Mersey Care
NHS Foundation Trust

Community and Mental Health Services

# Emergency Shelter and Accommodation Plan for inpatient Mental Health and Learning Disabilities Services

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|---|---|
| **Plan Number:** | **IRP06** |
| **Scope:** | **All staff in Local Division and specialist learning disabilities services<br>Corporate services<br>Executive Directors** |
| **Recommending Committee:** | **EPRR Group** |
| **Approving Committee:** | **Executive Committee** |
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**2020 – Version 1**

***Striving for perfect care and a just culture***

## Emergency Shelter and Accommodation Plan for inpatient Mental Health and Learning Disabilities Services

### Further information about this document:

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|---|---|
| Document name | Emergency Shelter and Accommodation Plan for inpatient Mental Health and Learning Disabilities Services |
| Document summary | This plan aims to provide a non prescriptive framework for Mersey Care staff to respond to an incident which will require decant of inpatient mental health learning disabilities patients. This includes the event of a full site evacuation. |
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| To be read in conjunction with | **IRP00 - Major Incident Plan**<br>**SA08-Fire Safety Policy** |
| **This document can be made available in a range of alternative formats including various languages, large print and braille etc** | |
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### Version Control:

| | | Version History: |
|---|---|---|
| Version 0.1 | Document created | October 2019 |
| | | |

## 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

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## 1. Background

1.1 The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients.

1.2 The organisation has procedures for evacuating areas of a facility in the event of major disruptions. These should be aligned with the organisation's incident response and business continuity plans. The total evacuation/decant of a facility would, however, be considered **only under extreme circumstances**. In such circumstances the decision to decant would be made locally taking into account:

- the overall risk to patients;
- appropriate safe transport and patient-tracking mechanisms; and
- a suitably resourced destination.

1.3 The organisation owes a duty of care to both their patients and their staff and therefore healthcare providers should be aware and understand that it is not the responsibility of the emergency services to decide to evacuate an NHS facility; this responsibility rests with the organisation under whose care the patient(s) are under. NHS organisations have responsibilities under:

- Health and Safety at Work Act 1974, (section 2(1) and (section 2(2)
- The Management of Health and Safety at Work Regulations 1999 (regulation 3), (regulation 4 and Schedule 1), (regulation 8(1)), (regulation 8(1)(a) and (b)) and regulation 4(4)
- Safety Signs and Signals Regulations 1996
- Regulatory Reform (Fire Safety) Order 2005 (article 14(1) and (article 14 (2)
- Department of Health Fire code guidance (HTM 05-01)
- Regulated Activities Regulations Section 9 sub section (2), Section 7 sub section (1 and 2) and Section 10 sub section (2)

## 2. Aim

2.1 This plan aims to provide a non prescriptive framework for Mersey Care staff to respond to an incident which will require decant of inpatient mental health and learning disabilities patients. This includes the event of a full site evacuation.

## 3. Scope

### 3.1 Context

3.1.1 This plan applies to clinical and non clinical members of staff employed by Mersey Care NHS Foundation Trust who would potentially be involved in any phase of the process.

3.1.2 The activation of this plan must take into account:

- The Trust's Major Incident Plan
- The Trust's Fire Safety Policy (where applicable)
- Local Business continuity plans
- Local evacuation procedures.

### 3.2 Out of scope

3.2.1 The evacuation process for each site is out of this document's' detailed scope. Staff should refer to their local evacuation procedures.

3.2.2 Secure services are also out of scope.

## 4. Glossary

4.1 **Command** is defined as; "The exercise of vested authority that is associated with a role or rank within an organisation, to give direction in order to achieve defined objectives)".

4.2 **Control** is defined as **"**The application of authority, combined with the capability to manage resources, in order to achieve defined objectives."

4.3 **Co-ordination** is defined as "The integration of multi-agency efforts and available capabilities, which may be interdependent, in order to achieve defined objectives."

4.4 **Decant** is the temporarily transfer (people) to another place.

4.5 **Evacuation** is defined as "Removal, from a place of actual or potential danger to a place of relative safety, of people and (where appropriate) other living creatures."

4.6 **Horizontal Evacuation** means moving away from the area of danger to a safer place on the same floor as the individual(s) is on. If fire is the cause of evacuation, movement should be to the next fire compartment section on that floor (i.e. through at least one set of fire doors)**.** If necessary those who have evacuated horizontally may need to consider a vertical evacuation.

4.7 **Vertical Evacuation** means using a stairwell, or lift to move to either the floor above or below, as appropriate, to move away from the area of danger to a safer place.

4.8 **Shelter** is defined as "a place giving temporary protection". It may be necessary to move patients into temporary shelters until such time as they are able to return to the affected healthcare facility, or until they are able to be transported to another healthcare facility.

4.9 **Shelter in place/ Invacuation:** In certain situations the safest place to take refuge or cover is to remain in the current location. This is often referred to "shelter-in-situ" or "invacuation".

4.10 **Vulnerable/vulnerability:** Vulnerability can generally be defined as affecting those that are less able to help themselves or who are unable to be 'self-reliant', however, it is diverse and can also be the result of one or more external factors coming together simultaneously that creates vulnerability in some people who

were previously not vulnerable.

## 5. Activation Triggers

5.1 This plan will be activated when an internal or external incident poses significant risk to the safety of patients and staff on site and which will lead to an emergency partial or whole site evacuation. Such incidents are:

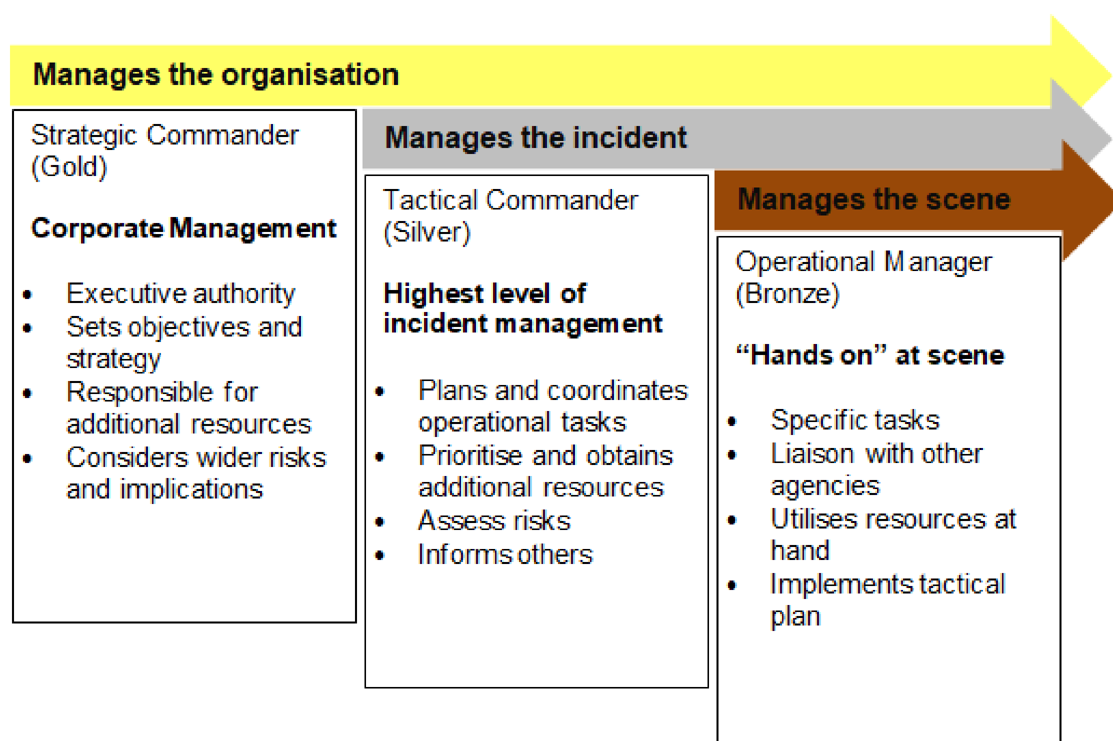
- Power and other utility failure
- Explosion or suspect package
- Flooding
- Fire
- Irritant fumes or hazardous materials release
- Terrorist event

## 6. Command, control and co-ordination

6.1 In the event of an emergency decant, the organisation will convene an Incident Response Team in the Incident Coordination Centre at strategic and tactical level to ensure monitoring, co-ordination and suitable communications from top to bottom and bottom up.

6.2 The command, control and coordination of the incident will take place in three tiers as per the organisation's current structure and arrangements which are outlined in detail in the Trust's Major Incident Plan.

6.3 The table below summarises the duties of each incident commander during emergencies.



## 7. Roles & Responsibilities

### 7A Internal

*staff with on call duties should refer to previous section**.**

**7.1 Executive Director of Nursing and Operations/ Strategic commanders (gold on call)**

As the Trust's Accountable Emergency Officer, the Executive Director of Nursing and Operations is accountable for:

- Deciding when, and in what form, command and control arrangements need to be initiated
- Ensuring Divisional Tactical and Operational Managers are taking appropriate action to maintain continuity of service and the safety and well-being of service users, staff and visitors
- Ensuring internal and external stakeholders are briefed

**7.2 Chief Operating Officer/ Tactical Commanders (silver on call)**

The Chief Operating Officer is responsible for:

- Ensuring that managers and team leaders are taking appropriate action to maintain continuity of service and the safety and well-being of service users, staff and visitors
- Considering all options for the identification of suitable emergency accommodation as soon as possible
- Activate the transport call out procedure
- Consider staffing requirements during and after decant
- Coordinate requests and
- Situation reports are produced and forwarded as appropriate
- Where applicable tactical commanders of more than one Division in the Trust, to liaise and cooperate to discuss internal solutions.

**7.3 Nurse in Charge or most senior manager on scene/ Bronze on call (OOH)**

The Nurse in Charge or most senior manager on scene will be managing the scene until the operational manager arrives. They are responsible for:

- Taking a leading role in the implementation of local evacuation protocols, ensuring that patient, staff and visitors safety during the process
- Ensuring that the incident is escalated as appropriate and in a timely manner both internally and to emergency services (if applicable)
- Ensuring that all patients, staff and visitors are accounted for
- Risk assess patient group prior to decant and share information as appropriate.– bronze

**7.4 Fire Marshals**

Fire Marshals will support the Nurse in Charge with the following:

- Ensure that the emergency services have been contacted
- Meet and greet emergency vehicles on arrival
- Facilitate accounting for everyone (roll call)
- Control people and vehicle movement
- Provide site information to emergency services

7.5 **All staff on ward**

All staff employed in an inpatient setting or visit inpatient areas must ensure that they are aware of and understand the arrangements within their workplace and of the action to take in the event of an incident and on hearing the fire alarm.

7.6 **Transport team**

Once the Emergency Evacuation Transport Call out Procedure is invoked by silver, the transport team will:

- prioritise the transfer of patients from the affected area to the new accommodation
- Liaise with the Medicines Management Team for delivering patient's medication supplies to their new accommodation.

7.7 **Medicines Management Team**

During an emergency evacuation, the Medicines Management Team will:

- Ensure that information on patients medications will be retrieved
- Liaise with silver and transport team for the delivery of patient's medication to their new accommodation (if appropriate).
- Liaise with receiving organisation (if external).

**Estates & Facilities Team**

7.8 The Estates & Facilities team will:

- ensure that sleeping arrangements in temporary areas are supported with the provision of catering services, spare mattresses, linen, blankets etc.
- Liaise with emergency services regarding the recovery of the affected site.

## 7B Partner organisations

7.9 **North West NHS England / NHS Improvement**

The regional NHS England/ NHS Improvement have the responsibility to lead the mobilisation of the NHS in the event of an emergency and coordinate the response to an incident 24/7 as appropriate.

7.10 **Police**

The police will normally co-ordinate all the activities of those responding at and around the scene of the emergency. The saving and protection of life is the priority, but as far as possible the scene must be preserved to provide evidence for subsequent enquiries and possible criminal proceedings.

7.11 **Fire and Rescue Service**

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

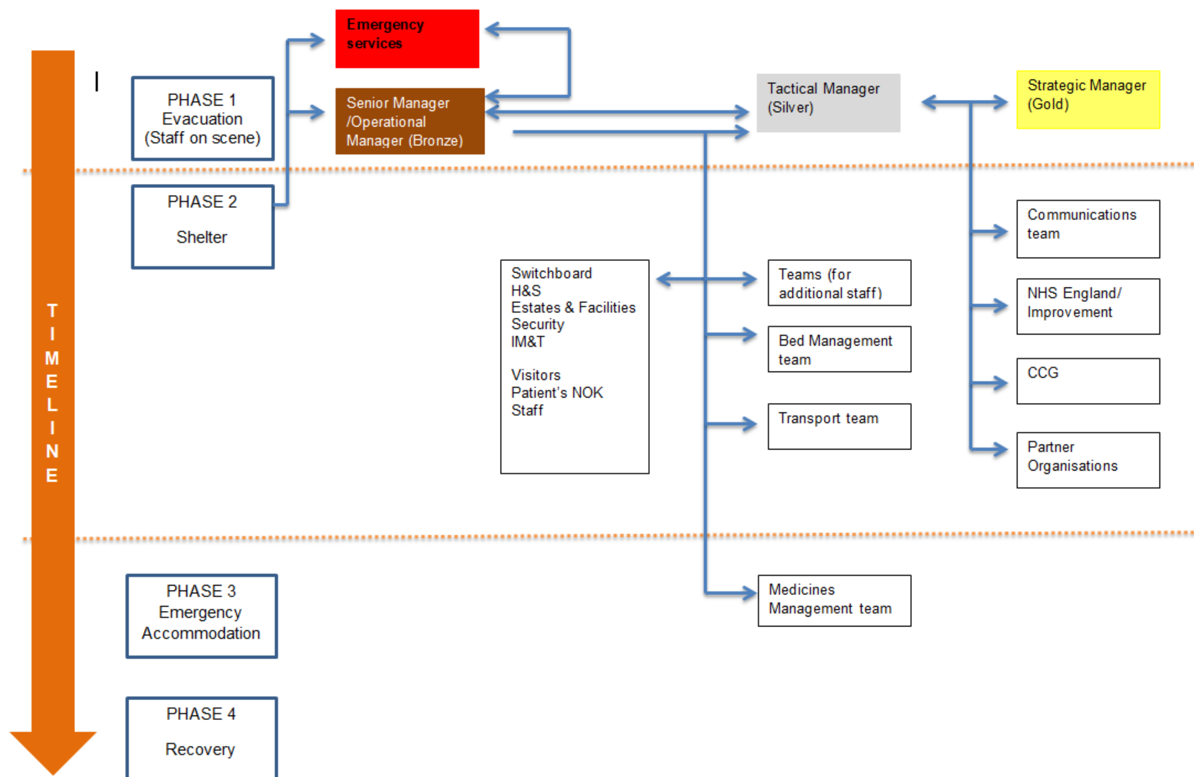
7.12 **North West Ambulance Service (NWAS)**

If necessary, NWAS will attend the scene of the incident, providing on site healthcare, decontaminating casualties where necessary (the Fire and Rescue Services would assist by decontaminating affected individuals if they are not ill or injured), and transporting injured patients to hospital.

## 8. Alert & Escalation

The flowchart below illustrates the alerting and escalation process of the incident to key stakeholders.

**Where applicable tactical commanders of more than one Division in the Trust, to liaise and cooperate to discuss internal solutions.**




## 9. PHASE 1: Whole or partial site evacuation

9.1 **Evacuation** is defined as "Removal, from a place of actual or potential danger to a place of relative safety, of people and (where appropriate) other living creatures."

9.2 For health and social care providers there are three primary levels when evacuation may be necessary or should be considered. This plan will be triggered at a Level 3 evacuation which is defined as "The situation where there is an immediate threat to life or safety (no advance warning provided)".

9.3 Partial evacuation (horizontal or vertical) will remove individuals away from the immediate threat whilst they take refuge in a different part of the building (shelter in place).

9.4 If moving away from the area of danger to a safer place within the site is no longer an option then staff and service users will move outside the building to the meeting

point which is also identified in local evacuation protocols/ plans.

## 10 PHASE 2: Shelter

10.1 In the initial stages of evacuation a number of ‘shelter in place’ locations should be considered to include options both on-site, as well as healthcare settings and non-healthcare settings off site.

10.2 Shelter in place should be considered for no-notice events when:

- there is no time to undertake an evacuation before the hazard arrives;
- going outside would expose people to greater harm or dangerous conditions; or
- the immediate risk is unclear.

10.3 On-site shelter points should take into account local fire compartment planning. Off-site shelter points should reflect an area of safety, away from the unit, where people can wait until they are re-directed to a different location (if necessary).

10.4 Due to the nature of services provided within Mersey Care, staff should aim to identify a suitable emergency accommodation as soon as possible and limit patients’ stay at temporary shelters to the minimum.

## 11 PHASE 3: Emergency Accommodation

11.1 As soon as it is clear that the site will be unrecoverable for a time, senior management must identify alternative locations which will accommodate patients for as long as needed.

11.2 The length of time patients will spend in emergency accommodation will depend on the suitability of the contingency, the availability of a similar to their original unit environment and the recovery time of the site they were evacuated from.

**Risk assessment**

11.3 Each unit would need to carry out a risk assessment on their patient group prior to any decant and establish where it would be most appropriate to move which patient to. They could then be clear about which area would be the most appropriate to provide the support depending on the risks identified.

11.4 Included in this risk assessment would also be consideration of how long the service will remain out of commission.

**Triage & Clinical decision making**

11.5 It is the responsibility of all healthcare staff to do the most for the most during an incident involving the evacuation of patients. In-patient clinical staff in charge will have a key role prioritising their in-patients for inter- hospital transfer if required. Triage assists with making decisions on whom to evacuate and in what order and needs to be a dynamic process.

11.6 During triage the following must be determined to enable operational and clinical decisions:

- resources required for decant,
- the mobility of patients and time needed to move patients
- the risks to patients of them being moved or remaining in situ
- the needs and particular requirements for patients in seclusion
- the type of shelter and equipment required,
- the length of time it will take to facilitate the relocation and
- the type of transport required for off-site evacuation.

11.7 The national ambulance service major incident triage card system (TSG Associates Smart cards) was adapted to assist with evacuating patients (see table overleaf).

11.8 The evacuation triage algorithm uses mobility and dependency to determine the evacuation triage priority, categorising patients into the groups: Very Dependent, Dependent, and Independent. Given the nature of services provided within Mersey Care, staff must ensure that this information is highlighted to emergency services that might be called to the scene.

**Tracking and identification of evacuated patients and staff**

11.9 Tracking is necessary to track the movement of all patients and staff from their originating department or ward to a place of safety (even if interim), other health location or outside of the area (Appendix B).

**Healthcare Evacuation Triage priorities**

| Evacuation Priority* | Category | Triage Card Colour (if used) | Definition |
|---|---|---|---|
| Evacuation Priority 1 | Very dependent | Red | a. patient is under section mental health act<br>b. patient requires 2 staff to effect evacuation<br>c. patient is of such a weight as to require the assistance of 3 or more staff to effect evacuation<br>d. patient is unconscious and in life threatened state<br>e. patient can only be moved on his/ her bed<br>f. patient is in critical condition/attached to more than 1 piece of apparatus<br>g. patient is unconscious<br>h. patient is blind or deaf or has other extra-ordinary communication needs<br>i. patient is on assisted ventilation |
| Evacuation Priority 2 | Dependent | Yellow | a. patient can only move on his/her bed<br>b. patient is connected to 1 piece of apparatus ( e.g. drainage bag)<br>c. patient must be moved in a wheelchair by another person<br>d. patient requires more than minimal assistance or is unwilling to be dressed in adequate clothing requiring therefore 1 or more persons to assist<br>e. patient has dementia to the extent that they cannot be left without supervision<br>f. patient can walk unaided for less than 5 metres<br>g. patient has severe sight impairment or severe hearing impairment |
| Evacuation Priority 3 | Independent | Green | a. patient can mobilize by him/herself in a wheelchair<br>b. patient can walk unaided at less than normal pace<br>c. patient has significant sight or hearing impediment<br>d. patient can walk at same speed and for same distance as a member of staff<br>e. patient can get out of bed and dress in adequate clothing with none or minimal assistance |
| ***Determined by mobility and dependency** | | | |

**Transport**

11.10 The following vehicles and drivers available via the organisation's facilities:

- Volkswagen Caravelle6 Seats
- Volkswagen Caravelle6 Seats
- Volkswagen Caravelle6 Seats
- Ford Tourneo 8 Seats
- Ford Tourneo 8 Seats (Based at MSU)
- Ford Tourneo 9 Seats
- Mercedes Vario 11 Seats (High Risk Vehicle)
- Mercedes Vario 11 Seats (High Risk Vehicle)
- Mercedes Vito 8 Seats
- Mercedes Vito 8 Seats
- Ford Transit Mini Bus 11 Seats
- Ford Transit Mini Bus 9 Seats
- Renault Master Wheelchair 5 Seats
- Renault Master Wheelchair 5 Seats

11.11 There are 24 staff trained to transport patients of which 3 are on call covering mental health services 24/7. All other drivers are available to cover emergencies.

11.12 The transport call out procedure can be found in Appendix A

11.13 Other possible sources of transport can be sourced via the activation of mutual aid agreements which include:

- Statutory ambulance service
- Taxi / private transport

**Staffing**

11.14 It is very likely that additional staff will be required to assist with the process and for the transfer of patients to other facilities. All options must be considered via command and control.

**Facilities and equipment**

11.15 If a temporary sleeping area needs to be created then a plan will include numbers of patients requiring sleeping arrangements in what area. Spare mattresses will be moved from storage areas and any other spare mattresses sourced from wards which may include seclusion mattresses if necessary. Bedding will need to be brought over from the linen stores and available.

11.16 The areas on the route to the temporary accommodation and the designated room will need to be cleared of any risk items and a security check carried out prior to receiving the identified patients.

**Access to Medication**

11.17 There is the possibility, particularly during emergency evacuations, that information on patient medications would be recovered through staff and electronic clinical systems notes. For areas utilising EPMA, that information can be retrieved by the Medicines Management team or a partner site.

## 12 PHASE 4: Recovery

12.1 Planning for business continuity and recovery must start as soon as possible, ideally during the evacuation stage, although it will be dictated by the circumstances at the time. Early consideration of recovery and patient repatriation options including the strategic opportunity to plan for a new normality will ensure a smooth transition through each phase of the incident.

12.2 There are four areas to consider in this stage:

| | |
|---|---|
| **Humanitarian** | Patient repatriation/return<br>Ongoing patient care<br>Updates to patients, families, and visitors<br>Displacement of staff to other healthcare sites, both within and outside the Trust [welfare, travel costs, providing managerial support and visibility<br>Psychological support |
| **Economic** | Insurance<br>Incident costs<br>Landlord / tenant agreements & responsibilities<br>SLAs with partner agencies / Trusts<br>Provision of supplies / equipment where Trust inpatients are in other healthcare Trusts<br>Budget arrangements |
| **Environmental** | Site clean-up requirements [Pollution or contamination – specialist companies required]<br>Waste |
| **Infrastructure** | Repair / rebuilding site<br>Consideration of leased modular buildings / trailers to provide specific areas, such as treatment rooms, Operating Theatres and Imaging facilities<br>Site security |

## 13 Communications

13.1 Communication and sharing information will be vital at all stages of the incident. Staff involved in the incident response must utilise all possible methods for communication with patients, visitors, other clinical and non clinical staff, external agencies and partner organisations.

13.2 This type of incident is likely to attract media attention which should be directed to the Trust's communication Team or the most senior manager involved at the time.

## 14 Training and Exercising

14.1 To verify that personnel have been made aware of this plan, and to validate that the plan is effectively embedded across the organisation, a series of exercises will be conducted periodically.

## 15 Monitoring

15.1 Characteristics of the plan will be monitored and analysed where appropriate.

15.2 Monitored information includes:

(a) Number of incidents that have invoked a formal response.

(b) Number of exercises completed (to help ascertain the comprehensiveness).

(c) The Executive Director of Nursing & Operations will provide assurance that effective arrangements are in place to the Board of Directors and NHS England as part of the annual self assessment on the EPRR Core standards.

## 16 Consultation

16.1 The following Trust representatives have been consulted in the development of this policy:

a) Executive Director of Nursing & Operations
b) Key stakeholders represented via EPRR working group
c) Local Division senior managers
d) Specialist Learning Disabilties Division senior managers
e) Police

## 17 References

17.1 NHS England Guidance: "Planning for the Shelter and evacuation of people in healthcare settings"
https://www.england.nhs.uk/wp-content/uploads/2015/01/eprr-shelter-evacuation-guidance.pdf

## Appendix A - Emergency Evacuation Transport Call out Procedure

The need to request collection of Staff, Pharmacy, Goods and/or Patients due to an evacuation is identified:

a) The operational manager on site or staff in charge will report to their Chief Operating Officer for information and agreement (if out of hours, then contact the tactical commander (silver) on call).

b) The Chief Operating Officer or the tactical commander (out of hours) will contact the Transport services following risk assessment.

c) In hours, the Transport Department can be contacted directly on **0151 472 4089**.

d) Out of hours the request must go via the High Secure Services Duty Managers on: **0151 471 2235**. The Secure Division Tactical Commander will be informed and make the appropriate arrangements with the Transport Department.

To be considered prior to request:

1. Number of vehicles required
2. Reason for use
3. Access to site
4. Please be aware patients must be risk assessed before traveling.

Please note that there are 3 drivers available out of hours, although more can be deployed during an emergency.

**If more than 3 vehicles are required simultaneously, then the caller is advised to request assistance as soon as possible.**

## Appendix B – Tracking and identification of evacuated patients and staff proforma

| Tracking and identification of evacuated patients proforma | | | | |
|---|---|---|---|---|
| Patient name: | | | | |
| Date | Number of Staff Required | Description of Incident/status of building | Current location | |
| | | | | |
| Time | Call received from | Discharged (Y/N) | Transport and Time of Arrival | |
| | | | | |
| Description of Patient being transferred – Mental Health Act Section | | Any other Requirements (catering/pharmacy/equipment) | Site/ area of transfer | |
| | | | | |
| Completed by | | | Signature | |

## Appendix C – Action Cards

## ACTION CARD 1 – NURSE / SENIOR PERSON IN CHARGE

| (red) | IMMEDIATE ACTION | (amber) | SECONDARY ACTION | (green) | FOLLOW UP ACTION | ✓ | COMPLETED |
|---|---|---|---|---|---|---|---|

| | ACTION | ✓ |
|---|---|---|
| (red) | **ON DISCOVERY**<br>Raise the alarm.<br>Adhere to fire evacuation process if applicable.<br>Escalate using internal escalation process.<br>Support decision making and mobilisation of staff in a safe and secure manner.<br>Prioritise and manage any situations of concern.<br>Identify any high risk health needs.<br>Prepare to assimilate and disseminate information including dynamic risks assessments on service users prior to any relocation.<br>Support the planning /mobilisation process of relocating service users.<br>Ensure that clinical information is available and is maintained appropriate to the on-going dynamic situation. | |
| (red) | **FEEDBACK OF ASSESSEMENT INFORMATION**<br>Feedback of assessment information to the next tier (Silver in hours – Bronze out of hours) | |
| (red) | *Inform and record your actions to this point.* | |
| (red) | **PATIENT and STAFF SAFETY**<br>Prioritise the safety of all groups within the incident – this may be Patients, Staff or Visitors | |
| (amber) | **CONTAINING AND MANAGING THE INCIDENT**<br>Following relocation, liaise and appraise receiving staff re clinical profiles and health needs both individually and collectively. | |

## ACTION CARD 2– Operational Commander / Bronze

| | IMMEDIATE ACTION | | SECONDARY ACTION | | FOLLOW UP ACTION | ✓ | COMPLETED |
|---|---|---|---|---|---|---|---|

| | | ✓ |
|---|---|---|
| (red) | **ON BEING INFORMED**<br>Attend the scene.<br>Escalate using internal escalation process.<br>Co-ordinate with on scene staff.<br>Identify the forward rendezvous point for emergency services if applicable to the dynamic situation.<br>Prioritise and manage any situations of concern.<br>Co-ordinate with the emergency services on scene commander.<br>Co-ordinate the operational aspects of the evacuation or containment.<br>Co-ordinate with support services e.g. Utilities, Estates, and Facilities etc.<br>Provide relevant information to staff to support mobilisation of staff and service users when relocation is required.<br>Communicate with tactical commander to warn and inform of the requirement to invoke the emergency shelter and accommodation plan.<br>Ensure that media enquiries are directed towards the Communications Lead via Switchboard. | |
| (red) | **FEEDBACK OF ASSESSEMENT INFORMATION**<br>Feedback of assessment information to the next tier | |
| (red) | *Inform and record your actions to this point.* | |
| (red) | **PATIENT and STAFF SAFETY**<br>Prioritise the safety of all groups within the incident – this may be Patients, Staff or Visitors | |
| (orange) | **CONTAINING AND MANAGING THE INCIDENT**<br>Remain at the scene until instructed otherwise by the next tier / escalation level. | |

## ACTION CARD 3 – Tactical Commander / Silver

| | IMMEDIATE ACTION | | SECONDARY ACTION | | FOLLOW UP ACTION | ✓ | COMPLETED |
|---|---|---|---|---|---|---|---|

| | | ✓ |
|---|---|---|
| | **ON BEING INFORMED**<br>Escalate using internal escalation process.<br>Maintain an incident log.<br>Establish the incident control room.<br>Reallocate the on call responsibility for all other services to a separate manager.<br>Establish a battle rhythm appropriate to the ongoing dynamic situation.<br>Conduct risks assessments in relation to the clinical profiles and health needs of the service users affected.<br>Ensure staff are adequately supported and welfare needs are considered.<br>Coordinate transportation requirements.<br>Seek assistance from the emergency services appropriate to the dynamic situation. | |
| | **FEEDBACK OF ASSESSEMENT INFORMATION**<br>Feedback of assessment information to strategic commander - Prepare Situation Reports as appropriate. | |
| | *Inform and record your actions throughout.* | |
| | **PATIENT and STAFF SAFETY**<br>Prioritise the safety of all groups within the incident – this may be Patients, Staff or Visitors. | |
| | **CONTAINING AND MANAGING THE INCIDENT**<br>Liaise with strategic commander – Gold as per the set battle rhythm.<br>Ensure receiving staff have clinical profiles and health needs both individually and collectively. | |

## ACTION CARD 4 – Strategic commander / Gold

| | IMMEDIATE ACTION | | SECONDARY ACTION | | FOLLOW UP ACTION | ✓ | COMPLETED |
|---|---|---|---|---|---|---|---|

| | | ✓ |
|---|---|---|
| | **ON BEING INFORMED**<br>Receive information from Tactical Commander / Silver.<br>Declare Major Incident/ Standby<br>Support, consider, authorise and action decisions as appropriate.<br>Inform Executive Team, NHS England and CCG.<br>Inform and liaise with partner organisation's strategic stakeholders.<br>Prioritise demands and allocate resources to meet requirements. Consider the need for additional resources and requesting mutual aid<br>Coordinate and maintain the overall communication strategy.<br>IWork with local agencies as appropriate | |
| | **FEEDBACK OF ASSESSEMENT INFORMATION**<br>Feedback of assessment information to NHS England / NHS Improvement | |
| | *Inform and record your actions throughout.* | |
| | **PATIENT and STAFF SAFETY**<br>Ensure the prioritisation of the safety of all groups within the incident – this may be Patients, Staff or Visitors | |
| | **CONTAINING AND MANAGING THE INCIDENT**<br>Liaise with tactical commander / Silver as per the set battle rhythm.<br>Liaise with partner organisations as appropriate. | |