information is available).

**Actions if Incident is declared**:

- Allocate staff to specific areas (including triage).
- Medical staff should be deployed in descending order of seniority as follows:
  8. ED Senior Doctor
  9. MIC (if requested) – only a MIMMS qualified doctor should undertake this roles.
  10. Triage Officer.
  11. Doctor in Resuscitation (i.e. immediate area) (P1)
  12. Doctor in ‘Urgents’ area (P2)
  13. Doctor for “normal” ED emergency and urgent care
  14. Doctor in delayed area (P3)

Communicate frequently with doctors 3 to 7 to find out what capacity remains and where additional staff are needed.

Arrange for additional medical staff to be called in – remember to ensure staffing for the next 24 hours will be adequate.

2. In liaison with the ED nursing co-ordinator, Manage the ED response to the incident.

3. Communicate with the Hospital Control Team so they can manage the hospital’s response (you lead on this by communicating with the doctor member of the HOSPITAL CONTROL TEAM)
   - Provide them with information about the status of ED and the casualties therein.
   - Let them know, in advance if possible, of additional resources required in ED.

**Note.** Communication between ED and areas / agencies inside or outside the hospital should be minimal.

4. A further challenge will be the restoration of the usual services provided by the ED after the incident. Towards the end of the incident, you should consider calling in another senior clinician to manage this recovery phase

- Record all your actions and decisions, together with times.
- After the incident copy your action decisions log and give a copy to the Manager Member of the Incident Control Team
- Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
- Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
- Do not make “off the cuff” comments to media.
<table>
<thead>
<tr>
<th>ACTION CARD 14</th>
<th>RECEPTIONISTS EMERGENCY DEPARTMENT POSTHOLDER – ED RECEPTION STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountable to</strong></td>
<td>Nurse Coordinator Emergency Department</td>
</tr>
<tr>
<td><strong>Responsible for:</strong></td>
<td>Responsible for ensuring accurate collection of patient information and documentation for all Major Incident victims and collaboration with the Police Documentation Team and to maintain administrative support to the department for non-incident casualties.</td>
</tr>
<tr>
<td>1.</td>
<td>Receive Two Action Cards from ED Sister</td>
</tr>
<tr>
<td><strong>Receptionist 1 (Triage)</strong></td>
<td></td>
</tr>
<tr>
<td>• Ensure pre-registration of 50 ED patients and produce labels and identification bracelets for same</td>
<td></td>
</tr>
<tr>
<td>• Report to Triage Officer (ambulance only entrance)</td>
<td></td>
</tr>
<tr>
<td>• Provide all patients with a Major Incident number and an identification bracelet with corresponding number</td>
<td></td>
</tr>
<tr>
<td>• Document scene triage number on ED card (in Christian name space)</td>
<td></td>
</tr>
<tr>
<td><strong>Receptionist 2 (Documentation)</strong></td>
<td></td>
</tr>
<tr>
<td>• Complete patient details within treatment areas</td>
<td></td>
</tr>
<tr>
<td>• Enter incident patient details into patient administrative system.</td>
<td></td>
</tr>
<tr>
<td>• Liaise with Police Documentation Team regarding patient’s details</td>
<td></td>
</tr>
<tr>
<td>• Maintain normal administrative functions</td>
<td></td>
</tr>
</tbody>
</table>

**Unknown unconscious** patients will be given in addition to their pre-registered number a mock forename and surname unique to that number e.g. the first patient arriving at DMH would accrue the name ‘Delta Alpha’ the next patient becoming ‘Delta Bravo’ and so forth. UHND would use the prefix ‘Uniform’. This 3 point identification system (Number, Name and Sex) has been found to be very useful in real events such as the London Bombings of July 2007.

The Police Documentation team usually comprising 2 officers, will report to reception to collect their Documentation Box and be escorted to their designated area.

- At DMH they will be accommodated in the reception office area.
- At UHND they will occupy the Medical Secretaries Office and the Documentation box can be found in the Major Incident Store.

Requests for missing persons from the incident should **NOT** be directed to the police documentation team.
## ACTION CARD 15

### NURSE CO-ORDINATOR
**SURGERY & DIAGNOSTICS**
**POSTHOLDER – MATRON / SENIOR NURSE**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Senior Nurse Incident Control Team</th>
</tr>
</thead>
</table>

### Responsible for:
Effective management of the Surgical in response to a major incident ensuring a timely and appropriate patient journey maximising use of the nursing compliment and health care resources.

### Actions if Stand by declared:
Determine if any current or planned activities should be cancelled or postponed. Consider keeping staff if a shift is about to end (until more information is available).

### Actions if Incident is declared:

1. Ensure that senior medical and nursing staff perform triage and review current patients in the surgical areas, using the Traffic Light Bed Status Tool (Appendix 3) so that those that can be treated elsewhere / later are discharged / transferred.

   Ensure these are forwarded to Hospital Information centre within 30 minutes of activation.

2. Identify the surgical areas’ capacity to cope with numbers of:
   - Critically ill or injured casualties
   - Less serious casualties

3. Working in collaboration with departmental leads assess status of Theatres, Trauma Wards & ITU/HDU

4. Inform Senior Nurse Incident control, of additional resources that may be required in surgical areas.

5. Allocate nursing staff to meet clinical demand and consider retaining staff if a shift is about to end.

6. Arrange for additional nursing staff to be called in – remember to ensure staffing for the next 24 hours will be adequate.

7. A further challenge will be the restoration of the usual services provided by the Surgical & Diagnostic care Group following the incident. Towards the end of the incident, you should consider calling in another senior nurse to manage this recovery phase.

### After an Incident:
- Record all your actions and decisions, together with times. After the incident copy your action/decisions log and give a copy to the Manager Member of the Incident Control Team.
- Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
- Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
- Do not make “off the cuff” comments to media.
## ACTION CARD 16

### MEDICAL CO-ORDINATOR
**IN SURGERY POSTHOLDER – CONSULTANT / REGISTRAR**
**SURGEON / ANAESTHETIST**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Doctor Member Incident Control Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible for:</strong> Organising the management and provision of surgical and anaesthetic care to incident casualties requiring operative care. Liaison with Medical co-ordinator in the Hospital Control Team and ensuring medical staff are deployed effectively.</td>
<td></td>
</tr>
</tbody>
</table>

### Actions if Stand by declared:
Determine if any current or planned activities should be cancelled or postponed. Consider retaining staff if a shift is about to end (until more information is available).

### Actions if Incident is declared:

1. On receipt of the activation notice identify the surgical areas’ capacity to cope with numbers of:
   - Critically ill or injured casualties
   - Less serious casualties

2. Arrange one or more members of staff to review patients using the Traffic Light Bed Status Tool (Appendix 3) to review patients already in the medical areas, so that those that can be treated elsewhere / later are discharged / transferred.

3. Medical staff should be deployed in the following roles:
   - **Lead Consultant identified for general surgery, orthopaedic surgery, anaesthesia and ITU** (one of these will be the co-ordinator, so two other posts needed). If the response is such that most consultants from these specialties are on site, these leads should remain with the co-ordinator to assist their work.
   - **Senior Consultant theatres** (responsible for prioritising patients for theatre) – this role can be surgical or anaesthetic and will involve **triage of patients in the emergency department**. Report to ED Medical Co-ordinator.
   - **Senior Consultant ITU** (responsible for prioritising patients for ITU /HDU care). Communicate frequently with these doctors to find out what capacity remains and where additional staff / resources are needed.

4. Arrange for additional medical staff to be called in – remember to ensure staffing for the next 24 hours will be adequate.

5. A further challenge will be the restoration of the usual services provided by Surgical & Diagnostic Care Group after the incident. Towards the end of the incident, you should consider calling in another senior clinician to manage this recovery phase.

6. • Record all your actions and decisions, together with times.
   - After the incident copy your action decisions log and give a copy to the Manager Member of the Incident Control Team
   - Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
   - Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
   - Do not make “off the cuff” comments to media.
# ACTION CARD 17

**NURSE CO-ORDINATOR ACUTE MEDICINE POSTHOLDER – MATRON / SENIOR NURSE**

### Accountable to
Senior Nurse Incident Control Team

**Responsible for:**
Effective management and provision of acute care

**Actions if Stand by declared:**
Determine if any current or planned activities should be cancelled or postponed. Consider keeping staff if a shift is about to end (until more information is available).

<table>
<thead>
<tr>
<th>Actions if Incident is declared:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ensure that senior medical and nursing staff perform triage and review current patients in medical areas, using the Traffic Light Bed Status Tool (Appendix 3) so that those that can be treated elsewhere / later are discharged / transferred. Ensure these are forwarded to Hospital Information centre within 30 minutes of activation</td>
</tr>
</tbody>
</table>
| 2. Identify the medical areas’ capacity to cope with numbers of the:  
  - Critically ill  
  - Medical emergencies |
| 3. Assess status of AMU, medical wards, diagnostic area’s and the discharge lounge |
| 4. Inform Senior Nurse Incident control, of additional resources that may be required in medical areas. |
| 5. Allocate nursing staff to meet clinical demand and consider retaining staff if a shift is about to end. |
| 6. Arrange for additional nursing staff to be called in – remember to ensure staffing for the next 24 hours will be adequate. |
| 7. A further challenge will be the restoration of the usual services provided by the Acute & Long Term Care Group following the incident. Towards the end of the incident, you should consider calling in another senior nurse to manage this recovery phase. |

**After an Incident**
- Record all your actions and decisions, together with times. After the incident copy your action/decisions log and give a copy to the Manager Member of the Incident Control Team
- Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
- Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
- Do not make “off the cuff” comments to media.
**ACTION CARD 18**

**MEDICAL CO-ORDINATOR FOR ACUTE MEDICINE**

**POSTHOLDER – CONSULTANT / REGISTRAR PHYSICIAN**

**Accountable to**

Doctor member Incident Control Team

**Responsible for:** Organising the management and provision of medical care to all existing patients and emergency referrals be they incident related or not. Liaison with Medical co-ordinator in the Hospital Control Team and ensure that medical staff are deployed effectively.

**Actions if Stand by declared:**

Determine if any current or planned activities should be cancelled or postponed. Consider retaining staff if a shift is about to end (until more information is available).

**Actions if Incident is declared:**

1. On receipt of the activation notice identify the Medical units’ capacity to cope with numbers of:
   - Critically ill
   - Emergency Admissions

2. Arrange one or more members of staff to review patients using the Traffic Light Bed Status Tool (Appendix 3) to review patients already in the medical areas, so that those that can be treated elsewhere / later are discharged / transferred.

3. Manage the medicine response to the incident
   - Liaise with the Incident Control team so they can manage the hospital’s response
   - Provide them with information about the status of medical areas and their existing patients and any casualties received from the incident.
   - Let them know, in advance if possible, of additional resources required in the medical areas.
   - There may be a requirement to triage patients in the emergency department

4. Arrange for additional medical staff to be called in – remember to ensure staffing for the next 24 hours will be adequate.

5. A further challenge will be the restoration of the usual services provided by the Acute & Long Term Care Group after the incident. Towards the end of the incident, you should consider calling in another senior clinician to manage this recovery phase.

6. Record all your actions and decisions, together with times.
   - After the incident copy your action decisions log and give a copy to the Manager Member of the Incident Control Team
   - Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
   - Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
   - Do not make “off the cuff” comments to media.
**ACTION CARD**

**DIAGNOSTIC AND SUPPORT SPECIALTIES CO-ORDINATOR (DASS)**

**POSTHOLDER - HEAD OF DIAGNOSTICS (RADIOLOGY & PATHOLOGY)**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Incident Control Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible for:</strong></td>
<td>Co-ordination of response for Pathology and Radiology departments. Liaison with Medical co-ordinator in the Hospital Control Team and ensure that staff are deployed effectively.</td>
</tr>
</tbody>
</table>

**Actions if Stand by declared:**

- Appoint leads for **Blood Sciences, Mortuary** and **Radiology**.
- Determine if any current or planned activities should be cancelled or postponed. Consider retaining staff if a shift is about to end (until more information is available).

**Actions if Incident is declared:**

1. • Obtain briefing from HCT Nurse and develop your plan.
   • Appoint leads for **Blood Sciences, Mortuary** and **Radiology**
   • The first person contacted and able to respond will be asked to assume the role of Lead. OOH BMS Biochemistry acts as temporary Blood Sciences Lead Card 21. OOH Mortuary Technician acts as temporary Mortuary Lead Card 45.
   • Brief these leads.
   • Activate planned response
   • Identify your capacity to cope with demand.
   • Arrange one or more members of staff to review work already underway or planned, to determine which can be safely postponed or cancelled.

2. • Liaise with the Incident Control team so they can manage the hospital's response
   • Provide them with information about the status of blood bank and any significant demands for supplies.
   • Let them know, in advance if possible, of additional resources are required.
   Related positions and card numbers
   - Blood Sciences Lead Card 20, OOH BMS Card 21, Mortuary Lead Card 44, OOH Mortuary Technician Card 45, Radiology Lead Card 22

3. Arrange for additional Biomedical science / Radiological staff to be called in – remember to ensure staffing for the next 24 hours will be adequate.

4. A further challenge will be the restoration of normal biomedical and radiological services towards the end of the incident, you should consider calling in another senior clinician to manage this recovery phase

5. • Record all your actions and decisions, together with times.
   • After the incident copy your action decisions log and give a copy to the Manager Member of the Incident Control Team
   • Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
   • Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
   • Do not make “off the cuff” comments to media.
## ACTION CARD 20

### LABORATORY LEAD – BLOOD SCIENCES

**POSTHOLDER - LEAD BMS BLOOD SCIENCES**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>DASS</th>
</tr>
</thead>
</table>

**Responsible for:**
- To co-ordinate the activities within the Blood Sciences Department to support the Major Incident
- To activate the business continuity plan for Blood Sciences
- Liaise with the Diagnostic & Support Specialties Co-ordinator (DASS)

**Actions if Stand by declared:**
Determine if any current or planned activities should be cancelled or postponed. Consider retaining staff if a shift is about to end (until more information is available).

**Actions if Incident is declared:**

1. The first person contacted and able to respond will be asked to assume the role of Lead. OOH BMS Biochemistry acts as temporary Blood Sciences Lead see card 21.

2. Receive incident briefing form Diagnostic and Support Specialties Co-ordinator (DASS)

3. Activate planned response

4. Identify your capacity to cope with demand.

5. Assess and call in additional staff as required, including BMS and consultant staff.

6. Notify On Call Consultants for Haematology and Biochemistry

7. Assess requirements for blood supplies etc. and liaise with the National Blood Service in Newcastle

8. Advise DASS of pressures or difficulties on the service during the incident

9. Contact Lead BMS for Mortuary services as required

### Notes:
- The Consultant Haematologist **not** on call will provide clinical advice on the Management of casualties
- Laboratory lead will ensure that adequate blood supplies are maintained as per Trust wide Transfusion policies.
- Emergency Department staff will endeavour to provide complete patient information. For those samples taken on scene the Major Incident triage number allocated on scene will be used (this number will be cross referenced with the predetermined Major Incident number within the Emergency Department)
- Unknown Patients will be a pre designated number with a pseudo forename and surname unique to that number e.g. the first patient arriving at DMH would accrue the name ‘Delta Alpha’ The next patient ‘Delta Bravo’ and so forth, UHND would use the prefix ‘Uniform’. *This system has been found to be very useful in ‘live’ events such as the London Bombings of July 2007*
# ACTION CARD

## OUT-OF-HOURS BIOMEDICAL SCIENTIST (BMS) BIOCHEMISTRY: Temporary Blood Sciences Lead.

### POSTHOLDER - OOH BMS BIOCHEMISTRY

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>DASS</th>
</tr>
</thead>
</table>

**Responsible for:** The activation of the business continuity plans for Blood Sciences Liaise with the Diagnostic & Support Specialties Co-ordinator (DASS)

**Actions if Stand by declared:**

Determine if any current or planned activities should be cancelled or postponed. Consider retaining staff if a shift is about to end (until more information is available).

**Actions if Incident is declared:**

1. The OOH BMS (Biochemistry) will contact the following until a response is obtained. The first person contacted and able to respond, from the list below, will be asked to assume the role of Laboratory lead:
   - Head of Diagnostics (unless already acting as DASS)
   - Lead BMS Blood Sciences
   - Departmental Manager Blood Sciences
   - Senior BMS Haematology & Blood Transfusion
   - Lead BMS Cell Sciences (unless already acting as Mortuary Lead)
   - Any Departmental Manager from the departmental list.

2. Liaise with DASS (or Hospital Information Centre to ascertain nature of the incident if DASS not yet appointed).

3. The BMS will then commence preparation of the department to deal with the additional workload.

4. Notify On Call Consultants for Haematology and Biochemistry

**Notes:**

- The Consultant Haematologist **not** on call will provide clinical advice on the Management of casualties
- Laboratory lead will ensure that adequate blood supplies are maintained as per Trust wide Transfusion policies.
- Emergency Department staff will endeavour to provide complete patient information. For those samples taken on scene the Major Incident triage number allocated on scene will be used (this number will be cross referenced with the predetermined Major Incident number within the Emergency Department)
- Unknown Patients will be a pre designated number with a pseudo forename and surname unique to that number e.g. the first patient arriving at DMH would accrue the name ‘Delta Alpha’. The next patient ‘Delta Bravo’ and so forth, UHND would use the prefix ‘Uniform’. This system has been found to be very useful in ‘live’ events such as the London Bombings of July 2007
**ACTION CARD 22**

**RADIOLOGY SERVICE MANAGER / ON CALL RADIOGRAPHER POSTHOLDER - AS ABOVE**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>DASS</th>
</tr>
</thead>
</table>

**Responsible for:** The activation of the business continuity plans for Radiology to meet the demands of a major incident

**Actions if Stand by declared:**

Do not undertake any further investigative radiological procedures until advise of Stand down / return to normal activity

**Actions if Incident is declared:**

1. Receive your own Action card from Hospital Information Centre (main reception)
2. Ensure all relevant staff are informed of the incident
3. Ensure adequate staff are available and deployed as appropriate
4. Out of hours call in Service Manager Radiology
   (On Call Consultant Radiologist will be contacted by Switchboard)
   Additional radiographers including CT Team
5. Clear department of existing patients by arranging rapid return transfer to area of referral
6. Ensure portable x-ray machine is available in Emergency Department (ED) Resuscitation Room
7. Ensure ED x-ray is adequately resourced to cope with additional workload and CT is available in the main department
8. Periodically advise of any pressures and difficulties on the service during the incident

**After an Incident**

1. Record all your actions and decisions, together with times. After the incident copy your action/decisions log and give a copy to the Manager Member of the Incident Control Team
2. Make a note of any ways in which you think the response/plan could be improved this will be useful in debriefing.
3. Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
4. Do not make “off the cuff” comments to media.
**ACTION CARD 23**

**HEAD OF PHARMACY / ON CALL PHARMACIST POSTHOLDER - AS ABOVE**

**Accountable to:** Nurse Manager Incident Control

**Responsible for:** To provide a comprehensive pharmacy service during and after the Major Incident / Trust Emergency

**Actions if Stand by declared:**

- Prepare to implement contingency plan

**Actions if Incident is declared:**

1. Receive your own Action card from Hospital Information Centre (main reception)
2. Ensure adequate staff are available and deployed appropriately
3. Initiate department call out if outside of working hours and ask staff to report to Pharmacy department. Within working hours bleep all pharmacy staff to report to pharmacy department
4. Liaise via Senior Nurse Incident Control Centre to determine requirements for pharmacy
5. Assess staffing levels and access help from other Trust pharmacy sites if required NB Request for such support must be made through the Incident Control Team.
6. Deploy staff as they become available, consider pharmacist/pharmacy technician support to:
   - Emergency Department
   - Trauma Wards
   - Theatres
   - ITU
   - Discharge areas
7. Liaise with Patient Discharge / Reunion Area to ensure those patients awaiting transport home have been issued with any take home prescriptions and assist with any additional requirements
8. Provide extra support to pharmacy procurement to ensure stock availability during the event, in particular IV fluids, medical gases, Over Labelled packs etc. In a regional Major Incident event the NHS Commissioning Board / Area Team may co-ordinate supply stocks
9. Liaise with other Trust pharmacy site leads to ensure the operational management of activities from other sites (i.e. supply of stocks, discharges etc. if UHND affected)
10. Plan for restoration and recovery. An audit of pharmaceuticals consumed during the event will be required.

**After an Incident**

- Record all your actions and decisions, together with times. After the incident copy your action/decisions log and give a copy to the Manager Member of the Incident Control Team
- Make a note of any ways in which you think the response/plan could be improved this will be useful in debriefing.
- Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
- Do not make “off the cuff” comments to media.
# ACTION CARD 24

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Nurse Manager Incident Control</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible for:</strong></td>
<td>To provide a comprehensive pharmacy service during and after the Major Incident / Trust Emergency</td>
</tr>
</tbody>
</table>

## Actions if Stand by declared:
- Prepare to implement contingency plan

## Actions if Incident is declared:

1. **Receive your own Action card from Hospital Information Centre (main reception)**
2. **Ensure adequate staff are available and deployed appropriately**
3. **Initiate department call out if outside of working hours and ask staff to report to Pharmacy department. Within working hours bleep all pharmacy staff to report to pharmacy department**
4. **Liaise via Senior Nurse Incident Control Centre to determine requirements for pharmacy**
5. **Assess staffing levels and access help from other Trust pharmacy sites if required NB Request for such support must be made through the Incident Control Team.**
6. **Deploy staff as they become available, consider pharmacist/pharmacy technician support to:**
   - Emergency Department
   - Trauma Wards
   - Theatres
   - ITU
   - Discharge areas
7. **Liaise with Patient Discharge / Reunion Area to ensure those patients awaiting transport home have been issued with any take home prescriptions and assist with any additional requirements**
8. **Provide extra support to pharmacy procurement to ensure stock availability during the event, in particular IV fluids, medical gases, Over Labelled packs etc. In a regional Major Incident event the NHS Commissioning Board / Area Team may co-ordinate supply stocks**
9. **Liaise with other Trust pharmacy site leads to ensure the operational management of activities from other sites (i.e. supply of stocks, discharges etc. if UHND affected)**
10. **Plan for restoration and recovery. An audit of pharmaceuticals consumed during the event will be required.**

## After an Incident:

- Record all your actions and decisions, together with times. After the incident copy your action/decisions log and give a copy to the Manager Member of the Incident Control Team
- Make a note of any ways in which you think the response/plan could be improved this will be useful in debriefing.
- Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
- Do not make “off the cuff” comments to media.
**ACTION CARD 25**

| ESTATES AND FACILITIES CO-ORDINATOR
| POSTHOLDER - ASSOCIATE DIRECTOR – SENIOR MANAGER

**Accountable to:** Manager Member Incident Control

**Responsible for:** Coordination of the provision of non-clinical support services (Estates and Facilities), across the relevant site.

**Actions if ‘Stand by’ is declared:** Determine if any current or planned activities should be cancelled or postponed. Consider keeping staff if a shift is about to end (until more information is available)

**Actions if Incident is declared:**

1. Receive your own Action card from Hospital Information Centre (main reception)
2. Join Incident Control Team in an advisory capacity
3. Ensure adequate staff are available and deployed appropriately to different areas as required by the Trust response (the manager on the ICT will brief you).
4. Determine levels of critical supplies and obtain as required (Information will be provided by Associate Director of Procurement on request)
   Communicate frequently with these to find out what capacity remains and where additional staff is required.
5. Consider keeping staff if a shift is about to end
6. Arrange for additional staff to be called in – remember to ensure staffing for the next 24 hours will be adequate.
7. Plan for restoration and recovery.

**After an Incident**

1. Record all your actions and decisions, together with times. After the incident copy your action/decisions log and give a copy to the Manager Member of the Incident Control Team
2. Ensure Adequate Supplies/stock levels are returned to normal
3. Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
4. Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
5. Do not make “off the cuff” comments to media.
## ACTION CARD 26  NURSE CO-ORDINATOR IN PAEDIATRICS

**Accountable to:** Nurse Manager Incident Control

### Responsible for:
Effective management and provision of acute paediatric care

### Actions if Stand by declared:
Determine if any current or planned activities should be cancelled or postponed. Consider keeping staff if a shift is about to end (until more information is available).

### Actions if Incident is declared:

<table>
<thead>
<tr>
<th>Action Number</th>
<th>Action Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Receive your own Action card from Hospital Information Centre (main reception)</td>
</tr>
<tr>
<td>2</td>
<td>Ensure adequate staff are available and deployed appropriately</td>
</tr>
<tr>
<td>3</td>
<td>Ensure that senior medical and nursing staff perform triage and review current patients in medical areas, using the Traffic Light Bed Status Tool (Appendix 3) so that those that can be treated elsewhere / later are discharged / transferred. Ensure these are forwarded to Hospital Information Centre within 30 minutes of activation</td>
</tr>
<tr>
<td>4</td>
<td>Identify the paediatric areas’ capacity to cope with numbers of the:</td>
</tr>
<tr>
<td></td>
<td>- Critically ill</td>
</tr>
<tr>
<td></td>
<td>- Medical emergencies</td>
</tr>
<tr>
<td>5</td>
<td>Assess status of SCUBU and Children’s wards.</td>
</tr>
<tr>
<td>6</td>
<td>Inform Senior Nurse Incident control, of additional resources that may be required in paediatric areas.</td>
</tr>
<tr>
<td>7</td>
<td>Allocate nursing staff to meet clinical demand and consider retaining staff if a shift is about to end.</td>
</tr>
<tr>
<td>8</td>
<td>Arrange for additional nursing staff to be called in – remember to ensure staffing for the next 24 hours will be adequate.</td>
</tr>
<tr>
<td>9</td>
<td>Liaise with Medical Co-ordinator in Paediatrics.</td>
</tr>
<tr>
<td>10</td>
<td>Plan for restoration and recovery.</td>
</tr>
</tbody>
</table>

### After an Incident
- Record all your actions and decisions, together with times. After the incident copy your action/decisions log and give a copy to the Manager Member of the Incident Control Team
- Make a note of any ways in which you think the response/plan could be improved this will be useful in debriefing.
- Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
- Do not make “off the cuff” comments to media.
### ACTION CARD 27

**MEDICAL CO-ORDINATOR IN PAEDIATRICS
POSTHOLDER – CONSULTANT / REGISTRAR IN PAEDIATRICS**

<table>
<thead>
<tr>
<th>Accountable to</th>
<th>Doctor member Incident Control Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible for:</strong> Organising the management and provision of medical care to all existing patients and emergency referrals be they incident related or not. Liaison with Medical co-ordinator in the Hospital Control Team and ensure that medical staff are deployed effectively.</td>
<td></td>
</tr>
</tbody>
</table>

#### Actions if Stand by declared:
- Determine if any current or planned activities should be cancelled or postponed. Consider retaining staff if a shift is about to end (until more information is available).

#### Actions if Incident is declared:

1. On receipt of the activation notice identify the Paediatric units' capacity to cope with numbers of:
   - Critically ill
   - Emergency Admissions

2. Arrange one or more members of staff to review patients using the Traffic Light Bed Status Tool (Appendix 3) to review patients already in the medical areas, so that those that can be treated elsewhere / later are discharged / transferred.

3. Determine the regional PICU capacity

4. **Deploy paediatric registrar to Emergency Department** as required by the Trust response (the doctor on the HOSPITAL CONTROL TEAM will brief you).

5. Manage the paediatric response to the incident
   - Liaise with the Incident Control team so they can manage the hospital's response
   - Provide them with information about the status of paediatric areas and their existing patients and any casualties received from the incident.
   - Let them know, in advance if possible, of additional resources required in the medical areas.
   - There may be a requirement to **triage patients in the emergency department**

6. Arrange for additional medical staff to be called in – remember to ensure staffing for the next 24 hours will be adequate.

7. A further challenge will be the restoration of the usual services provided by the Care Closer to Home Care Group after the incident. Towards the end of the incident, you should consider calling in another senior clinician to manage this recovery phase

8. **Record all your actions and decisions, together with times.**
   - After the incident copy your action decisions log and give a copy to the Manager Member of the Incident Control Team
   - Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.
   - Make sure that colleagues are aware that you are leaving – so that staff log is up to date.
   - Do not make “off the cuff” comments to media.
<table>
<thead>
<tr>
<th>ACTION CARD 28</th>
<th>CARDIAC ARREST PREVENTION TEAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable to</td>
<td>Doctor member Incident Control Team</td>
</tr>
</tbody>
</table>

**Responsible for:** During a Major Incident the responsibility of the Cardiac Arrest Prevention Team is to co-ordinate the emergency response for existing in-patients. You will attend all cardiac arrest and medical emergency calls on the base wards and will co-ordinate the resuscitation attempt.

**Actions if Stand by declared:**

Ensure that the emergency response teams are prepared to deal with any emergencies that arise.

**Actions if Incident is declared:**

1. Establish which members of the cardiac arrest, medical emergency and paediatric emergency teams are involved in caring for patients in the emergency department and the likelihood that they will be able to respond to an emergency on the base wards.

2. Where the emergency team cannot be fully staffed identify alternatives to support the team.

3. Test the emergency bleep system to ensure that they are fully operational.

4. Check the stock levels in the resuscitation store room.

5. Visit each base ward and identify any patients that the ward nursing staff have concerns about. Ensure that any urgent interventions that have been identified as being required to prevent deterioration are actioned.

6. Call in other members of the resuscitation service as required to assist in completing the above.

7. • Record all your actions and decisions, together with times.

   • After the incident copy your action decisions log and give a copy to the Manager Member of the Incident Control Team

   • Make a note of any ways in which you think the response/plan could be improved – this will be useful in debriefing.

   • Make sure that colleagues are aware that you are leaving – so that staff log is up to date.

   • Do not make “off the cuff” comments to media.
ACTION CARD 29  FACILITIES MANAGER / SENIOR PORTER

Accountable to: FACILITIES LEAD / HOSPITAL INFORMATION CENTRE SUPERVISOR

**Responsible for:** Assist with the movement of patients as required and Ensuring that all portering issues are appropriately managed.

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Time Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Receive own action card from Hospital Information Centre and identify additional resources if required.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Post an additional porter to the Emergency Department to assist in preparation of department and transfer of existing patients.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Detail additional porter too take signs from cage in Major Incident Store (Piermont Unit) and erect as per instruction sheet affixed to cage</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Arrange additional Portering Services for: (1) X-Ray Department (2) Theatre (3) Wards.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>To help with the discharge of patients in out-patients or to open department out of hours.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Assist with general communication duties.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Assist in the allocation of radios.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Liaise with on call facilities staff.</td>
<td></td>
</tr>
</tbody>
</table>
### ACTION CARD 30
**NURSE IN CHARGE OF THEATRES**

**Accountable to:** NURSE CO-ORDINATOR SURGERY & DIAGNOSTICS

**Responsible for:** To provide facilities and additional nursing support in preparation for emergency surgical list

<table>
<thead>
<tr>
<th>Major incident Stand-by</th>
<th>Action</th>
<th>Time complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inform Surgical teams occupying all Theatres of Major Incident Stand-by.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare to abandon scheduled procedures until the incident is Declared or Cancelled.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Major incident Declared In Hours**

1. Receive own action card from Hospital Information Centre/ BCP folder.
2. Inform all Theatre personnel to remain on duty
3. Inform HSSD Manager
5. In liaison with and under the direction of the Medical Director cancel planned routine theatre cases
6. Working in conjunction with Medical Co-ordinator in Surgery, Anaesthetics and Surgical Matron agree a plan to establish theatre time for casualties
7. Designate Theatre teams according to the severity and number of incoming surgical cases.
8. Deploy staff as they become available
9. Recruit off-duty staff to come in to reinforce current on-duty staff to assist in staffing theatres. Do not try to bring in staff from the immediately following shifts as at the time of the incident step-down there will be no staff to come on duty. Try and recruit staff from later shift patterns.
10. Day Surgery - proceeds as normal, but be prepared to suspend list if necessary, if advised to do so by major incident control team
11. Ensure Patient Tracking information is fed to the Hospital Information Centre

**Major Incident Procedure Out of Hours**

1. Following notification Theatre Manager or Deputy will initiate department call out
2. Call Theatre Co-ordinator or Deputy
3. Call Recovery Manager or Deputy
4. Call On-call Sister Charge Nurse, if not already on duty
5. Liaise with the Medical Co-ordinator in Surgery, Anaesthetics and Surgical Matron
## Theatre recovery
Theatre recovery may be used as an overflow area for the ED or ITU for the on-going resuscitation of critically injured patients before definitive care in theatre or transfer to the receiving ward.

## Day surgery and endoscopy
The day surgery unit will become a holding area for P2 patients awaiting definitive surgery. Out of hours the control room will ensure that it staffed by whomever available. In hours the day surgery unit should respond according to its own action card. If elective surgery and endoscopy is cancelled then staff from these areas should report to theatre suite for redeployment.

## Routine duties
The theatres senior nurse will:

- Maintain a current list of all staff contact telephone numbers
- Test the staff callout cascade for theatres staff when the major incident exercise test message is received from switchboard to ensure that contact numbers are correct.
- Report every 6 months to the Emergency Preparedness Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident.
### ACTION CARD 31

**NURSE IN CHARGE – INTENSIVE THERAPY UNIT**

**Accountable to:** NURSE CO-ORDINATOR SURGERY & DIAGNOSTICS

**Responsible for:** To provide Intensive therapy support to critical incident casualties in addition to those patients receiving such care

<table>
<thead>
<tr>
<th>Major incident Stand-by</th>
<th>Action</th>
<th>Time complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inform Intensive teams including Anaesthetists of Major Incident Stand-by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To identify any possible patients for decanting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Major incident Declared**

1. Receive own action card from Hospital Information Centre / BCP folder.
2. Inform all personnel to remain on duty.
3. On receipt of call Site Co-ordinator, initiate immediate staff call out, Senior Clinical Nurse and eight ITU nurses.
4. Prepare department for casualties nursing staff split into two teams:
   - **Team A** - To care for existing patients and prepare to decant where possible
   - **Team B** - Equip ITU for incoming patients.
5. With a Consultant Anaesthetist, assess current patients for transfer and decant as appropriate.
6. Liaise with Bed Manager/Site Co-ordinator to arrange for transfer beds.
7. Within 15 minutes complete and forward staff on site register to Hospital Information centre.
8. Within 30 minutes, post Major Incident declaration, inform Hospital Control Centre of ITU bed availability.
9. Recruit off-duty staff to come in to reinforce current on-duty staff to assist in staffing the unit. Do not try to bring in staff from the immediately following shifts as at the time of the incident step-down there will be no staff to come on duty. Try and recruit staff from later shift patterns.
10. Ensure Patient Tracking information is fed to the Hospital Information Centre.
<table>
<thead>
<tr>
<th></th>
<th>Routine duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>The senior nurse will:</td>
</tr>
<tr>
<td></td>
<td>Maintain a current list of all staff contact telephone numbers</td>
</tr>
<tr>
<td></td>
<td>Test the staff callout cascade for theatres staff when the major incident</td>
</tr>
<tr>
<td></td>
<td>exercise test message is received from switchboard to ensure that contact</td>
</tr>
<tr>
<td></td>
<td>numbers are correct.</td>
</tr>
<tr>
<td></td>
<td>Report every 6 months to the Trust Resilience Lead that the cascade has</td>
</tr>
<tr>
<td></td>
<td>been tested and how many staff members were able to attend to respond to the</td>
</tr>
<tr>
<td></td>
<td>incident.</td>
</tr>
</tbody>
</table>
**ACTION CARD 32**

**NURSE IN CHARGE – TRAUMA RECEIVING WARDS**

**Accountable to**

**NURSE CO-ORDINATOR SURGERY & DIAGNOSTICS**

**Designated Wards:**

**DMH Wards 31 & 33 - UHND Wards 12 & 16**

These are the nominated receiving wards for all casualties, from a major incident. When a major incident is declared the ward should be cleared by discharging patients home or transferring to other wards as soon as possible to free up beds for casualties. As the incident progresses, aim to keep all casualties together and preferentially transfer existing in-patients to other areas.

If there are *predominantly* young child casualties Ward 22, DMH and or Treetops, UHND will become the primary receiving wards. Unless intensive support is required

<table>
<thead>
<tr>
<th>Major incident Stand-by</th>
<th>Action</th>
<th>Time complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inform Care teams including medical staff of Major Incident Stand-by</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Start to identify which patients could be discharged of transferred, but do not activate the plan at this time. Ask staff due to go off duty to stay on site until the incident is declared or cancelled</td>
<td></td>
</tr>
</tbody>
</table>

**Major incident Declared**

<p>| 1. | Receive own action card from Hospital Information Centre / BCP folder. |
| 2. | Inform all personnel to remain on duty and on your area of responsibility |
| 3. | Complete Staff on Site register and send to Hospital Information Centre within 15 minutes |
| 4. | With a Medical Consultant/Registrar, assess current patients for transfer against traffic light audit tool and inform Hospital Information Centre within 30 minutes of activation. |
| 5. | Liaise with Bed Manager/Site Co-ordinator to arrange for transfer beds |
| 6. | Activate call in cascade- recruit off-duty staff to come in to reinforce current on-duty staff to assist in staffing the unit. Do not try to bring in staff from the immediately following shifts as at the time of the incident step-down there will be no staff to come on duty. Try and recruit staff from later shift patterns. Inform incoming staff to report to Hospital Information Centre in the first instance. |
| 7. | Activate Domestic Team to clean beds and bed area’s or Rapid response out of hours |
| 8. | Inform any visitors present that unless a relative is seriously ill/close to death that they should leave and return next day. This is a request and not mandatory |</p>
<table>
<thead>
<tr>
<th>9.</th>
<th>Ensure Patient Tracking information is fed to the Hospital Information Centre</th>
</tr>
</thead>
</table>
| 10. | **Routine duties**  
The senior nurse will:-  
Maintain a current list of all staff contact telephone numbers  
Test the staff callout cascade for their respective wards when the major incident exercise test message is received from senior manager to ensure that contact numbers are correct.  
Report every 6 months to the Trust Resilience Lead that the cascade has been tested and how many staff members were able to attend to respond to the incident. |
**ACTION CARD 33**

**MEDICAL INCIDENT OFFICER (MIO)**

**Reporting to**

**INCIDENT COMMANDER (AT SCENE)**

---

**Qualification**

Must hold current MiMMs Qualification and have completed appropriate training as directed by Public Health England

---

**The responsibilities of the Medical Incident Officer are:**

a. Overall responsibility for deployment of medical and nursing personnel at the site of the incident.

b. The maintenance of contact with receiving hospital(s) to provide situation reports, details of the number and type of casualties and confirmation of the evacuation plan.

c. The closest possible liaison with the Ambulance Incident Officer (AIO) to ensure effective management and use of health service resources at the scene.

d. Assessing the need for continuance of, addition to, or withdrawal of the MERITs at the scene.

e. Assessing with the AIO the need for the activation of additional Receiving Hospital(s).

---

**Action**

- Receive own action card from Hospital Control Team
- Go to Major Incident equipment store, dress in protective clothing and await transportation at front of Emergency Department
- On arrival on site make contact with the Senior Police Officer, Senior Fire Officer and Ambulance Incident Officer in the command centre (ambulance emergency control vehicle) and identify receiving and support hospitals
- Establish a Medical Services Report Centre adjacent to control vehicles of Police, Ambulance and Fire Services using sign-posting provided by Police
- Set up a casualty clearing station
- If not already requested establish need for Mobile Team and advise Ambulance Incident Officer who will initiate call out
- On arrival of Mobile Medical Team delegate appropriate tasks
- Review and monitor available supplies of equipment, drugs and staff and liaise with Ambulance Incident Officer for additional supplies if required
- In conjunction with the Ambulance Incident Officer periodically update Ambulance Liaison Officer based in receiving hospitals re number and range of casualties and likely time of arrival
- Arrange with Ambulance Incident Officer to isolate any persons suspected to be contaminated and control movement. Emergency services will provide specialist advice and/or neutralising agent/antidotes where chemicals are involved
- Advise re the transfer of patients contaminated by radioactivity to appropriately equipped hospitals
- Liaise with Ambulance Incident Officer and advise on evacuation of casualties from site
- Progress the release of activated receiving hospitals and Mobile Medical Teams and, in conjunction with the Ambulance Incident Officer, the ultimate issue of a “Casualty Evacuation Complete” message

Maintain Personal log and return to the manager of the Incident Control Room at your hospital for archiving.
### ACTION CARD 34

**SECURITY PERSONNEL**

**Accountable to:** HEAD OF SECURITY

**Responsible for:** To control and maintain access/egress to the hospital in the event of a Major Incident and to maintain the integrity of the site.

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Time Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Refer to action card and identify additional resources if required.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Collect security tabard</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Assist where possible in securing all entrances/exits to the hospital.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Refer to ‘designated areas’ card and direct enquirers accordingly</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Restrict/deter casual enquiries</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Ensure adequate access/egress of emergency vehicles</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Advise line manager / BBW manager of any problems in response of the Incident</td>
<td></td>
</tr>
</tbody>
</table>

**NB in the event of a declaration of a Major Incident with chemical/Biological element**

- Refer to Aid Memoir Card
- Refer to Lockdown Policy
- Requested Personal Protective Equipment (PPE) support from Emergency Department
- Liaise with senior nurse ED if patient presents with suspected chemical/biological contamination
- Identify contaminated vehicle holding area. May require PPE suited and trained staff to remove vehicle to holding area.
**ACTION CARD 35**  
**CATERING MANAGER**  
**CDDFT/ISS/BBW**  

**Accountable to**  
**Head of Facilities**

**Responsible for:** To facilitate the provision of catering services for patients, staff, relatives and associated groups (e.g. Emergency services, media etc) whilst maintaining existing service.

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Time Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Refer to action card and identify additional resources if required.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>If Incident has been live, for longer than <strong>two</strong> hours, consider light refreshment for all involved staff and patients as allowed.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>If Incident has been live, for longer than <strong>four</strong> hours, consider light refreshment and sandwiches for all involved staff and patients as allowed.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Consideration needs be given to the provision of meals for admitted patients to receiving wards. Hospital Control should be able to provide caterers with a current situation report regarding admissions.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Advise line manager / BBW manager of any problems in response of the Incident</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>Action</td>
<td>Time Completed</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>1.</td>
<td>Receive own action card from Hospital Information Centre</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Liaise with Service manager in the Patient Discharge / Reunion area</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>As part of the multi-disciplinary welfare team offer and provide support to relatives</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Respond to requests from the Emergency Department/ theatres / wards for particular religious and spiritual ministrations to patients (last offices etc).</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Liaise with Nurse member of Hospital Control Team to identify any specific religious and cultural requirements.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Review provision for support of patients and relatives and call in additional members of staff, volunteers and clergy from other denominations if required.</td>
<td></td>
</tr>
</tbody>
</table>
## ACTION CARD 37 - CLEANING SERVICES

### Accountable to
Head of Facilities

### Role
Head of Catering & Housekeeping and ISS/BBW counterpart to facilitate the provision of additional cleaning services that will be required, whilst maintaining existing services.

### Responsible for:

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Time Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Receive own action card from Hospital Information Centre</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Liaise with Facilities and Estates Co-ordinator (Card 25)</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Liaise with Patient Flow Co-ordinator to establish number of cleans required.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Post additional staff to Emergency Department</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Allocate staff as appropriate, calling in additional staff if required</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Please record all activity for post incident debrief.</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>Action</td>
<td>Time Completed</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>1.</td>
<td>Receive own action card from Hospital Information Centre</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Liaise with Service manager in the Patient Discharge / Reunion area</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Call in Volunteers from database</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Sign all volunteers in and record areas in which they are delegated to work</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Ensure all volunteers display ID Badges</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Liaise with Hospital Control to ascertain where they may be deployed</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>As part of the multi-disciplinary welfare team offer and provide support to relatives</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Respond to requests from the Hospital Control Team</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>You may be required to assist with supporting partner agencies staff such as the Local Authorities Hospital Crisis Officer</td>
<td></td>
</tr>
<tr>
<td>ACTION CARD 39</td>
<td>HOSPITAL VOLUNTEER DISCHARGE REUNION AREA</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Reporting to</td>
<td>Voluntary Service Co-ordinator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• You will be notified by the Voluntary Service Co-ordinator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• You are to report to Hospital Information Centre (Main reception) with your ID Badge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• You will be based in the Patient Discharge / Reunion Area (Main Outpatients)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• You may be detailed to another area of the hospital</td>
<td></td>
</tr>
<tr>
<td>Role</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To support relatives who are awaiting news</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To provide escort / commissionaire service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To be a relatives / patients ‘friend’</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To assist in providing refreshments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To provide support / assistance for ward based patients</td>
<td></td>
</tr>
</tbody>
</table>
# ACTION CARD 40  DIRECTOR OF FINANCE

**Reporting to**  
TRUST COMMANDER

- You are to report to the Trust Commanders Gold Room Executive Corridor DMH / Chairman’s office Trust HQ UHND
- You will form part of the Incident Response Co-ordination Team

## Role

The Director of Finance is responsible for:

1. Ensuring that adequate resources are made available for the discharge of County Durham & Darlington NHS Foundation Trusts emergency planning responsibilities
2. Recognising the need for a contingency budget
3. Ensuring that emergency cost codes are available
4. Helping to lead the recovery following a major incident.
### ACTION CARD 41  DIRECTOR OF ESTATES & FACILITIES

<table>
<thead>
<tr>
<th>Reporting to</th>
<th>TRUST COMMANDER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- You are to report to the Trust Commanders Gold Room Executive Corridor DMH / Chairman’s office Trust HQ UHND

- You will form part of the Incident Response Co-ordination Team

---

During a major incident, The Trusts Major Incident Response & Recovery teams, patients, staff and partners will require access to facilities, supplies and patient transportation.

---

The Director of Estates & Facilities is responsible for:

- Developing Business Continuity Plans for premises and support services that ensure services can continue to be delivered in the event that a major incident renders one of the trusts Healthcare premises unavailable

- Ensuring that the Estates and Support Services Business Continuity Plans allow for the flexible use of premises during an major incident

- Developing mutually beneficial relationships with partner organisations to allow for mutual aid.
<table>
<thead>
<tr>
<th>ACTION CARD 42</th>
<th>SWITCH BOARD OPERATOR DMH &amp; UHND (BBW)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting to</td>
<td>INCIDENT MANAGER (SILVER)</td>
</tr>
</tbody>
</table>

### IN RESPONSE TO A TRUST EMERGENCY

**NOTE CALLERS DETAILS SEE PAGE 21**
(Usually activated by Senior Manager/ Senior Nurse)

**COMMENCE RED CASCADE CALL OUT**
Note response and predicted arrival times

**CONFIRM CASCADE COMPLETE WITH ICC**
ICC = Incident Control Team

### IN RESPONSE TO MAJOR INCIDENT ALERT

**NOTE CALLERS DETAILS SEE PAGE 21**
ONLY ACTIVATED EXTERNALLY BY NEAS

**CONFIRM ALERT WITH NEAS (Password)**

**COMMENCE FULL CASCADE CALL OUT**
Note response and predicted arrival times

**CONFIRM CASCADE COMPLETE WITH ICC**
ICC = Incident Control Team

(A Major Incident may be declared by ED Consultant in times of extremis)
**ACTION CARD**

**43**

**MORTUARY LEAD – CELLULAR SCIENCES**

**POSTHOLDER - LEAD BMS CELLULAR SCIENCE**

**Accountable to**

DASS

**Responsible for:**

To co-ordinate the activities within the mortuary to support the Major Incident
To activate the business continuity plan for mortuary services
Liaise with the Diagnostic & Support Specialties Co-ordinator (DASS)

**Actions if Stand by declared:**

Determine if any current or planned activities should be cancelled or postponed.
Consider retaining staff if a shift is about to end (until more information is available).

**Actions if Incident is declared:**

1. The first person contacted and able to respond will be asked to assume the role of Lead. OOH Mortuary Technician acts as temporary Mortuary Lead see card 45.
2. Receive incident briefing form Diagnostic and Support Specialities Co-ordinator (DASS)
3. Activate planned response
4. Identify your capacity to cope with demand.
5. Assess and call in additional staff as required, including APT, BMS and consultant staff.
6. Notify On Call Consultant for Cellular Pathology
7. Assess site body storage capacity and liaise with colleague OOH mortuary technician if additional storage required & consider installing the Nutwell temporary body storage system or readying it for transport to the site of the incident
8. Advise DASS of pressures or difficulties on the service during the incident
9. Ensure Contact with Trust Designated Individual for post mortem related activities.

**Notes**

- The Designated Individual (DI) will liaise with the LRF in the event a temporary mortuary facility is required at site of incident.
- The DI will contact the Human tissue authority (HTA) to notify them of temporary licence requirement & liaise with their representative when on site to conduct inspection of temporary facility.
- Emergency Department staff will endeavour to provide complete patient information.
- Unknown Patients will be a pre designated number with a pseudo forename and surname unique to that number e.g. the first patient arriving at DMH would accrue the name ‘Delta Alpha’ The next patient ‘Delta Bravo’ and so forth, UHND would use the prefix ‘Uniform’. *This system has been found to be very useful in ‘live’ events such as the London Bombings of July 2007*
**ACTION CARD**

<table>
<thead>
<tr>
<th>44</th>
<th>OUT-OF-HOURS ANATOMICAL PATHOLOGY TECHNICIAN : Temporary Mortuary Lead.</th>
</tr>
</thead>
<tbody>
<tr>
<td>POSTHOLDER - OOH Anatomical Pathology Technician (APT)</td>
<td></td>
</tr>
<tr>
<td>Accountable to</td>
<td>DASS</td>
</tr>
<tr>
<td>Responsible for:</td>
<td>The activation of the business continuity plans for Mortuary services. Liaise with the Diagnostic &amp; Support Specialties Coordinator (DASS)</td>
</tr>
<tr>
<td><strong>Actions if Stand by declared:</strong></td>
<td></td>
</tr>
<tr>
<td>Determine if any current or planned activities should be cancelled or postponed. Consider retaining staff if a shift is about to end (until more information is available).</td>
<td></td>
</tr>
<tr>
<td><strong>Actions if Incident is declared:</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>The OOH APT will contact the following until a response is obtained. The first person contacted and able to respond, from the list below, will be asked to assume the role of Laboratory lead:</td>
</tr>
<tr>
<td></td>
<td>• Lead BMS Cell Sciences (unless already acting as Mortuary Lead)</td>
</tr>
<tr>
<td></td>
<td>• Trust Designated Individual for Post Mortem related activities</td>
</tr>
<tr>
<td></td>
<td>• Any Departmental Manager from the departmental list.</td>
</tr>
<tr>
<td>2</td>
<td>Liaise with DASS (or Hospital Information Centre to ascertain nature of the incident if DASS not yet appointed).</td>
</tr>
<tr>
<td>3</td>
<td>The APT will then commence preparation of the department to deal with the additional workload.</td>
</tr>
<tr>
<td>4</td>
<td>Notify On Call Consultant for Cellular Pathology</td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td></td>
</tr>
<tr>
<td>• The Designated Individual (DI) will liaise with the LRF in the event a temporary mortuary facility is required at site of incident.</td>
<td></td>
</tr>
<tr>
<td>• The DI will contact the Human tissue authority (HTA) to notify them of temporary licence requirement &amp; liaise with their representative when on site to conduct inspection of temporary facility.</td>
<td></td>
</tr>
<tr>
<td>• Emergency Department staff will endeavour to provide complete patient information.</td>
<td></td>
</tr>
<tr>
<td>• Unknown Patients will be a pre designated number with a pseudo forename and surname unique to that number e.g. the first patient arriving at DMH would accrue the name ‘Delta Alpha’ The next patient ‘Delta Bravo’ and so forth, UHND would use the prefix ‘Uniform’. <em>This system has been found to be very useful in ‘live’ events such as the London Bombings of July 2007</em></td>
<td></td>
</tr>
</tbody>
</table>
ANNEX TWO – REQUIRED/USEFUL DOCUMENTATION

Incident Control Team Meeting Number ( )
Time                  Date

Venue
1. Current situation report

2. Impact on the Trust

3. Current multiagency command arrangements

4. Communications
   • Reporting arrangements (NHS CB; DH; SCG)
   • Public information and media strategy
   • Internal Trust communications and staff briefings

5. Staff and other resources required

6. Authorisation of expenditure

7. Horizon scanning

8. AGREED
   • TRUST COMMAND ARRANGEMENTS
   • TRUST STRATEGY AND/OR OBJECTIVES (depending on level of incident)
   • NHS ACTIONS
   • NHS BATTLE RHYTHM (linked to SCG/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.
### 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.

<table>
<thead>
<tr>
<th>Organisation:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (completed by):</td>
<td>Time:</td>
</tr>
<tr>
<td>Telephone number:</td>
<td></td>
</tr>
<tr>
<td>Email address:</td>
<td></td>
</tr>
<tr>
<td>Authorised for release by (name &amp; title):</td>
<td></td>
</tr>
</tbody>
</table>

#### Exact location of Incident

#### Type of Incident (Name)

#### Resources Deployed\(^1\) (e.g. Ambulance, Air Ambulance, HART)

<table>
<thead>
<tr>
<th>Incident Casualties(^2)</th>
<th>Location</th>
<th>P1:</th>
<th>P2:</th>
<th>P3</th>
<th>P4:</th>
<th>Disch’d</th>
<th>Dead</th>
</tr>
</thead>
</table>

#### Pre-Hospital

#### List Receiving Hospitals

<table>
<thead>
<tr>
<th>Location</th>
<th>P1:</th>
<th>P2:</th>
<th>P3</th>
<th>Disch’d</th>
<th>Dead(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital # 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital # 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital # 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital # 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Total at Receiving Hospitals | |
|------------------------------| |

#### Impact on Critical Functions\(^4\)

<table>
<thead>
<tr>
<th>Capacity Issues(^5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capability Issues(^5) (e.g. major trauma, burns)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact on business as normal(^6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mutual Aid Request Made (Y/N) (^7)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current / Potential Media Messages(^8)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
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 casualties 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.
## NHS CB 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.

<table>
<thead>
<tr>
<th>Organisation:</th>
<th>County Durham &amp; Darlington NHS Foundation Trust</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (completed by):</td>
<td></td>
<td>Time:</td>
</tr>
<tr>
<td>Telephone number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorised for release by (name &amp; title):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Type of Incident (Name)

#### Organisations reporting serious operational difficulties

#### Impact/potential impact of incident on services / critical functions and casualties

#### Impact on other service providers

#### Mitigating actions for the above impacts

#### Impact of business continuity arrangements

---

HIC DMH 43017 - 102 - HIC UHND32517
<table>
<thead>
<tr>
<th><strong>Media interest expected/received</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mutual Aid Request Made (Y/N) and agreed with?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Additional comments</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other issues</strong></td>
<td></td>
</tr>
<tr>
<td><strong>NHS CB Regional Incident Coordination Centre contact details:</strong></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Telephone number:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>
ANNEX THREE (1) – COMMUNICATIONS AND MEDIA

The NHS CB AT Director will also contact the AT communications lead on-call as soon as they are made aware of an incident.

It is the responsibility of the AT communications lead to alert other NHS communications leads and liaise with partner agencies communication leads, as appropriate, including:

- Department of Health
- NHS CB North
- NEAS
- Public Health England North East
- Appropriate acute hospitals trust(s)
- NHS Direct / 111
- Multi-agency fora

If any health organisations hear first about an incident via a media contact, it is the responsibility of that organisation to alert the AT communications lead in addition to keeping key people in their own organisation informed. The AT would then complete the cascade.

Public Information

In the event of an incident which affects health and safety, the NHS will need to release key messages to the general public within the first hour of becoming aware of the emergency.

These messages are deliberately generic and as such, do not depend on exact details of the incident or confirmation of any substance involved. The messages are to provide early information for the public and likely to be issued by whichever director of public health has the lead role in a major incident (which may be the Regional Director) or Consultant in Health Protection from PHE. The messages may be released before the formation of the strategic coordinating group or the science and technical advice cell (STAC).

Key health messages to the public before the formation of the strategic coordinating group (SCG) are outlined at the end of this section.

Once a strategic coordinating group (SCG) has been established, it 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 SCG. This will be via the NHS communication lead(s) present at SCG and the PHE communication lead who will be present at the science and technical advice cell (see below).

Communications leads from local health organisations should limit initial media statements to how the incident affects their organisation directly, and refrain from commenting on the incident/overall situation or providing general advice to members of the public. Any media statements issued should be provided to the SCG for information.

The regular public health advice that needs to be issued until the incident is closed will be provided via the SCG, using the input of the science and technical advice cell. The STAC, which is established to provide specific advice to the multi-agency SCG, will support decision-
making, advise the SCG on content of public health messages and liaise / seek input from local NHS organisations.

**Priority actions for health communications within the first hour of strategic coordinating group being established**

In order to protect the public and improve public safety as early as possible, generic (non-specific) public health messages should be issued within the first 30 minutes of the initial SCG meeting, if they haven’t already been issued by the health service before the strategic coordinating group is established.

**Public messages have already been agreed by NHS organisations in the region and shortened for use on social media channels.** They do not depend on knowing what substance/contaminant is involved and will act as a holding statement until more specific advice can be given when the substance is confirmed/more information is known.

Designated media spokespeople should be identified for all health organisations as soon as the strategic coordinating group is convened and their contact details should be shared with communications leads from all agencies/organisations represented at SCG.

Early agreement should be reached on the regularity and timing of media updates, e.g. on the hour. This agreement should be communicated to the media as soon as possible, to assist with managing incoming calls. This must be adhered to even if there is no extra information to be shared - a message to that effect can still be given at the hourly briefing.

Individual(s) should be identified to monitor media coverage, start collating Q&As/FAQs and pull together any necessary corrections or rebuttals if coverage is inaccurate or misleading. In most cases this would be the communications lead at the NHS CB.

**Mass Casualty Incidents**

During incidents involving large numbers of casualties, all NHS organisations will need to respond directly to initial media enquiries in the early stages of the incident. However, once the virtual communications cell and emergency media liaison centre has been established, all media requests for updates on casualty numbers and the NHS response should be channelled through this single point of contact.

**Media Liaison Group**

In a major incident, it is the responsibility of the lead responder to establish an incident media liaison group to coordinate incoming enquiries, responses and information going out to the media. This will normally be undertaken by the police but in the event of a health led incident then this will be co-ordinated by the AT /PHE.

**Social media**

A number of local NHS organisations now have established social media channels on Facebook and Twitter. In the event of a major incident these channels will be used to get messages out to the public alongside traditional media (TV, radio and print). A list of local NHS social media channels is provided below along with the pages for NHS Direct and NHS Blood:
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Facebook</th>
<th>Twitter</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Direct</td>
<td><a href="http://www.facebook.com/NHSDirect.uk">www.facebook.com/NHSDirect.uk</a></td>
<td>@nhsdirect</td>
</tr>
<tr>
<td>NHS Blood Donation</td>
<td><a href="http://www.facebook.com/NHSBlood">www.facebook.com/NHSBlood</a></td>
<td>@NHSBT</td>
</tr>
<tr>
<td>NHS North of Tyne</td>
<td><a href="http://www.facebook.com/pages/NHS-North-of-Tyne/50373072460">www.facebook.com/pages/NHS-North-of-Tyne/50373072460</a></td>
<td>@NHSNorthofTyne</td>
</tr>
<tr>
<td>NHS County Durham and Darlington</td>
<td><a href="http://www.facebook.com/pages/NHS-County-Durham/126076425184">www.facebook.com/pages/NHS-County-Durham/126076425184</a></td>
<td>@DurhamDtonPCTs</td>
</tr>
<tr>
<td>NHS Tees</td>
<td><a href="http://www.facebook.com/NHSTees">www.facebook.com/NHSTees</a></td>
<td>@NHSTees</td>
</tr>
<tr>
<td>Northumbria Healthcare NHS Foundation Trust</td>
<td><a href="http://www.facebook.com/northumbriahealthcare">www.facebook.com/northumbriahealthcare</a></td>
<td>@NorthumbriaNHS</td>
</tr>
</tbody>
</table>
ANNEX THREE (2): MEDIA MESSAGES

Generic message to media

- Please do not descend on the scene or receiving hospitals – the presence of media could make it difficult for emergency services to deal with this major incident.

- Regular proactive updates will be issued from XXX. All media enquiries should be directed to XXX.

Generic Early Public Health Messages – Major Incidents

All messages should be prefixed with the following phrase:-

“This is an important public health message…”

If the North East Information Line (NEIL) has been activated, the message will end with the phrase:

“and ring 08456 004 004 for the latest information."

Smoke caused by a large fire (NB not involving chemical plume)

- Unless you have been advised by the emergency services to leave the area, the advice to those who live in the area affected by the smoke from the fire is to stay indoors with doors and windows closed as much as possible.

  - **Social media feed:** Unless you have been advised by emergency services to leave the area affected by the smoke, please stay indoors with doors & windows closed

- If people need to be outdoors, they are advised to avoid areas affected by any smoke or ash, or to limit the time that they spend in them.

  - **Social media feed:** If people need to be outdoors, they are advised to avoid areas affected by any smoke or ash, or to limit the time that they spend in them

- Chemicals in smoke can worsen existing health problems like asthma so people with these conditions should carry their inhaler and use it as appropriate.

  - **Social media feed:** Chemicals in smoke can worsen health problems like asthma. People with such conditions should carry their inhaler and use as appropriate

- Any smoke can be an irritant and some of the substances present can sometimes irritate the lining of the air passages, the skin and the eyes. If respiratory symptoms such as coughing and wheezing or breathlessness occur, people should seek medical advice or call NHS Direct 0845 4647 or call 111.

  - **Social media feed:** Any smoke can be an irritant and some of the substances present can sometimes irritate the lining of air passages, the skin and the eyes
- **Social media feed**: If symptoms such as coughing and wheezing or breathlessness occur, people should seek medical advice or call NHS Direct 0845 4647 or 111

### Chemical, biological, radiological, nuclear – deliberate or accidental

- Unless you have been advised by emergency services to leave the area, stay indoors, keep the doors and windows closed and don’t go out until you hear more about the nature of the incident on local radio/TV and social media channels – regular updates will be broadcast /issued.

- **Social media feed**: Unless you have been advised by emergency services to leave the area, please stay indoors, keep the doors and windows closed

- **Social media feed**: Please stay indoors until you hear more about the nature of the incident on local radio, TV & social media – regular updates will be issued

- Emergency services are advising people involved in the incident to remain at the scene for decontamination and treatment. Anyone who was involved in the incident but who has made their way home should remove all clothing and put it in plastic bags before showering or washing themselves thoroughly. The bagged clothes should then be placed outdoors. This is a precautionary measure to protect the individual and anyone else they may come into contact with. If you start to feel unwell after going home you should ring NHS Direct straight away on 0845 4647. (Call 111 if you live in County Durham or Darlington)

- **Social media feed**: If you have been involved in the incident please remain at the scene for decontamination and treatment

- **Social media feed**: If you have already left the scene and gone home, please remove all clothing, put it in plastic bags and shower / wash yourself thoroughly

- **Social media feed**: The bagged clothes should be placed outdoors as a precautionary measure

- **Social media feed**: If you start to feel unwell after going home you should ring NHS Direct straight away on 0845 4647 or call 111

- If you were outside when it happened and were not close enough to the scene to be affected by the explosion or fumes but start to feel unwell - for example, if you develop a headache, running nose or streaming eyes - contact NHS Direct on 0845 4647, (call 111 if you live in County Durham or Darlington) where a trained nurse will give you advice.

- **Social media feed**: If you were outside and start to feel unwell (headache, running nose or streaming eyes) - contact NHS Direct on 0845 4647 or call 111

- **Social media feed**: If you think someone you know has been involved in the accident do not ring local health or emergency services for information. They will be too busy dealing with the incident and casualties to take your call. Instead, listen to local radio, watch television and monitor social media channels for helpline details. The number will be advertised as soon as possible and the people operating this helpline will have the latest information.
- **Social media feed**: If you think someone you know has been involved please listen to local radio, watch TV & monitor social media for helpline details

- **Social media feed**: A helpline number will be advertised as soon as possible and the people operating this helpline will have the latest information

- **Social media feed**: Please do NOT ring local health or emergency services for information about loved ones – they are busy dealing with casualties

**Large scale accident – train/plane/rail**

- Avoid the area of the accident. The presence of traffic or pedestrians could make it difficult for emergency services to get to and from the scene.

  - **Social media feed**: Please avoid the area of the accident - increased traffic & people will make it difficult for emergency services to get to & from the scene

- If you think someone you know has been involved in the accident do not ring local health or emergency services for information. They will be too busy dealing with the incident and casualties to take your call. Instead, listen to local radio, watch television and monitor social media channels for details of a helpline to ring. The number will be advertised as soon as possible. The people operating this helpline will have the latest information.

  - **Social media feed**: If you think someone you know has been involved please listen to local radio, watch TV & monitor social media for helpline details

  - **Social media feed**: A helpline number will be advertised as soon as possible and the people operating this helpline will have the latest information

  - **Social media feed**: Please do NOT ring local health or emergency services for information about loved ones – they are busy dealing with casualties

- If you have been involved in the accident but have no injuries please do not leave the scene without giving professionals your details. It will be important for the emergency services attending the scene to account for everyone present. If you leave the scene without telling them they may spend time looking for you.

  - **Social media feed**: If you have been involved in the accident but have no injuries please do not leave the scene without giving professionals your details

  - **Social media feed**: Emergency services at the scene need to account for everyone present. Please don’t leave the scene without telling them

- If you have been involved in the accident and have received minor injuries the professionals on site will tell you where to go for treatment.

  - **Social media feed**: If you have been involved in the accident & have minor injuries the professionals on site will tell you where to go for treatment

- If you have not been involved in the accident in any way but have a routine appointment at the local hospital check with the outcasualties’ clinic to see if it is still on as doctors and nurses at the hospital may be all helping with the incident. In the same way, if you are
thinking of going to A&E for something totally unrelated to the accident, don’t go without first ringing NHS Direct on 0845 4647 or call 111.

- Social media feed: Please check with your local hospital before attending any routine / non-emergency appointments - staff may all be helping with the incident

- Social media feed: If you think you need A&E for something totally unrelated to the accident, please call NHS Direct 0845 4647 or 111 first

- If the ambulance or medical staff at the scene have seen you and have said it is all right for you to go home or continue with your journey but you later feel ill, ring NHS Direct on 0845 4647 or 111 for advice.

- Social media feed: If you have left the scene of the accident and later feel ill, please ring NHS Direct on 0845 4647 or 111 for medical advice

Terrorist related incident

- Please avoid the area of the incident. The presence of traffic or pedestrians could make it difficult for emergency services to get to and from the scene.

  - Social media feed: Please avoid the area of the incident - increased traffic & people will make it difficult for emergency services to get to & from the scene

- If you think someone you know has been injured do not ring local health and emergency services for information and do not turn up at hospital. They will be too busy dealing with the incident and casualties to take your call. Instead, listen to local radio, watch television and monitor social media channels for details of a helpline to ring. The number will be advertised as soon as possible. The people operating this helpline will have the latest information.

  - Social media feed: If you think someone you know has been involved please listen to local radio, watch TV & monitor social media for helpline details

  - Social media feed: A helpline number will be advertised as soon as possible and the people operating this helpline will have the latest information

  - Social media feed: Please do NOT ring local health or emergency services for information about loved ones – they are busy dealing with casualties

- If you have been involved in the incident but have no injuries please do not leave the scene without giving professionals your details. It will be important for the emergency services attending the scene to account for everyone present. If you leave the scene without telling them they may spend time looking for you.

  - Social media feed: If you have been involved in the incident but have no injuries please do not leave the scene without giving professionals your details

  - Social media feed: Emergency services at the scene need to account for everyone present. Please don’t leave the scene without telling them
• If you have been involved in the incident and have received minor injuries the professionals on site will tell you where to go for treatment.
  - Social media feed: If you have been involved in the incident & have minor injuries the professionals on site will tell you where to go for treatment

• If you have not been involved in the incident in any way but have a routine appointment at the local hospital check with the out-casualties clinic to see if it is still on as doctors and nurses at the hospital may be all helping with the incident. In the same way, if you are thinking of going to A&E for something totally unrelated to the accident, don’t go without first ringing NHS Direct on 0845 4647 or call 111.
  - Social media feed: Please check with your local hospital before attending any routine / non-emergency appointments - staff may all be helping with the incident
  - Social media feed: If you think you need A&E for something totally unrelated to the accident, please call NHS Direct 0845 4647 or 111 first

• If the ambulance or medical staff at the scene have seen you and have said it is all right for you to go home or continue with your journey but you later feel ill, ring NHS Direct on 0845 4647 for advice or call 111.
  - Social media feed: If you have left the scene of the accident and later feel ill, please ring NHS Direct on 0845 4647 or 111 for medical advice
ANNEX FOUR: EQUITY & DIVERSITY

Full Assessment Form

Division/Department: Health Care Governance

Title of policy, procedure, decision, project, function or service: Major Incident & Emergency Response Plan

Lead person responsible: Executive Director of Nursing

People involved with completing this: Trust Resilience Lead, Equity & Diversity Lead

Type of policy, procedure, decision, project, function or service:

- Existing [X]
- New/proposed [ ]
- Changed [ ]
Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

The Civil Contingencies Act 2004 and NHS Commissioning Board Emergency Planning Framework 2013 require the County Durham & Darlington NHS Foundation Trust to maintain arrangements to enable it to prepare for, respond to, and recover from a major incident. This plan will ensure ongoing compliance with legislation and guidance, including the NHS Commissioning Board Core Standards for Emergency Preparedness Resilience & Response

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Victims from a Major Incident
Trust Staff and Trust reputation
Families & Significant others
Stakeholders
All will benefit from a coordinated and structured response by the organisation.

What outcomes do you want to achieve?

Preserve and protect lives
(b) Mitigate and minimise the impact of an incident
(c) Inform the public and maintain public confidence
(d) Prevent, deter and detect crime
(e) Assist an early return to normality (or as near to it as can be reasonably achieved)

What barriers are there to achieving these outcomes?

In itself the incident will be an extraordinary event
Service may become overwhelmed
There may be poor or difficult communication amongst rescue services or the trust
The possibility of providing an uncoordinated response.

How will you put your policy, procedure, project, decision, function or service into practice?

Plan will have been approved by partner agencies
Plan will have been ratified by Trust board
Plan will have been validated by exercising, and updated through lessons learned culture
Staff will have been trained or made aware of plan dependant on role
Plan will be implemented in the event of a major incident.
Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

Plan is part of a multi-agency response amongst all Category 1 responders as defined in the Civil Contingencies Act 2004. It aligns with our response to the Hazardous Materials / CBRN Plan and Business Continuity Plans.

Step 2 – Collecting your information

What existing information / data do you have?

- Equity Act 2010
- Equity and Diversity Policy
- Emergency Preparedness Guidance
- Data Protection and Sharing Guidance for Emergency Planners and Responders 2007
- Identifying People who are Vulnerable in a Crisis Guidance for Emergency Planners and Responders
- Civil Contingencies Secretariat – 2008
- Engaging the capacity and capabilities of faith communities in Civil Resilience- 2008

Who have you consulted with?

- Equity & Diversity lead.
- Stakeholders

What are the gaps and how do you plan to collect what is missing?

- No Gaps identified

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

Potential difficulties for people whose first language is not English therefore individual departments or wards will have local policies and plans that consider how communication will be facilitated in the event of an emergency and an interpreter is not present at the time.
Sex/Gender –

Potential impact for ensuring compliance with same sex wards should relocation of patients be required. Local business continuity plans are designed to ensure like for like accommodation is available however in critical circumstances this may be compromised.

The Trust workforce profile indicates that a significant proportion of staff are female, who are predominately the main carers in most family units and therefore should there be an incident that requires absence to care for dependants: this may be considerably disruptive for the business continuity of the area. For example pandemic flu, or school closure. Local business continuity plans will reflect this depending on the gender profile of the particular staff group.

Age

Potential safeguarding impact for children who are hospitalised in an evacuation scenario. Local business continuity plans within children’s services will reflect how safeguarding will be maintained.

Potential issues for elderly patients as they make up a significant proportion of inpatients in the Trust and therefore if there was a major incident may be subject to a more rapid discharge from acute care than would normally occur to free up beds for trauma victims. Local plans will identify when and where tertiary/community care may be necessary.

Elderly patients are more likely to have a disability or long term medical conditions, therefore see disability below.

Disability

The Trust will work with local authorities, who maintain lists of vulnerable patients (including mental health conditions, learning disabilities, physical and mobility disabilities and sensory impairments) who would be prioritised in a major incident for example extreme weather conditions when delivering community health care.

Potential access and egress issues for patients or staff with physical or mobility problems should there be a major incident or requirement to relocate. Local contingency plans will identify suitable alternative accommodation dependant on the nature of the service.

Staff with disabilities who need to be relocated were auxiliary aids, specialist IT software, reasonable adjustments etc. are required; this will be reflected in local level contingency plans which have been identified from the business impact analysis.

Religion or Belief

Potential impact for people with particular religions or beliefs in birth and death/dying situations (where relevant) should there be a major incident may compromise normal religious observance practices. Local chaplaincy and individual service policies and plans will mitigate impact.

Account has been taken of new guidance engaging faith communities in civil resilience.
Engaging the capacity and capabilities of faith communities in Civil Resilience - 2008

Sexual Orientation

National evidence suggest that LGB people (particularly older people) are more likely to be single and estranged from family groups therefore consideration must be given in a rapid discharge situation regarding their ongoing health support.

Marriage and Civil Partnership

No differential impact

Pregnancy and Maternity

People who are pregnant may be considered vulnerable in an incident situation because of their physiological status, and may have mobility issues especially in later stages of pregnancy. Local level plans within services and organisational plans e.g. pandemic flu plans will consider relevant issues for people who are pregnant.

Gender Reassignment

National evidence suggest that transgender people (particularly older people) are more likely to be single and estranged from family groups therefore consideration must be given in a rapid discharge situation regarding their ongoing health support.

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills

The Trust will work with local authorities in determining provision of care or support services for vulnerable patients in a major incident for example extreme weather conditions when delivering community health care or discharge management planning for vulnerable patients e.g. homeless, rural communities etc.

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

See above discussion on impact. Local service level policies will identify and outline issues relevant to their area of work. Organisational wide policies such as those for pandemic flu etc will consider the needs of protected groups relevant to the nature of the particular incident.
Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act?

Yes ☒ No ☐

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

There may be a potential in some major incident situations for individual’s rights to be compromised due to the nature of the particular incident and the immediacy or availability of provision of care and treatment.

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

Document has been circulated in draft via Trust Resilience Forum and external stakeholders for comment. Plan was then updated in view of the comments or suggestion made then circulated to the forum for final acknowledgement.

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

The Major Incident & Emergency Response Plan will be updated on an annual basis, or on receipt of further guidance or following the lessons learned from an incident.
Step 6 – Completion and central collation

Once completed this Equality Analysis form must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk and must be attached to any documentation to which it relates.

Equity & Diversity
# ANNEX FIVE

## Private & Confidential

### Contact List North

#### Bulk Text Message

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wendy Bagnall</td>
<td>Health Improvement Manager</td>
<td>07979505213</td>
</tr>
<tr>
<td>Kelly Bentham</td>
<td>Finance</td>
<td>07770 635969</td>
</tr>
<tr>
<td>Ian Briggs</td>
<td>AD Business Development</td>
<td>07500089478</td>
</tr>
<tr>
<td>David Brown</td>
<td>AD Finance</td>
<td>07427654169</td>
</tr>
<tr>
<td>Julia Clark</td>
<td>Head Nutrition &amp; Dietetics</td>
<td>07920083934</td>
</tr>
<tr>
<td>Angela Davidson</td>
<td>Head Child Health</td>
<td>07980726825</td>
</tr>
<tr>
<td>Warren Edge</td>
<td>AD Assurance &amp; Compliance</td>
<td>07931551762</td>
</tr>
<tr>
<td>Harry Greenwood</td>
<td>Head of Cellular Pathology</td>
<td>07850119159</td>
</tr>
<tr>
<td>Lynn Hartley</td>
<td>AD Financial Services</td>
<td>07879813372</td>
</tr>
<tr>
<td>Margaret Herkes</td>
<td>Patient Booking Manager</td>
<td>07557317110</td>
</tr>
<tr>
<td>Catherine Hodgkiss</td>
<td>Manager Rapid Response</td>
<td>07803150601</td>
</tr>
<tr>
<td>Anne Holt</td>
<td>Head Midwifery Services</td>
<td>07770728766</td>
</tr>
<tr>
<td>Graeme Kirkpatrick</td>
<td>Chief Pharmacist</td>
<td>07884476452</td>
</tr>
<tr>
<td>Wendy Lyons</td>
<td>Strategic lead for Integration</td>
<td>07967627886</td>
</tr>
<tr>
<td>Sarah Perkins</td>
<td>Ops &amp; Business development</td>
<td>07833553422</td>
</tr>
<tr>
<td>Calum Polwart</td>
<td>Lead Pharmacist</td>
<td>07825853874</td>
</tr>
<tr>
<td>Julie Race</td>
<td>AD Service transformation</td>
<td>07990570795</td>
</tr>
<tr>
<td>Jill Robson</td>
<td>Service manager Orthopaedics</td>
<td>07785328324</td>
</tr>
<tr>
<td>Lesley Rowe</td>
<td>Head Learning &amp; Development</td>
<td>07920467854</td>
</tr>
<tr>
<td>Anne Sewell</td>
<td>Head Quality &amp; Governance</td>
<td>07887510172</td>
</tr>
<tr>
<td>Chris Shaw</td>
<td>Head of Diagnostics</td>
<td>07554406886</td>
</tr>
<tr>
<td>Donna Swan</td>
<td>Trust secretary</td>
<td>07824342718</td>
</tr>
<tr>
<td>Dean Trainer</td>
<td>Head of Service S&amp;D</td>
<td>07500990648</td>
</tr>
</tbody>
</table>
### Contact List South

#### Bulk Text Message

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nichola Allen</td>
<td>Clinical Program Manager</td>
<td>07766901168</td>
</tr>
<tr>
<td>Debbie Anderson</td>
<td>AD Information</td>
<td>07743706593</td>
</tr>
<tr>
<td>Martin Armitage</td>
<td>Head of Information</td>
<td>07811442442</td>
</tr>
<tr>
<td>Pauline Burton</td>
<td>Cancer Service Manager</td>
<td>07825845371</td>
</tr>
<tr>
<td>Lisa Cole</td>
<td>Stroke/Elderly Service Manager</td>
<td>0777070395</td>
</tr>
<tr>
<td>Jane Curry</td>
<td>Head Cardiac &amp; Respiratory</td>
<td>07876030542</td>
</tr>
<tr>
<td>Elizabeth Garnett</td>
<td>Business Manager S&amp;D</td>
<td>07825963919</td>
</tr>
<tr>
<td>Alison Gill</td>
<td>Head Human Resources</td>
<td>07500125114</td>
</tr>
<tr>
<td>Patricia Gordon</td>
<td>Senior Nurse Infection Control</td>
<td>0782526575</td>
</tr>
<tr>
<td>Eileen Haliday</td>
<td>Head Occupational Therapy</td>
<td>07980729610</td>
</tr>
<tr>
<td>Craig Holden</td>
<td>AD Service Transformation</td>
<td>07920540077</td>
</tr>
<tr>
<td>Gill Hunt</td>
<td>Senior Nurse</td>
<td>07811442421</td>
</tr>
<tr>
<td>Mark Jones</td>
<td>Specialist Service Manager</td>
<td>07811442421</td>
</tr>
<tr>
<td>Judith Kent</td>
<td>Radiology Manager</td>
<td>07812186099</td>
</tr>
<tr>
<td>Lorraine Legg</td>
<td>AD Corporate Medical Services</td>
<td>07919398822</td>
</tr>
<tr>
<td>Claire Mathews</td>
<td>Health Improvement Manager</td>
<td>07770334660</td>
</tr>
<tr>
<td>Alison McCree</td>
<td>AD Facilities</td>
<td>07803150574</td>
</tr>
<tr>
<td>Carol McIver</td>
<td>Lead Biomedical Scientist</td>
<td>07971895047</td>
</tr>
<tr>
<td>Steve Morley</td>
<td>Head Clinical Engineering</td>
<td>07966237789</td>
</tr>
<tr>
<td>Paul Cummings</td>
<td>Head of Personnel</td>
<td>07739351047</td>
</tr>
<tr>
<td>Carol Robinson</td>
<td>Head of Physiotherapy</td>
<td>07971895327</td>
</tr>
<tr>
<td>Ros Russell</td>
<td>Service Manager Surgery</td>
<td>07979853972</td>
</tr>
<tr>
<td>Ian Stiff</td>
<td>AD Payroll</td>
<td>07980729871</td>
</tr>
<tr>
<td>Paul Thurland</td>
<td>Head of Service S&amp;D</td>
<td>07775026884</td>
</tr>
<tr>
<td>Joanne Todd</td>
<td>AD Patient safety &amp; Governance</td>
<td>07825226759</td>
</tr>
<tr>
<td>Lyndall Ann Wallace</td>
<td>Senior Manager</td>
<td>07771960879</td>
</tr>
<tr>
<td>Christopher Williams</td>
<td>Deputy Chief Pharmacist</td>
<td>07554438004</td>
</tr>
</tbody>
</table>
Annex 6 Rail Incident Care Teams

Rail Emergencies

Train Operating Companies have teams of specially selected volunteers who have been trained and equipped to respond to the needs of those affected in the hours and days immediately following a rail emergency. These are referred to as Rail Incident Care Teams.

In the event of an emergency involving a passenger train or station, Rail Incident Care Team members may be deployed to hospitals, Emergency Assistance Centres and train stations. Their aim is very much to work alongside and complement the efforts of other responding agencies, but uniquely among these, they are able to provide ‘ownership’ (in recognition that whatever the cause of the emergency, persons affected were customers of and hence the responsibility of the rail industry) and acknowledge/validate the loss suffered.

Rail Incident Care Teams can provide and/or fund/arrange the following for those directly involved along with their families and friends and those bereaved:

• Information (particularly that specific to the railway)
• Assistance with getting/keeping in touch with friends/family members e.g. access to phones or email
• Refreshments
• Accommodation
• Travel
• Purchase of basic personal items, e.g. toiletries, clothing
• Return/replacement of lost or damaged personal effects
• Signposting to other support agencies
• General emotional support

In the event of a major rail incident, the train operating company concerned will be seeking to make early contact with the relevant hospitals, local authorities and police forces so as to facilitate the rapid deployment and most effective use of Rail Incident Care Team members.

All members of Rail Incident Care Teams will carry a special photo-id card identifying them as such. They should be given all reasonable assistance in fulfilling their role of providing emotional and practical support to those affected. Specifically this should include:

Being given access to passenger/casualty lists and contact information

Being granted access to [reception centres/the Humanitarian Assistance Centre/the hospital]

Where possible, being provided with a private area they can engage with those they are seeking to assist

Being represented on whatever body takes responsibility for the overall humanitarian response
### Annex 7 List of Red Phones

<table>
<thead>
<tr>
<th>Ext No</th>
<th>Location in DMH</th>
<th>Ext No</th>
<th>Location in UHND</th>
<th>Ext No</th>
<th>Location in UHND</th>
</tr>
</thead>
<tbody>
<tr>
<td>43017</td>
<td>Reception</td>
<td>32017</td>
<td>Cardiac Rehab</td>
<td>54948</td>
<td>Theatres</td>
</tr>
<tr>
<td>43020</td>
<td>Ward 21 Fax</td>
<td>32019</td>
<td>ITU Nurse Base</td>
<td>55002</td>
<td>Ward 2 Fax</td>
</tr>
<tr>
<td>43034</td>
<td>Ward 33 Fax</td>
<td>32021</td>
<td>Neo Natal</td>
<td>55004</td>
<td>Ward 4 Fax</td>
</tr>
<tr>
<td>43107</td>
<td>X-Ray Finishing Room</td>
<td>32034</td>
<td>CCU Nurse Base</td>
<td>55006</td>
<td>Ward 6 Fax</td>
</tr>
<tr>
<td>43112</td>
<td>Medical OPD N Station</td>
<td>32052</td>
<td>Ward 11a Nurse Base</td>
<td>55007</td>
<td>Ward 7 Fax</td>
</tr>
<tr>
<td>43116</td>
<td>Physio Reception</td>
<td>32130</td>
<td>A&amp;E Staff Base</td>
<td>55008</td>
<td>Ward 8 Fax</td>
</tr>
<tr>
<td>43121</td>
<td>Theatres Reception</td>
<td>32131</td>
<td>A&amp;E Staff Base</td>
<td>55010</td>
<td>Ward 10 Fax</td>
</tr>
<tr>
<td>43128</td>
<td>Endoscopy</td>
<td>32135</td>
<td>A&amp;E Main Reception</td>
<td>55016</td>
<td>Ward 16 Fax</td>
</tr>
<tr>
<td>43154</td>
<td>Cardio Respiratory</td>
<td>32139</td>
<td>A&amp;E Resuscitation</td>
<td>55018</td>
<td>Ward 18 Fax</td>
</tr>
<tr>
<td>43156</td>
<td>SOPD Reception</td>
<td>32180</td>
<td>CSSD Managers Office</td>
<td>55023</td>
<td>UCC Fax</td>
</tr>
<tr>
<td>43167</td>
<td>Blood transfusion</td>
<td>32199</td>
<td>Radiology CT Room</td>
<td>55029</td>
<td>Urgent Care Nurse Base</td>
</tr>
<tr>
<td>43194</td>
<td>Ward 23</td>
<td>32267</td>
<td>Day Surgery Ward</td>
<td>55048</td>
<td>UCC Reception</td>
</tr>
<tr>
<td>43199</td>
<td>ANC Reception</td>
<td>32361</td>
<td>Theatres Recovery Nurse Base</td>
<td>55101</td>
<td>Ward 1</td>
</tr>
<tr>
<td>43257</td>
<td>SCBU</td>
<td>32362</td>
<td>Theatres Nurse Base</td>
<td>55102</td>
<td>Ward 2 Pain Management</td>
</tr>
<tr>
<td>43266</td>
<td>SSD</td>
<td>32401</td>
<td>Eye Clinic Exam Room</td>
<td>55103</td>
<td>Ward 3</td>
</tr>
<tr>
<td>43295</td>
<td>Security</td>
<td>32448</td>
<td>Pathology Microbiology Lab</td>
<td>55104</td>
<td>Ward 4</td>
</tr>
<tr>
<td>43312</td>
<td>DSU Reception</td>
<td>32458</td>
<td>Pharmacy</td>
<td>55105</td>
<td>Ward 5</td>
</tr>
<tr>
<td>43315</td>
<td>Ward 33 Sister</td>
<td>32463</td>
<td>Pharmacy Secretaries</td>
<td>55106</td>
<td>Ward 6</td>
</tr>
<tr>
<td>43316</td>
<td>Ward 33</td>
<td>32470</td>
<td>Porters</td>
<td>55107</td>
<td>Ward 7 Childrens Ward</td>
</tr>
<tr>
<td>43354</td>
<td>SOPD Nurses</td>
<td>32477</td>
<td>A&amp;E X Ray Staff Base</td>
<td>55108</td>
<td>Ward 8 Delivery Suite</td>
</tr>
<tr>
<td>43360</td>
<td>CCU</td>
<td>32489</td>
<td>Radiology CT Room</td>
<td>55109</td>
<td>Ward 9</td>
</tr>
<tr>
<td>43401</td>
<td>Ward 21</td>
<td>32496</td>
<td>Radiology Corridor</td>
<td>55110</td>
<td>Ward 10</td>
</tr>
<tr>
<td>43406</td>
<td>Ward 21</td>
<td>32557</td>
<td>Ward 7 Medical Staff Office (Treetops)</td>
<td>55116</td>
<td>Ward 16</td>
</tr>
<tr>
<td>43419</td>
<td>Ward 61 Fax</td>
<td>32562</td>
<td>Pathology Haematology</td>
<td>55117</td>
<td>Ward 17</td>
</tr>
<tr>
<td>43427</td>
<td>Ward 41 Fax</td>
<td>32566</td>
<td>Car Park Security (Old Trust HQ)</td>
<td>55118</td>
<td>Ward 18</td>
</tr>
<tr>
<td>43429</td>
<td>Ward 41</td>
<td>32585</td>
<td>Physio Out Patients</td>
<td>55119</td>
<td>Ward 19</td>
</tr>
<tr>
<td>43430</td>
<td>Ward 41 Sister</td>
<td>32591</td>
<td>Physio Occ Therapy</td>
<td>55135</td>
<td>Day ward / Day Surgery</td>
</tr>
<tr>
<td>43437</td>
<td>Ward 43</td>
<td>32646</td>
<td>BBW Estates Helpdesk</td>
<td>55144</td>
<td>Day ward Endoscopy</td>
</tr>
<tr>
<td>43439</td>
<td>Ward 43 Sister</td>
<td>32681</td>
<td>Urgent Care Centre Reception</td>
<td>55155</td>
<td>Mara Unit</td>
</tr>
<tr>
<td>43440</td>
<td>Ward 43 Fax</td>
<td>32726</td>
<td>Dermatology</td>
<td>55220</td>
<td>Reception Day Surgery</td>
</tr>
<tr>
<td>43442</td>
<td>Ward 44 Sister</td>
<td>32759</td>
<td>Pathology Bio Chem.</td>
<td>55280</td>
<td>OPD Sisters office</td>
</tr>
<tr>
<td>43445</td>
<td>Ward 44</td>
<td>32767</td>
<td>A&amp;E Fax</td>
<td>55290</td>
<td>Pathology</td>
</tr>
<tr>
<td>43448</td>
<td>Ward 61 Reception</td>
<td>32794</td>
<td>Cardiac Day Unit</td>
<td>55319</td>
<td>Bowl Screening</td>
</tr>
<tr>
<td>43449</td>
<td>Labour Ward</td>
<td>32900</td>
<td>AMU Fax</td>
<td>55375</td>
<td>CT</td>
</tr>
<tr>
<td>43472</td>
<td>A&amp;E Reception</td>
<td>32901</td>
<td>Ward 01 Nurse Base</td>
<td>55398</td>
<td>Radiology</td>
</tr>
<tr>
<td>43481</td>
<td>A&amp;E Nurse Station</td>
<td>32902</td>
<td>Ward 02 Nurse Base</td>
<td>55422</td>
<td>Physio Occ Therapy reception</td>
</tr>
<tr>
<td>No</td>
<td>Location in DMH</td>
<td>Ext No</td>
<td>Location in UHND</td>
<td>Ext No</td>
<td>Location in UHND</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------</td>
<td>--------</td>
<td>--------------------------</td>
<td>----------</td>
<td>----------------------</td>
</tr>
<tr>
<td>43504</td>
<td>Ward 31</td>
<td>32903</td>
<td>Ward 03 Nurse Base</td>
<td>55435</td>
<td>Physio Office</td>
</tr>
<tr>
<td>43505</td>
<td>Ward 34</td>
<td>32904</td>
<td>Ward 04 Nurse Base</td>
<td>55463</td>
<td>OPD Orthopaedics</td>
</tr>
<tr>
<td>43513</td>
<td>Ward 32</td>
<td>32905</td>
<td>Ward 05 Nurse Base</td>
<td>55478</td>
<td>OPD Reception</td>
</tr>
<tr>
<td>43521</td>
<td>Ward 62</td>
<td>32906</td>
<td>Ward 06 Nurse Base</td>
<td>55512</td>
<td>Cardio Pulmonary</td>
</tr>
<tr>
<td>43526</td>
<td>Ward 52</td>
<td>32907</td>
<td>Ward 07 Nurse Base</td>
<td>55523</td>
<td>Orthotics</td>
</tr>
<tr>
<td>43628</td>
<td>Pharmacy Secretary</td>
<td>32908</td>
<td>Ward 08 Nurse Base</td>
<td>55529</td>
<td>OPD Annexe</td>
</tr>
<tr>
<td>43633</td>
<td>Pharmacy</td>
<td>32909</td>
<td>Ward 09 Nurse Base</td>
<td>55532</td>
<td>Helpdesk</td>
</tr>
<tr>
<td>43755</td>
<td>Estates Energy Centre</td>
<td>32910</td>
<td>Ward 10 Nurse Base</td>
<td>55560</td>
<td>IT</td>
</tr>
<tr>
<td>43773</td>
<td>Ward 14 Sister</td>
<td>32911</td>
<td>Ward 11 Nurse Base</td>
<td>55596</td>
<td>Childrens Centre</td>
</tr>
<tr>
<td>43803</td>
<td>Ward 23 Fax</td>
<td>32912</td>
<td>Ward 12 Nurse Base</td>
<td>55682</td>
<td>PABX Room</td>
</tr>
<tr>
<td>43811</td>
<td>Ward 62 Sister</td>
<td>32913</td>
<td>Ward 13 Nurse Base</td>
<td>55767</td>
<td>Dental OPD</td>
</tr>
<tr>
<td>43908</td>
<td>X-Ray Reception</td>
<td>32914</td>
<td>Ward 14 Nurse Base</td>
<td>55845</td>
<td>Fertility Clinic</td>
</tr>
<tr>
<td>43912</td>
<td>ITU 1 Reception</td>
<td>32915</td>
<td>Ward 15 Reception Office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43916</td>
<td>Ward 32 Sister</td>
<td>32916</td>
<td>Ward 16 Nurse Base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43926</td>
<td>Ward 14</td>
<td>32924</td>
<td>GUM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43938</td>
<td>Ward 42</td>
<td>32973</td>
<td>Ward 08 Theatre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43958</td>
<td>ITU 2</td>
<td>36953</td>
<td>Surgical Admissions Nurse Base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43989</td>
<td>DSU Ward</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44325</td>
<td>Theatre Recovery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44397</td>
<td>Ward 31 Sister</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44505</td>
<td>Medical OPD Reception</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Shotley Bridge**
- OPD Sisters office: Extension 36700
- Porters/Post room: Extension 36707
- Urgent Care/Minor Injuries: Extension 36710
- Estates: Extension 36702
- Health Records: Extension 36708
- Ante natal: Extension 36704
- Ward 2: Extension 36705
- Endoscopy Reception: Extension 36706

**Chester-le-Street**
- Main Reception: 0191 3892753
- Ward 1: 0191 3893305
- Ward 2: 0191 3889983
Annex 8 Emergency Communication Methods

Conference Call Details (For more detail refer to SOP-NQ-BCP151)
This facility is intended to facilitate communications in the event of an emergency incident across a team or multiple teams.

To use this facility the plan owner should click on the link below or paste it into a web browser and follow the on screen instructions. Once the information has been added you will receive an email with the telephone that you and all participants have to call. The email will also contain the ‘chairman’ ID and password and other participant details. Forward this email to all others who you want to be involved in the conference call http://10.97.145.220/ or from the Intranet select popular links, systems, audio bridge

Please note:
1. The person setting up this facility must have access to the trust network
2. You can’t call this number before the allocated time

Bulk Text Facility (For more details refer to SOP-NQ-BCP149, SOP-NQ-BCP150)
This facility can be used to push a text message out to a number of distribution groups as detailed in Emergency Contact Details of this plan.

To use this facility logon to NHS mail and select Tools followed by and select one or more of the distribution groups as detailed under emergency contact details. Type your message and then click send

Bulk Fax Facility (For more details refer to SOP-NQ-BCP149, SOP-NQ-BCP150)
This facility can be used to send multiple fax messages from your PC, logon as Bulk Text

Emergency Information page
This section is used to communicate information relating to an emergency incident. In the event of an incident this page will be activated by the Communications Department.

For more information please go to www.cddft.nhs.uk/BCP

If you need to activate this page please contact one of the following:

<table>
<thead>
<tr>
<th>Name</th>
<th>Tel</th>
<th>Mobile</th>
<th>Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Paul Scott, Communications Manager</td>
<td>01325 743576 (internal 43576)</td>
<td>07717816628</td>
<td>01325 74 3622</td>
<td><a href="mailto:paul.scott@cddft.nhs.uk">paul.scott@cddft.nhs.uk</a></td>
</tr>
<tr>
<td>2. Edmund Lovell, Ass Director Communications and Marketing</td>
<td>07775712713</td>
<td>07825 722597</td>
<td>07597 170459</td>
<td><a href="mailto:EdmundLovell@dcdft.nhs.uk">EdmundLovell@dcdft.nhs.uk</a></td>
</tr>
<tr>
<td>3. Gary Sidds, Lead Resilience Manager</td>
<td>01325 743650</td>
<td>07825 722597</td>
<td><a href="mailto:Gary_Siddles@cddft.nhs.uk">Gary_Siddles@cddft.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>4. Joanne Walker, Web Developer</td>
<td>Tel: 01207 594340</td>
<td>07825 722597</td>
<td>Email: <a href="mailto:Gary_Siddles@cddft.nhs.uk">Gary_Siddles@cddft.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>5. Adrian Currie, Business Continuity Manager</td>
<td>Tel: 07597 170459</td>
<td>07825 722597</td>
<td>Email: <a href="mailto:Gary_Siddles@cddft.nhs.uk">Gary_Siddles@cddft.nhs.uk</a></td>
<td></td>
</tr>
</tbody>
</table>

You will need to provide them with the information that you would like communicating to your staff

Section 7.5 Emergency Information Line: Still to be setup
Annex 9 – Health System ERPP Operating Model – Response

- Lead Government Department
- Government Liaison Officer*
- National
- Regional
- Local Resilience
- Local Services
- Strategic Coordinating Group (SCG)
- department of Health Secretary of State
- PHE National Office
- PHE North of England
- PHE North East
- NHS Commissioning Board (NHS CB)
- NHS CB North of England
- NHS CB DD&Ts
- NE Ambulance Service
- NHS Provider Organisations
- Other Relevant Organisations
- Clinical Commissioning Groups (CCGs)

*Normally led by DCLG RED. But can vary depending on the type of emergency