NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

TRUST-WIDE NON-CLINICAL DOCUMENT

MAJOR INCIDENT PLAN

Policy Number:	**IRP00**
Scope of this Document:	**All Staff**
Recommending Committee:	**Executive Committee**
Approving Committee:	**Board of Directors**
Date Ratified:	**March 2018**
Next Review Date (by):	**March 2021**
Version Number:	**2018 – Version 5**
Lead Executive Director:	**Executive Director of Nursing & Operations**
Lead Author(s):	**Director of Patient Safety**

TRUST-WIDE NON-CLINICAL DOCUMENT

Version 5 - 2018

Striving for Perfect Care for the People we Serve

TRUST-WIDE NON-CLINICAL DOCUMENT

MAJOR INCIDENT PLAN

Further information about this document:

Document name	**MAJOR INCIDENT PLAN IRP00**
Document summary	This plan covers the following: • A major incident which affects the local community. • A major incident which threatens the continuity of critical Trust services. • A major incident which affects the health services in Merseyside/Lancashire and/or beyond. • A multi-agency major incident requiring a coordinated health service response in Merseyside/Lancashire and/or beyond. The plan is supported by additional plans and business continuity plans at divisional and local levels.
Author(s) Contact(s) for further information about this document	**Steve Morgan** **Director of Patient Safety** **Email: steve.morgan@merseycare.nhs.uk**
Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Foundtion Trust** **V7 Building** **Kings Business Park** **Prescot** **Merseyside, L34 1PJ** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**EPRR POLICY (EP01)** **Business Continuity Policy (EP02)**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control

		Version History:
Consultation Draft Version 1	Document presented to Policy Group	22nd December 2015
Version 2	Equality and Human Rights Analysis	29th December 2015
Version 3	Trust Board	27th January 2016
Version 4	Acquisition Steering Group	May 2016
Version 4	Board of Directors	September 2016
Version 5	Annual review	February 2018

A copy of this plan will be issued to selected appointments within NHS Mersey Care Foundation Trust and other relevant organisations and external partners. A copy of the plan (without confidential and sensitive contact information) will be published on the public Internet site at URL required.

SUPPORTING STATEMENTS

this document should be read in conjunction
with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child/ adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/ adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/ adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

STOP

1. **IF A SIGNIFICANT OR A MAJOR INCIDENT HAS BEEN DECLARED AND YOU ARE READING THIS PLAN FOR THE FIRST TIME**

DO NOT CONTINUE.

2. **GO DIRECTLY TO THE ACTION CARD SECTION**

3. **SEEK OUT YOUR ACTION CARD AND FOLLOW IT**

4. **IF YOU DO NOT HAVE AN ACTION CARD, THEN AWAIT FURTHER INSTRUCTIONS FROM YOUR MANAGER**

Contents

INTRODUCTION

Mersey Care NHS Foundation Trust must be prepared to respond to internal disruptions and externally as part of a wider NHS and/or multi-agency response to major incidents. The Trust must have the ability to recognise a major incident, significant incident or business interruption; establish an effective command, control and communications framework across the Divisions, with the ability to respond proportionately, consolidate and recover quickly from the incident/emergency. Whilst recognising the diversity of operations across the Trust, it is essential that all staff are familiar with the arrangements detailed within this plan. All members of staff play a vital role in ensuring a professional Trust response to a major incident, significant incident or business interruption. It is therefore essential that all staff are familiar with the procedures contained in this plan and with the support they will be asked to provide.

SECTION A: THE COMMAND FRAMEWORK

A1. NHS Command and Control

A1.1 Incidents can take many forms; therefore the responses need to match individual situations. Most incidents will be dealt with by individual NHS organisations at operational, tactical, strategic level without the need for others to be involved. However, some incidents may require a wider NHS or multi-agency response.

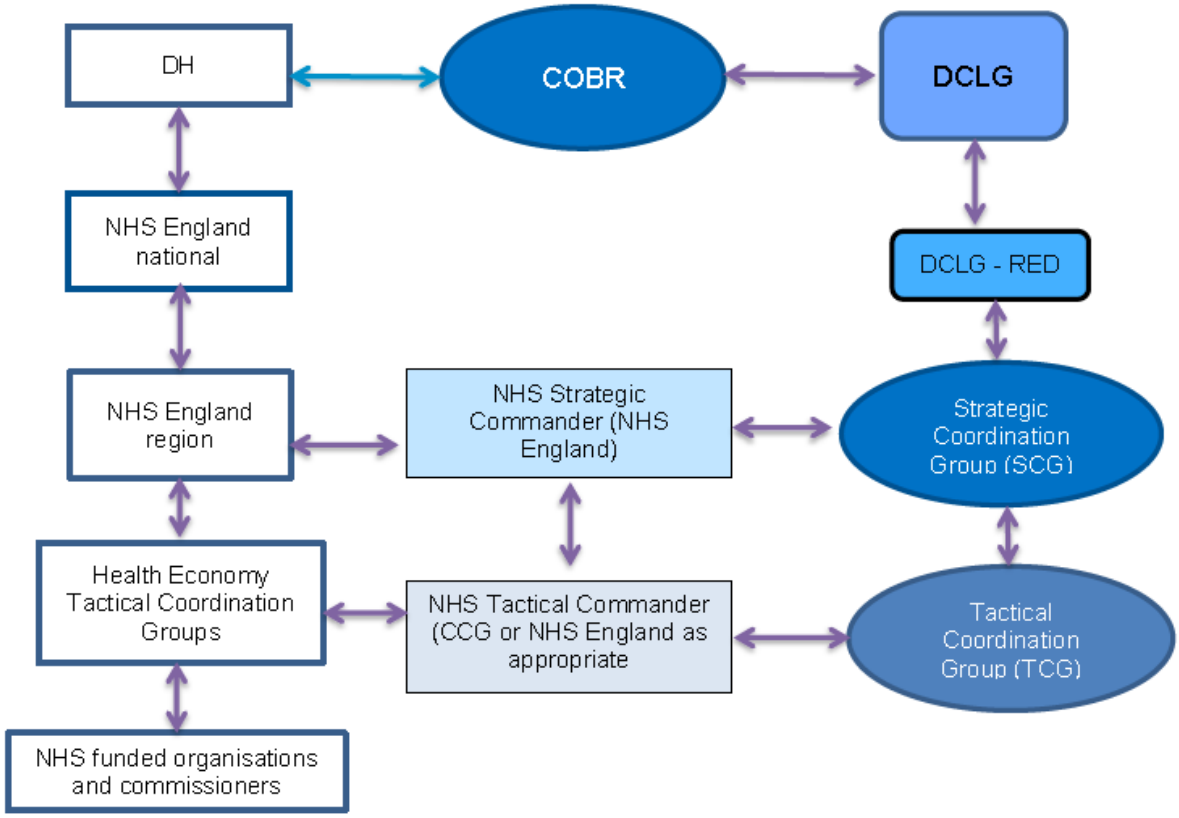
A1.2 During times of severe pressure and when responding to significant incidents and emergencies, NHS organisations need a structure which provides:

- Clear leadership;
- Accountable decision making; and
- Accurate, up to date and far-reaching communication.

A1.3 Types of severe pressure can include winter periods, a sustained increase in demand for services (surge or escalation) or an infectious disease outbreak such as pandemic influenza.

A1.4 This structured approach to leadership under pressure is commonly known as 'command and control'.

A1.5 The response structure for the NHS in England and its interaction with key partner organisation is shown at the figure below.



A1.6 The different command levels in NHS and partner agencies are:

A2 Operational Command

A2.1 The term 'Operational' refers to the departments and teams who provide the main operational response in an incident and control the immediate resources at hand within a specific area of the incident. They implement the tactics defined by the Trust Tactical Commander(s).

A2.2 The Trusts Operational Commanders (also known as Bronze) will be located at the scene of the incident and their role and responsibilities are to:

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

A3 Tactical Command

A3.1 The term 'Tactical' refers to those who are responsible for formulating the tactics to be adopted by their service to achieve the strategic direction set by the Trusts' Strategic Commander. The Trust Tactical Commander(s) will oversee but not be directly involved in providing the operational response to the incident.

A3.2 The Trust's Tactical Commanders (also known as Silvers) are responsible for the tactical coordination of resources within their respective division(s). They are required to cooperate/consult with the Trust Strategic Commander and any response teams that may be formed, where appropriate. The Trust Tactical Commander(s) will:

- Assume tactical coordination of their respective Divisions' response.
- Conduct an initial assessment using the Internal Escalation template (SBAR), and the Decision Making Model (DMM).
- Escalate to the Trust Strategic Commander, where appropriate.
- Request a Major Incident Standby/Declared to the Trust Strategic Commander.
- Declare a Major Incident Standby/Declared in the absence of the Trust Strategic Commander.
- Activate divisional emergency and business continuity plans, as appropriate.
- Activate/inform divisional operational locations, as appropriate.
- Identify and activate the Divisional Incident Coordination Centre (ICC).
- Agree roles and identify initial tasks.

A3.3 **Note:** Trust Tactical Commander(s) will be required to maintain contemporaneous notes until such times as a dedicated Loggist assumes this activity on their behalf.

A4 Strategic Command

A4.1 The term 'Strategic' refers to the person in overall executive command of Mersey Care response and is responsible for formulating the strategy for the incident. The Strategic Commander has overall command of the resources of the Trust and delegates tactical decisions to the respective Divisional Tactical Commander(s).

A4.2 During a major incident or large scale disruptive event, the Executive Director on-call assumes the role of the Trust Strategic Commander, responsible for strategic control of the Trusts' overall response.

A4.3 The Trust Strategic Commander (also known as Gold) will:

- Assume strategic control of the Trusts' overall response.
- Conduct an initial assessment using the Decision Making Model (DMM).
- Escalate to NHS England via NWAS Regional Health Control Desk, where appropriate
- Confirm a Major Incident Standby/Declared to NHS England.
- Inform the local Clinical Commissioning Group (CCG) or/ and the Specialist Commissioner on call (as appropriate).
- Oversee and co-ordinate the Trust's media response.
- Activate any response teams (Crisis/Incident) as appropriate.
- Activate/inform the Trust Tactical Commander(s), as appropriate.
- Identify and activate the Incident Coordination Centre (ICC) or alternative location.
- Convene a meeting of the appropriate response team(s), confirming the time of the first meeting.
- Agree roles, and identify initial tasks.
- The Strategic Commander is also responsible for cooperating/consulting with the NHS Strategic Commander and/or Tactical Commander from NHS England, other NHS providers and Responder agencies.

A5 Mersey Care On-Call

A5.1 The organisation has an on-call rota in place 24/7, which includes at all times, operational Managers, Senior Managers, and an Executive Director.

A5.2. In the event of a significant incident, internal command and control arrangements will be put in place with an Executive Director on-call as Strategic Commander leading the response for the Trust with the support of Tactical Commander(s). Operational Commanders will be responding at the scene.

A5.3 Other roles will be required to support the on-call staff during an incident and rotas will be developed dependent upon the size and complexity of it.

A5.3.1 Mersey Care Command Structure

A6. Incident Coordination Centre

A6.1 Each NHS organisation has the responsibility to provide a suitable environment for managing an emergency. This is known as the Incident Coordination Centre. It provides a functional space for making decisions and collecting and sharing information quickly and efficiently. It will serve as a focal point for all liaisons both internal and external. It will be equipped with robust and resilient IT and telecommunications.

A6.2 The function of an Incident Coordination Centre is to:

- Act as a focal point for everybody involved in the response to the incident
- Gain intelligence about NHS capacity and response
- Make that intelligence available
- Bring together all staff involved in responding to an incident (Incident Response Team)
- Facilitating handover between shifts
- Provide a single clear focus for the response
- Avoid staff being distracted by unrelated issues

A6.3 The Incident Coordination Centre (ICC) at V7 will have direct contact with the NHS England and the ICCs in the Divisions will be in contact with the strategic commander in V7.

A6.4 **The Trust primary ICC is located at:**
Room 16,
V7 Building
Kings Business Park
Prescot
Merseyside
L34 1PJ

A6.5 **Note:** There is one ICC within each Division. Their addresses and how they can be accessed are included in the on call packs.

A7 Incident Response Team (IRT)

A7.1 The Incident Response Team will include the following roles:

- Incident Director (Strategic commander)
- Incident Manager (Tactical commander)
- Support Manager (Head of Risk & EPRR or Senior Manager)
- Operational Manager (Operational commander)
- Operational Support Staff
- Public Health (as appropriate to the incident)
- Minute taker
- Administrator
- Loggist
- Communications Officer

A7.2 Other staff may be asked to support the Incident Response team by invitation by the Incident Manager, for example, HR, Estates or IT staff. The staff identified to support the Incident Response team will be determined by the type and size of the incident.

A8 Activation of the Incident Response Team

A8.1 The decision to establish an Incident Response Team rests with the Strategic on-call. For smaller incidents internal incidents, the Strategic on-call may decide to activate an Incident Response Team, the Tactical on-call must be made aware and informed.

A8.2 The Incident Response Team will form to provide support in the organisation's response to any incident.

A9 Crisis Management Team (CMT)

A9.1 A Crisis Management Team (CMT) can be established to deal with a prolonged crisis which could result in financial, legal and reputational damage to the Trust, but does not require a major incident response. The CMT will comprise of a number of senior members of the Trust who will convene at a pre-determined frequency. The members of the CMT also support the NHS Strategic Commander role and provide input to the Incident Response Team, therefore careful planning is required to ensure capabilities are not affected.

A10. Recovery and Restoration Team (RRT)

A10.1 The Trust recovery and restoration arrangements from an incident will form a vital component of the overall response. Whilst the Incident Response Team is dealing with the immediate issues affecting the Trust or its partner agencies, the Recovery and Restoration Team (RRT) will focus upon the consequence management of the incident including the identification of issues that could continue to disrupt the services provided by the Trust.

A10.2 The Recovery and Restoration Team would work closely with the Incident Response Team by holding regular briefing sessions.

A10.3 **Note:** The establishment of any of the teams highlighted above must be considered carefully due to limited number of resources within the Trust.

A11 Loggist

A11.1 The loggist will be required to complete the incident log. It is the responsibility of the commander managing the incident to ensure a log is kept detailing all relevant decisions made and actions taken.

A11.2 Entries are to be made in black ink, deletion of errors must be by use of single line through the text, which must remain legible for audit purposes and each change must be initialed.

A11.3 All details must be recorded contemporaneously, including:

- Date
- Time
- Situation
- Decision/ action taken by whom
- Reasons for this action
- Follow up actions and by whom
- Any other information relevant to the action/ decision.

A11.4 **Please note:** The Loggist is not a minute taker; other resources should be identified if this is required.

A12 Administrative Support

A12.1 Once Administrative support has been identified, the person(s) would move to the location identified by the Trust Strategic Commander and establish the Incident Coordination Centre (ICC), including:

- Laying out the room in the pre-determined manner.
- Set up and test all equipment (electronic, phones, etc.).
- Ensure the provision of enough stationery.
- Access to the Incident Control Centre during the silent hours

A12.2 **Note:** For a sustained response, the Trust will need to consider how staff will rotate through the Administrative Support role. Trust Tactical locations may also establish similar rooms/functions at their respective locations to assist with coordination.

A13 Switchboard

A13.1 Switchboard acts as the initial point of contact for internal and external agencies. Upon receipt of an initial message, the Switchboard Operator will:

- Take down as much information as possible Contact the Trust Strategic Commander immediately (keep trying until contact is made).
- Relay and confirm the information with the Trust Strategic Commander.
- Confirm if the Trust Strategic Commander requires any further assistance.
- Standby to record further information and provide support, as required.

A13.2 All media enquiries MUST be directed towards either the Communications Lead during normal working hours or the on-call Strategic or Divisional Tactical Commander, out of normal working hours.

A14 Record Keeping

A14.1 When responding to a significant incident people sometimes forget to keep records of what they are doing in the situation due to the level of work, stress, complexity and the challenging environment. However, record keeping is necessary to:

- Provide up to date information to people newly arrived at the incident room, e.g. when a new shift comes on duty – inform them of what has already been done and what has not been done.
- Provide evidence after the event to help us respond better to future incidents
- Provide evidence, if required, for internal or public reviews of the incident

A14.2 The types of records we keep during a major incident can be Chronological, personal, minutes and decision logs. Records can be recorded on message sheets, personal note books, computer records, flip charts, maps etc. Decision logs must always be recorded in the decision log book by a trained loggist.

A14.3 **Personal notes** should be contemporaneous which means that note should be made at the time or as soon as reasonably practicable thereafter. Contemporaneous notes are not in themselves evidence, but they can be used by a respondent to refresh his/her memory.

A14.4 **Decision log books** should be regarded as official documents. It is considered good practice that notes recorded should be:

- Factual – write nothing you would be unhappy to read out in court
- Made in ink – at the time of an event or as soon as is reasonably practicable
- Dated, signed and timed
- Original

A15 Battle Rhythm

A15.1 The frequency of meetings and timescales for collation of requested information (situation reports), or ‘battle rhythm’ must be established at the earliest opportunity. This will drive the process to enable the timely receipt of information to be collated and considered so that the person(s) leading the incident the can develop the response in support of the incident. (a template for situation reports (SitRep) can be found in Appendix A. . If the response is multiagency or wider NHS, the organisation will be required to take into account the battle rhythm set regionally or nationally by NHS England.

A15 Shift Arrangements

A15.1 In the event of a significant / major incident or emergency having a substantial impact on the Trust and the wider area population, it may be necessary to continue operating the incident response team for a number of days. Particularly, in the early phase of an incident the requirement may be for 24/7continuous operation.

A15.2 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 meetings and activities.

A15.3 When planning a shift system it should not require staff to operate for longer than 8-12 hours maximum due to the potential of the stress and fatigue with the subsequent deterioration of non technical skills in decision making.

A15.4 During shift changes, 1 hour handover time is required. A template of a handover/ takeover sheet can bee found in Appendix B.

SECTION B: Communications & Media

B1 Communications

B1.1 The overall communications strategy in a significant or major incident will be to provide effective, accurate and timely communications to the public, staff and other stakeholders.

B1.2 The following extract from the Emergency Preparedness Guidance to the Civil Contingencies Act illustrates the scope of the warning and informing duty –

- **Public Awareness** (pre-event):

Informing and educating the public about risks and preparedness

- **Public Warning** (at the time of an event or when one is likely):

Alerting by all appropriate means the members of a community whose immediate safety is at risk

- **Informing and Advising the Public** (immediate and long-term post-event)

B1.3 Providing relevant and timely information about the nature of the unfolding event:–

- Immediate actions being taken by responders to minimise the risk to human or animal health and welfare, the environment or property;
- Actions being taken by responders to assist the recovery phase;
- Actions the public themselves can take to minimise the impact of the emergency;
- How further information can be obtained; and
- End of emergency and return to normal arrangements.

B2 Communications Lead Officer

B2.1 When dealing with a wider NHS incident or multi-agency incident, a lead agency will be appointed for Communications. Any health related communications to press/media must be authorised by NHS England, any contact made with the Trust from local press or media outlets will be forwarded to NHS England Communications Team to ensure a consistent response.

B2.2 The Trust Strategic Commander based in the Incident Coordination Centre (ICC) will establish and maintain contact with the NHS England Tactical/Strategic Commander throughout the response phase. The NHS Tactical/Strategic Commander will provide a communications route to all other NHS and non-NHS Responders, e.g. Public Health England (PHE) at local, regional and national levels, where appropriate.

B2.3 If the Trust requires advice or support concerning an internal incident, contact should be made with the appropriate agency. (All agencies have 24/7 alert and response capability).

B3 Internal and External Communications Methods

B3.1 Communications methods that the Trust could employ include:

- Landline Phones.
- Mobile Phones.
- Fax.

- E-mail.
- Face to Face communications
- Internet/ Intranet.
- Staff briefings.
- Staff bulletins.
- Social Media.

B4 Lost Communications

B4.1 In the event of not being able to establish, or a loss of communications, the following alternative methods are to be considered for the passage of information:

- Mobile phones /SMS Text messages
- Alternative land line (BT line in Incident Coordination Centres)
- Analog Phone (in Incident Coordination Centres)
- Alternative broadband line (in Incident Coordination Centres)
- E Mail (3G & 4G connectivity)
- Fax
- Runner – consider lone working regulations

B4.2 The interrupted system should be continually tested until the landline is functioning again.

B5 Briefing Staff

B5.1 Regular staff briefings will be issued according to the severity and type of incident to ensure staff are aware of what is happening, what they can do to play their part and what to advise their patients. If there is information from a wider incident, expect agreed communication briefings to be provided by NHS England.

B5.2 Once commanders have made decisions and decided on actions, information must be relayed in a structured way that can be easily understood by those who will carry out actions or support activities. This is commonly known as briefing. When preparing a briefing it is helpful to consider the following:

- Brevity is important - if it is not relevant, leave it out
- Communicate using unambiguous language free from jargon and in terms people will understand
- Check that others understand and explain if necessary
- Consider whether an agreed information assessment tool or framework has been used

B.6 Staff working away from their office base

B6.1 It is essential that during a significant incident line managers are kept informed of their staff's whereabouts at all times.

B6.2 When a significant incident occurs many Trust staff may be away from their office base, working at a remote site, working in the community or off duty. All staff must contact their office base as soon as they are made aware of a significant or major incident. This is so they can:

- Assure their manager of their personal safety
- Inform their manager of their location
- Receive instructions from their manager about any changes to their duties arising from the incident

B6.3 During a significant or major incident, staff may be directed to work at locations other than their usual workplace. Examples include:

- Working at or near the site of the significant or major incident
- Working at an established survivor reception centre or rest centre at the request of NHS England
- Working in a different Trust department
- Working at another site managed by Mersey Care (e.g. if the site where they normally work is inaccessible due to the major incident)

B6.4 All staff working away from their normal location must inform their office base:

- When they come on duty
- If they are directed to work somewhere else
- When they go off duty

B7 Media

B7.1 During an emergency, the relevant Local Forum Media Protocol will be adopted by all agencies to provide advice and reassurance to the public.

B7.2 The protocol provides for all agencies issuing their own media statements on matters within their individual remit. Statements will be factually correct and restricted to confirmed information. All health related information must be authorised via NHS England before release to media.

B8 Mersey Care Media Protocol

B8.1 This area of emergency management requires careful and expert handling and the Trust has specific arrangements in place to manage communications during emergencies which are likely to produce significant media attention. These arrangements are intended to supplement national, regional and local arrangements defined in associated plans and protocols.

a) All media enquiries and interview requests will be channelled through the Executive Director of Communications and Corporate Governance. This is standard practice but the message to staff in the event of a major incident should be strongly reinforced to prevent unguarded and incorrect messages.

b) The Executive Director of Communications and Corporate Governance will discuss these with the Chief Executive or the nominated senior manager who may refer them to the Incident Response Team for discussion before a response is given.

c) Nominated spokespersons will be identified to ensure continuity in dealing with the media. Only these staff and the Executive Director of Communications and

Corporate Governance will have any communication with the media. Where more than one person is identified to act as spokesperson, contacts between these and the media should be strictly controlled and co-ordinated by the Communications Team.

d) Briefing and background notes to inform the understanding of the media in relation to the particular issue should be produced where relevant during the early stages of the event or in any available lead-up time to a likely event.

e) A list of appropriate people/organisations that need to be informed of the incident prior to and during media attention will be drawn up in the early stages and an outline of the situation transmitted to them.

f) Where a service user is involved, the service user and/or family will be kept fully informed before the media.

g) Early press statements will be prepared and press conferences arranged in order to take the initiative in dealing with and controlling media activity.

B9 NHS England Media Support

B9.1 NHS England can provide media support and advice 24/7, via england.northmedia@nhs.net during working hours and 0773 038 1690 out of hours or alternatively via NHS England 1st on call.

B10 Media Briefing Centres

B10.1 The Trust has a number of key locations identified as Media Briefing Centres, including:

- The Boardroom at V7 Building.
- Indigo Building at Ashworth for press conferences.
- Indigo Building for press use/wait.
- North Lodge Control for Police if appropriate. (North Lodge is the main staff and visitor entrance building at Ashworth).

B10.2 The locations, although identified, may not be suitable at the time of the incident, so alternatives may be used.

B11 Public Relations - VIP Visits

B11.1 VIPs may wish to visit the affected area, often at short notice. Visits are likely to involve the scene, the victims, including those in Local Authority care, and the staff and volunteers involved in the response.

B11.2 During the response to an incident or during the recovery stage, visits by VIPs can be anticipated. VIPs can include:

- Religious leaders.
- Local MPs, mayors and local authority leaders.
- A Government minister.
- Prime Minister.
- Royal Family members.

- Foreign nationals - Ambassador, High Commissioner or other dignitaries.

B11.3 Visiting ministers and other VIPs will require comprehensive briefing before the visit and will require briefing before any meetings with the media. VIPs are likely to want to meet service users who are well enough and prepared to see them. This will be dependent upon medical advice and respect for the wishes of individual patients and their relatives. In the case of such visits to hospitals it is common for VIP interviews to take place at the hospital/ ward entrance to cover how service users and medical staff are coping.

B11.4 VIP visits will be organised by the Police and Local Authority and will be co-ordinated via the Communications Team.

B12 Vulnerable Persons/ groups

B12.1 Given the sensitive nature of attempting any pre-identification of those who may be considered vulnerable, there is a reluctance to share specific details between agencies ahead of an emergency. Also, in the case of the Trust, the vulnerability of patients in most cases is time limited. Those who are deemed vulnerable will vary depending on the nature of the emergency.

B12.2 The Trust is able to and will share certain information with partner agencies in advance of an incident including:

- An indication of the type and indicative numbers of patients considered to be vulnerable.
- The method and format in which specific information will be shared in an emergency.

B12.3 During the early stages of an incident, the Trust will initially consider:

- Residential patients.
- Community patients.
- Staff.
- Visitors (including contractors).
- To identify persons who are or could be vulnerable and identify prioritised and appropriate care.

B12.4 More detailed analysis can include:

- Those who have mobility difficulties, including people with physical disabilities or a medical condition.
- Those with mental health difficulties.
- Pregnant women.
- Dependent persons, such as the elderly, babies and children.
- Limited or no use of English
- Deaf, blind and visually impaired or hearing impaired

B12.5 This information will be communicated via the respective Chief Operating Officer (COO) in normal working hours and the Divisional Tactical Commander(s), out of normal working hours, whilst maintaining patient confidentiality. Any external requests for information about vulnerable persons will be communicated in accordance with the relevant LRF Information Sharing Protocol.

SECTION C: ALERT AND ACTIVATION

C1 Activation of the Plan and Declaring Incidents

C1.1 The organisation can be notified of a significant incident or threat from a variety of sources including other Category 1 and 2 Responders; through the NHS England activation process and it is possible members of staff or the public may contact the Mersey Care directly to inform the organisation. However, to prevent inappropriate activation of the Major Incident Plan there will always be an assessment phase prior to activation.

C1.2 The Trusts' Strategic on call commander has the responsibility for activating the Major Incident Plan. Similarly, the Strategic on call commander or the nominated Strategic on-call Commander has the responsibility for declaring the incident closed and will instruct the Incident Response Team to notify partners to Stand Down.

C1.3 If the plan is activated then the Trust's own internal cascade procedure must then be activated to inform the required personnel.

C.1.4 In certain circumstances Mersey Care may independently declare a significant incident or emergency in the light of events or information received. The most senior person immediately available would normally do this.

C1.5 To avoid confusion about when to implement plans, it is essential to use these standard messages in relation to either **significant or major** incidents:

Standby	''Major incident standby'' alerts NHS organisations that a major incident may need to be declared and is likely to involve the participating NHS organisations in making preparatory arrangements appropriate to the incident.
Declared	''Major incident Declared'' - This alerts NHS organisations that they need to activate their plan and mobilise additional resources immediately.
Stand down	''Major Incident Stand Down'' alerts NHS organisations that the incident has been dealt with and they can implement their internal Stand Down procedures.
Cancelled	This message cancels either of the first two messages at any time. Non-NHS Responders do not recognise this term.

C1.6 Declaring a Significant Incident does not automatically mean every organisation will activate its plan in full or indeed at all. It is a method for alerting others to the seriousness of the situation, enabling immediate co-operation and implementation of communication links between responding organisations. Each organisation will have plans to assess the individual situation and respond accordingly.

C1.7 Mersey Care has 24 hour access to the NHS Tactical and/or Strategic Command if guidance or advice is necessary upon notification of an incident. The organisation also has 24 hour access to the CCGs in the event of a serious escalation issue.

C1.8 During the assessment phase of an incident, prior to activation of this plan, a decision will be made by a Strategic commander whether to call the NHS Tactical Command and/or the CCGs.

C2 Mersey Care On-Call and Escalation Arrangements

C2.1 The normal period of on-call duty depends on the arrangements in place for each Division. The rota will be subject to change during Christmas and Easter holiday periods or in the event of a protracted incident.

C2.2 The Operational on-call commander will be the first point of contact for any calls relating to incidents, whether internal or external, in hours or out of hours, and relating to minor or significant incidents.

C2.3 Staff making that first call, will use SBAR to gather and provide critical information. SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. (The full Internal Escalation template can be found in Appendix C.

Internal Escalation template (SBAR)	
Situation	Describe the situation/incident that has occurred
Background	Explain the history and impact of the incident on services/patient safety
Assessment	Confirm your understanding of the issues involved
Recommendation	Explain what you need, clarify expectations and what you would like to happen

C2.4 The Operational on-call commander will decide if they can deal with the call /incident or if they need to discuss with, or escalate to the Tactical on-call commander on call via Switchboard.

C2.5 Similarly, the Tactical on-call commander will decide if further escalating to the Strategic on- call Commander is required. The call will take place via Switchboard.

C2.6 If the Strategic on call commander decides to escalate the call to the NHS England, they will need to follow the steps above and consider the following:

a) Will or has the incident the potential to affect the wider health economy

b) Will or has the incident the potential to affect multi agency partners

c) Will Mersey Care require additional support from NHS England

C3 Initial Alerting

C3.1 The Trust may be alerted in a number of different ways to an incident occurring dependent upon the nature of the incident. These include:

- A call to the Operational manager on-call
- Information from any of the NHS organisations including Out of Hours services within Merseyside and Lancashire
- Information from NHS England
- Information from first responders, Police, Fire, Ambulance
- Information from Local Authority partners or other agencies e.g. United Utilities, Cadet Gas, Scottish Power

C3.2 Out of hours alerting will be initiated through the organisations' on-call system.

C4 Alerting and mobilising staff

C4.1 It may be necessary to reduce or suspend non-essential work in accordance with internal business continuity arrangements in order to create resources needed to support the overall response.

C4.2 Where it is clear that staff will need to be mobilised in the organisations' response to a significant incident, the responsibility will be delegated from the Incident Response Team.

C4.3 Staff who work in either a senior management role or a community role are provided with a mobile telephone. This would be the first method of contact to staff where there is an urgent need to mobilise staffing resources. Alternative methods for contacting staff could be by telephone, fax, SMS text messaging or email.

C4.4 **In response to a known large scale major incident, staff at home are NOT to self deploy. Should their services are required, a manager will contact them with clear instructions.**

C4.A M/ETHANE Alerting Model

The agreed alerting model for all Responders is METHANE:

- Major Incident declared?
- Exact Location
- Type of incident Hazards present or suspected
- Access - routes that are safe to use
- Number, type, severity of casualties
- Emergency services present and those required

When receiving the Major Incident Standby/Declared message, all those involved within the Trust, will use the M/ETHANE template form at Appendix D

C5 Staff Recall

C5.1 In the event of a major incident, staff are expected to respond outside their contracted hours, subject to their personal availability. This may include the introduction of shift working and may involve duties, which are different from their normal roles. The numbers and type of staff required will be co-ordinated by the organisation's Incident Response Team, who will delegate the responsibility to Divisional/ Team level. Out of hours, the duty staff on call will be responsible for staff

recall. Staff may be contacted through the business continuity arrangements outside of normal working hours and will be asked to bring their ID badge with them, particularly if they have patient facing roles.

C6 Mersey Care Plan Activation Considerations

C6.1 Mersey Care will need to consider the activation of its Major Incident Plan in a number of different circumstances, namely:

- An incident affecting the organisation only (Level 1)
- An incident affecting the wider NHS (Level 2)
- An incident which affects multi-agency partners (Level 3)
- An incident with national impact (Level 4)

Incident level	
Level 1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
Level 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.
Level 3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.
Level 4	An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.

C7 Criteria for Activating the Major Incident Plan

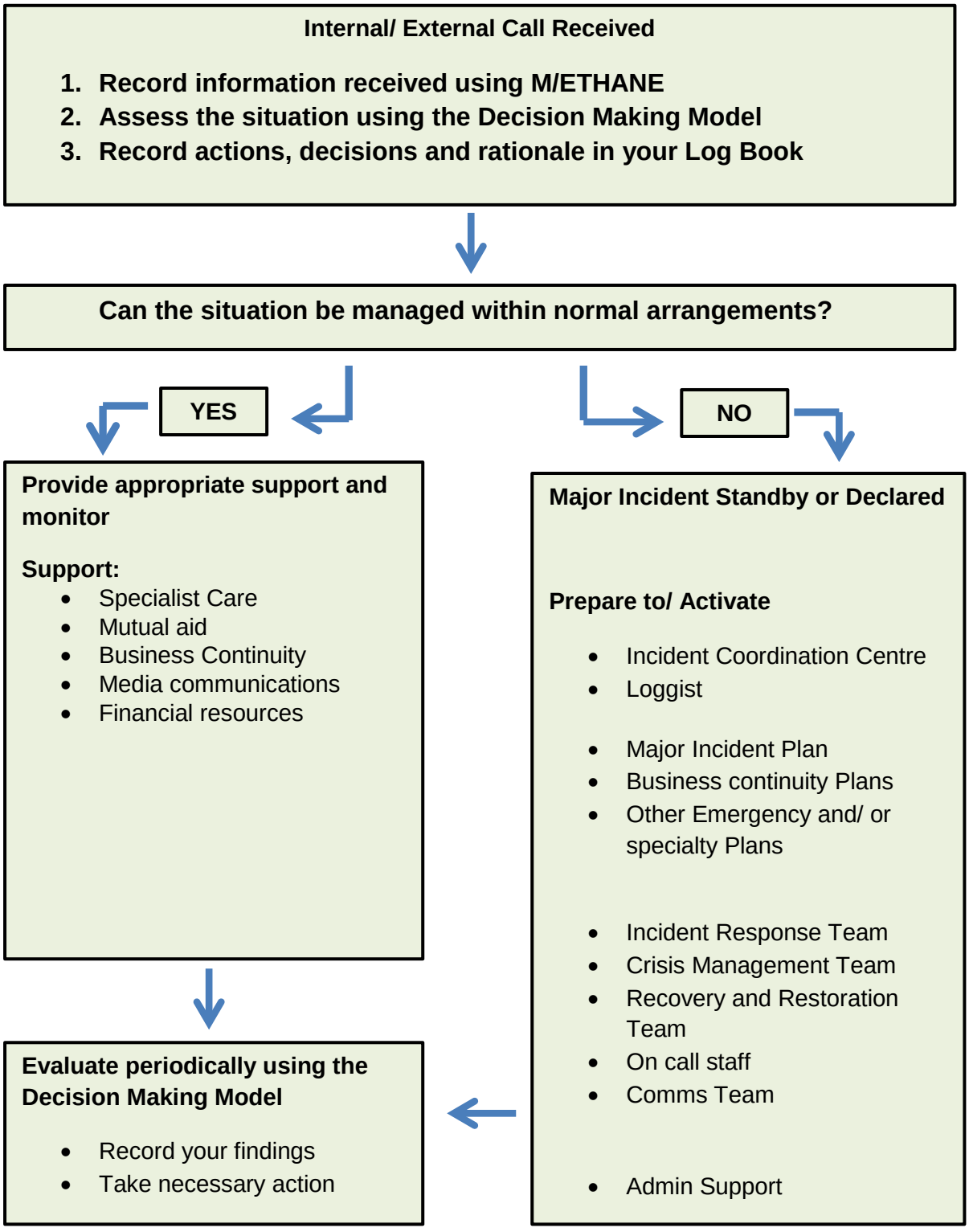
C7.1 The following list is not exhaustive but indicates the form of assessment that will be undertaken when the Tactical/ Strategic on call commander determines both the appropriate level of response and any subsequent escalation for activation of this plan.

C7.2 The Major Incident Plan will be activated when:

- An incident which cannot be managed by normal business continuity management e.g. the closure or evacuation of one or more health care premises, or major equipment failure, serious staffing issues.
- An incident causes serious disruption to one or more of the services provided by the Trust.
- An incident that results in exceptional increase in the demand for a service provided by the Trust and requires special arrangements to be put in place
- An incident that causes or could cause implications for partner organisations
- An incident occurs which represents a threat to public health or well-being or involves serious concern or alarm and is within the scope of the Trust to manager and contain

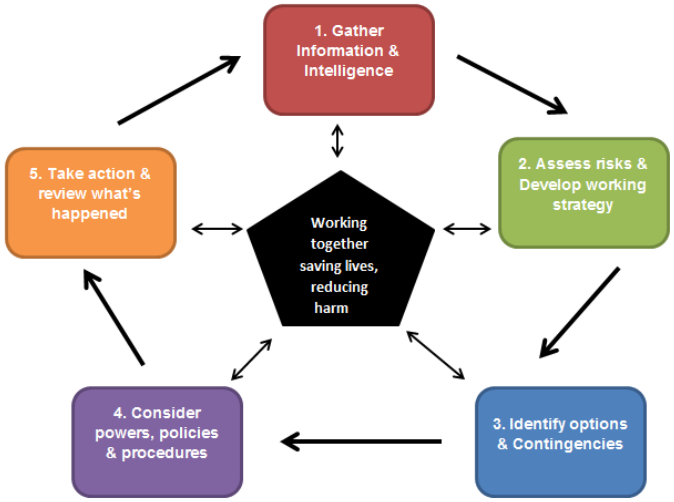
- There is a requirement for a co-coordinated response across Mersey Care boundaries
- There is a request from NHS England activation Team via the command and control structure

C7.2.1 Activation of the Major Incident Plan Flowchart



SECTION D: NATIONAL DECISION MAKING MODEL (DMM)

D 01 The National Decision Making Model (DMM) can be used as a framework for decisions 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 (template in appendix E).



D1 Gather Information and Intelligence

D1.1 During this stage you need to define the situation (what is happening or has happened) and clarify matters relating to any initial information and intelligence:

- What has happened?
- What is happening?
- What do I know so far?
- What further information do I need?

D2 Assess Threats and Risk

D2.1 Assess the situation, including any specific threat, the risk of harm and the potential of benefits:

- Do I need to take action immediately?
- Do I need more information?
- What could go wrong (and what could go well)?
- What is the likelihood of harm and how serious would it be?
- Is that level of risk acceptable?
- Is this an NHS only situation?
- Am I the appropriate person to deal with this?
- What are you trying to achieve? Develop a working strategy to guide subsequent stages

D3 Powers and Policy

D3.1 This stage involves considering what powers, policies and legislations might be applicable in this situation:

- What legislation applies?
- Does the Trust have the power to initiate action?
- Is there any guidance covering the situation?
- Do any NHS, LHRP or MRF plans or guidance apply?

D3.2 **As long as there is a good rationale for doing so, it may be reasonable to act outside of policy.**

D4 Identifying Options and Contingencies

This stage involves considering the different ways to make a particular decision (or resolve a situation) with the least risk of harm.

D4.1 Options

D4.1.1 What options are open to you?

D4.1.2 Consider the immediacy of any threat; the limits of information to hand; the amount of time available; available resources and support; your own knowledge, experience and skills; the impact of potential actions on the situation and the public. If you have to account for your decision, will you be able to say it was:

- Proportionate, legitimate, necessary and ethical?
- Reasonable in the circumstances facing you at the time?

D4.2 Contingencies

What will you do if things do not happen as you anticipate?

D5 Action and Review

The stage requires you to make and implement appropriate decisions. It also requires you, once an incident is over, to review what happened.

D5.1 Action

a) Respond

- Implement the option you have selected
- Does anyone else need to know what you have decided?

b) Record

- Rationale for your actions (what, when, why)

c) Monitor

- What happened as a result of your action?
- Was it what you wanted or expected to happen?

If the incident is continuing, go through the decision model as necessary.

D5.2 Review

If the incident is over, review your decisions, using the Decision model:

- What lessons can you take from how things turned out?
- What might you do differently next time?

SECTION E: BUSINESS CONTINUITY

E1 Business Continuity Arrangements

E1.1 Planning Business Continuity is a process which compliments the Major Incident Plan and extends beyond it. Business Continuity Management is an essential tool in establishing the organisation's resilience to maintain business critical activities and provides a framework for identifying and managing risks that could disrupt normal service. It addresses potentially serious disruptions in the services provided by the Trust that may not be of sufficiently high risk to trigger the Major Incident Plan.

E1.2 Each division will have identified critical services within their BIA that must be maintained during a disruption or interruption.

E1.3 Further information on dealing with a wide range of events can be found in Divisional/ Service Business Continuity Plans.

E2 Mutual Aid

E2.1 Mutual Aid is an agreement to lend assistance across neighbouring boundaries and partner organisations. This may occur due to a significant incident response that exceeds local resources. It can involve offering resources to help support partners e.g. man hours, materials etc. Prior to Mutual Aid being agreed, the Trust will take reasonable appropriate steps to assess that all services and supplies are self-protected during a Major Incident or emergency.

E3 Financial Resource

E3.1 The Trust will delegate authority to incur any necessary expenditure to the Trust Strategic and Tactical Commanders to use in an emergency. This is done via the Scheme of Delegation.

E3.2 It will be the responsibility of the Executive Director of Finance to establish a procedure for processing, recording and monitoring such expenditure in compliance with the requirements of the Standing Financial Instructions and reporting such expenditure accordingly.

SECTION F: Stand Down and Recovery

F1 Incident Stand Down

F1.1 For incidents managed within NHS England Command and Contro, NHS England North, Cheshire and Merseyside or Lancashire and Cumbria will inform all NHS Trusts when a significant incident is closed. The Strategic Incident Commander will have the responsibility of formally making the decision for the organisation to stand down, following consultation with key personnel and relevant stakeholders. The following matters will be taken into account in reaching this decision:

- The incident has been controlled
- The immediate needs of the affected people and the community have been met
- Immediate public concerns have been addressed

F1.2 This will result in a notification to the NHS Tactical Commander and to Mersey Care staff to 'stand down' from all emergency or alternative procedures.

F2 Hot Debrief

F2.1 As the incident is drawn to a formal conclusion, attention must turn to ensuring that a hot de-brief takes place. This hot debrief should consider what worked well and conversely what did not, along with wider lessons to be learnt from the incident. Lessons learnt will be reviewed to improve policies and procedures and incorporated into future planning and training. The Incident Tactical on-call manager should appoint a senior manager to supervise the completion of these tasks. If appropriate any lessons learnt from the incident should be shared with NHS England and/or CCGs and other key stakeholders and partners.

F2.2 More information on Hot Debrief can be found in section H.

F3 Formal De-brief

F3.1 It is vital that a senior officer be appointed to assume responsibility for ensuring that the recommendations listed below are undertaken as part of the Formal De-brief process, and that the records and files created with regard to the incident are collected, safely stored and, if required, produced for the revision of plans, the preparation of an official report or to assist with the gathering and preparation of evidence for any subsequent inquiry:

- The appointment of an officer to oversee the debriefing and recording process
- Apart from ensuring that all relevant areas of concern are formally addressed,
- Conduct formal review, feeding results into a review procedure.
- Evaluation of the response to the incident (including nominated staff to attend a multi-agency de-brief) on incident handling, issues and needs for improved future response.
- Assessing the continued health needs of those affected by the incident including psychological needs and the identification and referral route of any support services needed for staff, patients and relatives involved in the major incident. This may be delegated to the appropriate staff for continued assessment.
- Consideration of the effect of the incident on targets and services

- All relevant documents should be collected and a major incident report prepared. Patient confidentiality must be respected at all times.
- Careful, secure storage of all records relating to the incident. This should include all papers, logs and notes made during and related to the incident response.

F3.2 No copies of draft reports, incomplete messages or calculations should be discarded. ALL such papers must be retained.

- Consider the need for additional training to be undertaken by members of staff
- Identify on-going issues
- Consider the impact of the incident on the ability of the organisation to maintain or prioritise the delivery of its services
- Review Health & Safety issues
- Ensure that equipment and supplies used during any incident are appropriately replaced and replenished as required.

F3.3 More information on Formal De-Brief can be found in section H.

F4 Recovery Stage

F4.1 In the immediate and intermediate response phases, all NHS Trusts will focus on responding to the urgent and obvious needs of casualties. Longer-term actions can be planned and absorbed into normal services. Staff may need to re-establish contact with people seen in the immediate response phase to assess their altered health care needs (especially community staff). This is likely to be particularly valuable for people who received social or psychological support.

F5 Aftermath

F5.1 In many incidents, such as transport accidents, the ambulance service and acute hospitals take the operational lead. In the aftermath comes another role, of taking stock of the overall impact, and facilitating the restoration of normal health services. Tasks for Mersey Care could include:

- Extra support to hospitals or diversions of workload;
- Renegotiating priorities
- Assessing the continuing need for primary and community health services
- Liaison with social services and voluntary organisations;
- Checking that adequate arrangements have been made to protect the long-term health of NHS staff who may have been personally affected;
- Consideration of the legal and financial risks that might ensue.

F6 Social, psychological and Psychiatric Support

F6.1 Individuals, including staff, patients and relatives caught up in a major incident may need the supportive framework provided by social and psychological services in which they can come to terms with the effects of the disaster on their lives. Not only

does this rapidly get help to those who need it, but it may also reduce long-term and chronic demands on health and social services.

F6.2 There is a crucial role for properly trained mental health personnel in the treatment and support of victims of all ages, their families and carers, and of staff involved in the response. Support may be needed both in the immediate aftermath of the incident and in the longer term. Psychiatrists, psychologists, social workers and religious leaders may carry out this work.

F6.3 A system of triage will help to identify priorities and ensure that those who most need help receive it. Many people are best served by support from family and friends but some may need further professional help some time after the events.

F6.4 It is important to continue to assess the health needs of those affected by the incident including psychological needs, including the needs of staff.

F6.5 Mersey Care staff have access to counselling services via the Staff Support Service and other independent support organisations.

SECTION G: TRAINING AND EXERCISES

G.1 Mersey Care staff expected to deliver this Plan during an emergency should receive the appropriate level of training in its use. They should be confident in working with partner agencies where necessary for their role and be familiar with:

- Their roles and responsibilities.
- The strategic objectives for the Trust.
- The workings of the Incident Coordination Centre.
- The Command & Control arrangement.
- The decision making processes and recording.
- The integration points of other internal and external plan response, business continuity and recovery.

G.2 The Trust will attend suitable comprehensive multi-agency training and exercise programmes by invitation via NHS England or Clinical Commissioning Groups. High Secure Services will attend suitable multi-agency exercise programmes by invitation via the Home Office and Ministry of Justice.

SECTION H: LEARNING LESSONS FROM INCIDENTS AND EXERCISES

H1 Hot Debrief

H1.1 A hot de-brief is a lessons learned review carried out there and then after the incident or exercise, when all the key people are still present and any lessons learned can immediately influence future events. Minor details are not lost because of time delay, or a later emphasis on the bigger issues.

H1.2 The format of a hot debrief is very simple and quick- it is a "pencil and paper" or flipchart exercise. In an open and honest group discussion, usually no longer than twenty minutes, where each participant in the event discusses four simple questions:

- What was supposed to happen?
- What actually happened?
- Why were there differences?
- What can we learn from that?

H1.3 The major learning comes from comparing what was supposed to happen with what actually did happen. It is usually helpful to appoint a facilitator to guide people through these questions. If you experience a situation where there was no preconception of what should happen you could try discussing these two questions:

- What worked well and should be repeated in future?
- What did not work well and needs work now to improve?

H1.4 The drawback of a hot debrief is that people can be tired after an intensive period of work. Hot debriefs are often not needed after table top exercises because the learning lessons discussion usually takes place during the exercise itself.

H1.5 A Debrief template can be found in Appendix F.

H2 Formal De-brief

H2.1 A **Formal De-Brief** has the same basic objectives as a hot debrief, but it is convened at some point after the incident/ exercise and participants are allowed more time to identify the lessons to be learned. The cold debrief should be a face to face meeting ideally held within a couple of weeks of the event.

H2.2 The person coordinating the incident needs to attend, as do key members of the incident team, people responsible for preparing any plans used, and any other key stakeholders. It is necessary to appoint a facilitator, ideally someone who was not closely involved in the incident who can ask questions from an independent, but non-threatening standpoint. The facilitator should be briefed to acknowledge feelings and press for the facts.

H2.3 It is usually helpful to either:

- Go through the incident response step by step. Revisit the emergency/ BC plan and identify any deviation from it. What changed and why?
- Ask for specific feedback on a series of headings based on the key issues/areas e.g. notification, activation, joint working etc.
- Take notes for lessons to be learned action plan. Quotes may be recorded as required.
- Recommendations should be made with responsible agency to action

H2.4 The Facilitator can use these standard questions to encourage feedback from the participants:

- What did we set out to do?
- What went well?
- What were the successful aspects of the response?
- What could have gone better?
- What successful processes did we use?
- What were the stumbling blocks and pitfalls, so they can be avoided in future?
- What would your advice be to future teams, based on your experiences here?

H3 Multi-Agency Debrief

H3.1 The Trust must be prepared to attend and contribute to external NHS and where appropriate, a multi-agency debrief will also be held at a later date allowing sufficient time for participating agencies to hold internal debriefs. The objective of a multi-agency debrief is to:

- Agree on the basic principles of the actions taken during the incident.
- Identify lessons.
- Identify issues that may be subject to further review.
- Identify positive points of good practice.
- Identify areas of concern for future action.
- Complete an Action Plan identifying agencies responsible and timescales.
- Produce a Post Incident Report.

H3.2 The Police often chair multi-agency debrief meetings but the chair could be provided by the agency that declared the major incident or a senior officer of a lead agency who was not directly involved in the response.

ACTION CARDS

ACTION CARD 1: Strategic Commander (Gold on call)

Actions

Gather as much information as possible in relation to the incident and assess the situation (use the Decision Making Model)

Declare major incident/ standby

Ensure tactical commanders on call are aware of the situation and have set up the appropriate mechanisms to coordinate the response to the incident.

Activate external responders as appropriate (NHS England, CCG etc.) - Prepare Situation Reports as appropriate.

Activate the Incident Coordination Centre (room 16 at V7)

Convene a meeting with relevant directors/ senior managers, loggist and admin support.

Establish and communicate the 'Battle Rhythm'

Ensure communication strategy is developed - Work with Communications team for all media enquiries

Ensure there is a mechanism to get regular updates from each relevant Division/ Team.

Inform neighbouring NHS organisations / local authorities / social services as appropriate Work with local agencies as appropriate

Prioritise demands and allocate resources to meet requirements. Consider the need for additional resources and requesting mutual aid where appropriate

Consider the need for a shift system for the duration of the incident.

At the end of shift

Produce handover notes for the incoming shift (1 hour handover time is required).

Ensure all documents/records within the Incident Coordination Centre are tidy and filed according to the records management at the end of each shift

At the end of the incident

Authorise "stand down" - Activate "stand down" procedure and cascade to staff and key stakeholders

Conduct a hot debrief at the ICC and close ICC

Ensure cold debrief meetings are arranged and attend any external debriefs.

Compile the formal report on the incident including lessons learnt.

Hand all documentation to the Head of Risk & EPRR

ACTION CARD 2: Tactical Commander (Silver on call)

Actions

Gather as much information as possible in relation to the incident and assess the situation (use the Decision Making Model)

Note down in writing the key facts

Ensure operational staff on call are aware of the situation and have set up the appropriate mechanisms to manage the incident.

Notify the strategic commander - Prepare Situation Reports as appropriate.

Activate external responders where appropriate (NHS England, CCG etc.)

Activate the Incident Coordination Centre in your area and invite relevant managers. Ensure a loggist and support staff are in attendance.
(*The purpose of the meeting is to have overall coordination of the response and ensure priority tasks are agreed and actioned*).

Ensure there is a mechanism to get regular updates from each relevant team.

Ensure that the Strategic commander is kept fully briefed on actions and progress.

Ensure that media enquiries are directed towards the Communications Lead via Switchboard. (If the incident is taking place out of hours follow the communications strategy set by the strategic commander).

Consider the need for a shift system for the duration of the incident.

At the end of shift
Produce handover notes for the incoming shift (1 hour handover time is required).

Ensure all documents/records within the Incident Coordination Centre are tidy and filed according to the records management at the end of each shift

At the end of the incident
Authorise local “stand down” - Activate local “stand down” procedure and cascade to staff and key stakeholders

Conduct a hot debrief at the ICC and close ICC

Ensure cold debrief meetings are arranged and contribute to them

Ensure a report is compiled on the incident including lessons learnt

Hand all documentation to the Head of Risk & EPRR

ACTION CARD 3: Operational Commander (Bronze on call)
Actions Gather as much information as possible in relation to the incident (use SBAR) Assess the situation (use the Decision Making Model) Activate emergency response/ Business Continuity Plans Ensure staff in your area are aware of the situation. Warn and inform visitor/ public as appropriate. Set up the appropriate mechanisms to manage the incident. Notify the tactical commander or partner organisations as appropriate (e.g. police) Ensure that the tactical commander is kept fully briefed on actions and progress. Ensure that media enquiries are directed towards the Communications Lead via Switchboard.

ACTION CARD 4: LOGGIST

Work in conjunction with either the Strategic on-call or the Tactical on-call and to whom they are accountable to.

The loggist must use the log book provided (Green Emergency Log Book 101).

The log must be clearly written, dated and initialled by the loggist at the start of a shift and include the location.

All persons in attendance to be recorded in the log – clarify name and role.

The log must be a complete and continuous record of all issues/decisions/actions/ rationale as directed by the on call.

Ensure the on call agrees entries and signs the log at the end of the shift/ incident.

Once an incident has been stood down, gather all records and give to the on call.

Contribute to the post-incident debriefing sessions.

About Entries:
They must be timed and chronological
Begin each entry on a new line but ensure there are no complete line gaps between entries.
Unused space at the end of the series of entries must be ruled through with a Z then signed in full, dated and timed
All entries must be in black ink
Do not tear out pages from the book
Do not write in the margins
Initial any crossings out or mistakes you make
If you make a mistake whilst compiling your note, score through the mistake with a single line, initial it and insert the correct word after the error using red ink.
Do not include any assumptions, comments or opinions

ACTION CARD 5: COMMUNICATIONS LEAD

Confirm with the Strategic commander the nature and implications of the incident occurring/occurred – obtain a brief

Agree roles and immediate action with strategic commander and confirm:

- who you are supporting,
- what support is required and by when
- What media enquiries have been received already
- What warning and informing messages have been cascaded/ what other messages are required to who and when by

Establish contact with NHS England Communications team.

Inform NHS England, who the Communication Lead for the incident is – contact details to be given to them.

Ensure that media and staff know that all media enquiries are directed to yourself.

Respond to enquiries from the Press

Manage the media response to a major incident by liaising with the Strategic commander or Chief Executive regarding press arrangements.

In conjunction with the Chief Executive, Strategic commander and NHS England, prepare press briefings as appropriate.

Communicate briefings and updates to all staff so that they are aware of the incident and the response the organisation is providing.

Determine what continued commitment is required to maintain the continued longer term response

Contribute to post-incident debriefing sessions

APPENDICES

APPENDIX A: Incident Situation Report (SitRep) Template

Note: Please complete all fields. If there is nothing to report, or the information requested is not applicable, please insert NIL or N/A
The source, time and assessed quality of information should be reported. Uncertainties and working assumptions must be clearly identified

Organisation/ Exact Location of the Incident: **(if the incident is internal please state the Division and team)**		**Date:**	
Name (completed by):		**Time:**	
Telephone number:			
Email address:			
Authorised for release by (name & title):			
Type of Incident (please circle)	**Business Continuity Incident**	**Critical Incident**	**Major Incident**
Description of Incident			

Divisions/ Teams and other organisations reporting serious operational difficulties	
Impact/ potential impact of incident on services / critical functions and patients	
Business continuity arrangements	
Capacity/ Capability Issues	
Mitigating actions taken/ planned	
Media interest expected/received	

Media Lead Name **Telephone number/ Email**	
Mutual Aid Request Made (Y/N) and agreed with?	
Other Information	
Additional comments	
Incident Coordination Centre contact details: **Incident Manager:** **Telephone number:** **Email:**	

Appendix B: Handover/ Takeover Sheet

Incident Name:		**Date:**	
Handover Name:		**Time:**	
Telephone number:			
Email address:			
Takeover Name:			
Initial Overview	Type in or write overview:		
Current Situation			
Hazards and Risks			
Issues			
Priorities & Tasks			
Supporting Information • **Timings** • **Resources Deployed** • **Resources Required** • **Plans & Policies Invoked**			

Incident Log **Decision Log**	
Handover Complete: **Name** **Role** **Department**	Sign
Takeover Complete: **Name** **Role** **Department** **Contact Details** **Date & Time**	Sign

APPENDIX C: Internal Escalation Template – SBAR

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

Organisation/ Area:		**Date & Time**	
Name (completed by):		**Tel No**	
Situation	Describe situation/incident that has occurred		
Background	Explain history and impact of incident on services and patient safety		
Assessment	Confirm your understanding of the issues/ risks involved		
Recommendation	Explain what is needed, clarify expectations and what you would like to happen		

APPENDIX D: M/ETHANE Alerting Model

Please use this template to alert others or record the initial alert received.

Calling Organisation:		**Date & Time:**			
Name (completed by):		**Email address:**		**Telephone number:**	
Major Incident Stand By/or Declared					
Exact Location					
Type of Incident					
Hazards (Present or Suspected)					
Access Routes That Are Safe to Use					
Number, Type and Severity of Casualties					
Emergency Services Present and Those Required					

APPENDIX E: Decision Making Model (DMM) Template

Completed by: **Date:** **Tel:** **E-mail:**

Gather Information & Intelligence	Situational awareness • What has happened? • What is happening • What do I know so far? • What further information do I need?	
Assess threats & risks	• Do I need to take action immediately? • Do I need more information? • What could go wrong? • What is the likelihood of harm and how serious would it be? • Is that level of risk acceptable? • Is this an NHS only situation? • Am I the appropriate person to deal with this?	
Power & Policy	• What legislation applies? • Does the Trust have the power to initiate action? • Is there any guidance covering the situation? • Do any NHS, LHRP or MRF plans or guidance apply?	
Identify options & Contingencies	Consider: • The immediacy of the threat • The limits of available time, resources and support • The limits of your own knowledge, experience & skills • The impact of actions upon the situation and the public	
Action & review	**RESPOND** • Implement the option you have selected • Does anyone else need to know what you have decided? **RECORD** • Rationale for your actions (what, when, why) **MONITOR** • What happened as a result of your action? • Was it what you wanted or expected to happen?	

APPENDIX F: Debrief Template/ Lessons Learned Action Plan

Summary of Incident

Identified Learning from Incident

Notification			
What went well	Issues	Identified Learning	By whom / date

Command and Control/ Working Together / Battle Rhythm			
What went well	Issues	Identified Learning	By whom / date

Incident Response Providers			
What went well	Issues	Identified Learning	By whom / date

Communications / Media Management			
What went well	Issues	Identified Learning	By whom / date

Business Disruption			
What went well	Issues	Identified Learning	By whom / date

Recovery			
What went well	Issues	Identified Learning	By whom / date

Any other issues			
What went well	Issues	Identified Learning	By whom / date

APPENDIX G: Glossary

The following terms and references may be used in this plan or during an incident by Mersey Care or other agencies.

Term/acronym	Definition
A&D	Accident & Emergency
BCM	Business Continuity Management
BCP	Business Continuity Plan
CBRN(E)	Chemical Biological Radiological Nuclear (Explosive)
CCA	Civil Contingencies Act
CCDC	Consultant in Communicable Disease Control
CCG	Clinical Commissioning Group
CMT	Crisis Management Team
COBR	Cabinet Office Briefing Rooms
COMAH	Control of Major Accident Hazards
COO	Chief Operating Officer
CRR	Community Risk Register
DEFRA	Department for Environment, Food and Rural Affairs
DCLG	Department of Communities & Local Government
DH	Department of Health
DPH	Director of Public Health
EA	Environmental Agency
EPRR	Emergency Preparedness, Resilience and Response
FOI	Freedom of Information
FSA	Food Standards Agency
GLO	Government Liaison Officer
GLT	Government Liaison Team
GP	General Practitioner
HAC	Humanitarian Assistance Centre
HART	Hazardous Area Response Team
HazMat	Hazardous Materials
IC	Infection Control
ICC	Incident Coordination Centre
ICT	Information Computer Technology
IOR	Initial Operational Requirement
IM&T	Information Management & Technology
IRT	Incident Response Team
JCC	Joint Command Centre
JDM	Joint Decision Model
JRLO	Joint Regional Liaison Officer
JESIP	Joint Emergency Services Interoperability Programme
LA	Local Authority
LHRP	Local Health Resilience Partnership
LRF	Lancashire Resilience Forum
MoJ	Ministry of Justice
MOU	Memorandum of Understanding
MERM	Merseyside Emergency Response Manual
MFRS	Merseyside Fire and Rescue Service
MIP	Major Incident Plan

Term/acronym	Definition
MRF	Merseyside Resilience Forum
NHS	National Health Service
NME Comms	North Midlands and East Communications Service
NWAS	North West Ambulance Service
PHE	Public Health England
PODS	Portable Decontamination System
PPE	Personal Protective Equipment
RC	Reception Centres
RCCC	Regional Civil Contingencies Committee
RCG	Regional Coordinating Group
RHCD	Regional Health Control Desk
RRF	Regional Resilience Forum
RRT	Recovery and Restoration Team
SCG	Strategic Coordinating Group
SITREP	Situation Report
SLDS	Specialist Learning Disability Services
SRCs	Survivor Reception Centre
STAC	Science and Technical Advice Cell
TCG	Tactical Coordinating Group
UCAT	Urgent Care Action Team
VAS	Voluntary Aid Societies
VIP	Very Important Person
WIC	Walk in Centre

APPENDIX H: NHS definition of an Incident or Emergency & Types of Incidents

A. Definitions

Business Continuity Incident

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

Critical Incident

A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

Major Incident

A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

B. Types of Incidents

A significant incident or emergency to the NHS may not be any of these for the other agencies and equally the reverse is also true. An incident may present as a variety of different scenarios, they may start as a response to a routine emergency situation and as this evolves it may then become a critical incident or be declared as a major incident, examples of these scenarios are:

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

Business continuity/internal incidents – fire, breakdown of utilities, significant equipment failure, infections and violent crime

Big bang – a serious transport accident, explosion, or series of smaller incidents

Rising tide – a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action

Cloud on the horizon – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action

Headline news – public or media alarm about an impending situation, reputation management issues

Chemical, biological, radiological, nuclear and explosives (CBRNE) – CBRNE terrorism is the actual or threatened dispersal of CBRNE material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent

Hazardous materials (HAZMAT) – accidental incident involving hazardous materials

Cyber attacks – attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality

Mass casualty – typically events with casualties in the 100s where the normal major incident response must be augmented with extraordinary measures

APPENDIX I: Equality and Human Rights Analysis

Title: Mersey Care Foundation Trust Major Incident Plan
Area covered: Trust wide

What are the intended outcomes of this work? This plan covers the following:- • A major or significant incident which affects the local community. • A major or significant incident which threatens the continuity of critical Trust services. • A major incident which affects the health services in Merseyside/Lancashire and/or beyond. • A multi-agency major incident requiring a coordinated health service response in Merseyside/Lancashire and/or beyond. The plan is supported by additional emergency plans and business continuity plans at divisional and local levels.
Who will be affected? All staff and service users. Partner stakeholders. Potentially members of the public.

Evidence
What evidence have you considered? The Plan
Disability (including learning disability) None identified
Sex Nothing noted.
Race None identified
Age None identified
Gender reassignment (including transgender) Nothing noted.
Sexual orientation Nothing noted.
Religion or belief Nothing noted.
Pregnancy and maternity Reference noted in relation to vulnerability as above on page 28.
Carers Nothing noted
Other identified groups Nothing noted
Cross Cutting Nothing noted

Human Rights	Is there an impact? How this right could be protected?
Right to life (Article 2)	Plan is supportive of the protection of life.
Right of freedom from inhuman and degrading treatment (Article 3)	Not engaged.
Right to liberty (Article 5)	Not engaged.
Right to a fair trial (Article 6)	Not engaged.
Right to private and family life (Article 8)	Policy is protective of personal confidentiality.
Right of freedom of religion or belief (Article 9)	Not engaged.
Right to freedom of expression **Note: this does not include insulting language such as racism (Article 10)**	Not engaged.
Right freedom from discrimination (Article 14)	Not engaged.

Engagement and Involvement
No engagement or involvement within this process.

Summary of Analysis
Eliminate discrimination, harassment and victimisation The plan seeks to ensure that all people within a major incident are protected. This includes specific reference to staff who may be involved.
Advance equality of opportunity Nothing indicated
Promote good relations between groups Nothing indicated

What is the overall impact
Plan not noted to be directly or indirectly discriminatory and is respectful of people's human rights.

Addressing the impact on equalities
There needs to be greater consideration re health inequalities and the impact of each individual development /change in relation to the protected characteristics and vulnerable groups

Action planning for improvement
None identified

For the record
Name of persons who carried out this assessment: Steve Morgan Christiana Vasiliou Burt Burtun
Date assessment completed: 31 January 2018
Name of responsible Director: Trish Bennett
Date assessment was signed: