Northern Devon Healthcare Trust

MAJOR INCIDENT PLAN

IF A MAJOR INCIDENT HAS BEEN DECLARED
DO NOT READ THIS PLAN NOW BUT REFER TO YOUR ACTION CARD
## Document Control Report

### Title
MAJOR INCIDENT PLAN

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Foreword by the Chief Executive

This major incident plan outlines the strategic and operational arrangements implemented by Northern Devon Healthcare NHS Trust in response to a major incident.

As Chief Executive, I accept executive responsibility for Emergency Planning as defined by the Civil Contingencies Act (2004).

This plan has been prepared in accordance with the Civil Contingencies Act, 2004 and the NHS Emergency Planning Guidance 2005. It brings together arrangements recommended in “Handling Major Incidents: An Operational Doctrine” and it also incorporates the lessons learned from:

- responses to actual incidents
- participating in exercises
- operational changes that impact on individual areas
- the development of off-site plans with other agencies

All staff should familiarise themselves with the content of this plan, not only to as part of their preparation for an incident response but to feed back useful information and suggested improvements. The information contained within it offers guidance and gives direction but every incident will require staff to display flexibility, professionalism and initiative.

By the very nature of major incident plans and arrangements, this plan will be subject to frequent review and amendment (as necessary) - to reflect the changeable requirements both within the NHS and within our local community.

This Major Incident Plan has been adopted and approved by the Trust Board.

Jac Kelly
Chief Executive
Northern Devon Healthcare NHS Trust
# Northern Devon Healthcare Trust
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1. INTRODUCTION

The Civil Contingencies Act (CCA) 2004 places a statutory duty on all designated responders in NHS organisations with respect to their role in the management of Major Incidents. The CCA sets out clear expectations and responsibilities for front line responders at the local level to ensure they are prepared to deal effectively with the full range of emergencies from localised incidents through to catastrophic emergencies.

Northern Devon Healthcare NHS Trust is designated as a Category 1 responder under the CCA and is subject to the full set of civil protection duties. These are to:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place business continuity arrangements;
- Put in place arrangements to make information available to the public and maintain; arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance coordination and efficiency.

In addition, the NHS Operating Framework for 2010/2011 makes specific reference to emergency preparedness under paragraph 2.8 and 2.37. These sections identify that all NHS organisations should give high priority to putting in place and testing plans and arrangements to deliver an effective response to threats and hazards.

This document outlines the Major Incident Plan for Northern Devon Healthcare NHS Trust.

1.1 SCOPE

All staff should be aware of the existence of the plan and of their general responsibilities when responding to a major incident. These may be found in Section ?. Staff that have a named designated role in the plan should be aware of the detail of the plan and the relevant action card. Staff and departments that have other designated roles and responsibilities in the plan should be aware of the existence of the plan and their action cards. An introduction to the plan will form part of Trust induction.

The NDHT Major Incident Plan links to the following Major Incident Plans:

- South West Strategic Health Authority
- NHS Devon
- South West Ambulance Services NHS
- Devon County Council

1.2 DEVELOPMENT OF THE PLAN

The plan is developed and reviewed by the Major Incident Planning Group, under the leadership of the Divisional General Manager for Medicine and A&E. The plan is reviewed annually, unless there is significant new central guidance in the interim, or in response to lessons learned from tests, exercises or internal incidents.

1.3 THE MAJOR INCIDENT PLANNING GROUP AND BOARD REPRESENTATION

The Major Incident Planning Group provides the Board with regular reports including an annual report, a specific statement relating to the emergency preparedness including reports on exercises, training and testing undertaken by the organisation and that adequate resources are made available to allow discharge of these responsibilities. The Director of Operations and a nominated non-executive director are designated to take responsibility for emergency preparedness on behalf of the organisation.
Membership of the Major Incident Planning Group, as detailed in this plan includes:

- Director of Operations
- Divisional General Manager, Medicine (or deputy)
- Consultant in Emergency Medicine
- ED Matron
- Risk and Incident Manager
- Consultant Anaesthetist
- Health and Social Care representative
- Head of Learning and Development
- Deputy Estates Manager (or deputy)
- Health and Safety Manager
- SWAST representative

The Major Incident Planning Group reports to the Director of Operations.

1.4 AUDIT

1.4.1 Care Quality Commission

Major incident planning, training, exercising and testing is monitored under the Care Quality Commission Essential Standards of Quality and Safety, Outcome 6 (Co-operating with other Providers) and Outcome 4 (Care and Welfare of People who use Services).

1.4.2 Internal audit

The Major Incident Plan and supporting arrangements are audited by Internal Audit Department.

1.4.3 External audit

The Trust participates in national and regional audits and surveys of its emergency planning arrangements.
2. BACKGROUND

2.1 DEFINING A MAJOR INCIDENT

This section describes various definitions of emergencies and major incidents as they may apply to the Trust, including North Devon District Hospital and all community sites. It describes the varying scale of major incidents and the alerting mechanism to be used in the event of a major incident.

2.1.1 Definition: the Civil Contingencies Act 2004

The Civil Contingencies Act 2004 defines an emergency as:

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

The definition is concerned with consequences rather than the cause or source and what is a major incident to the NHS may not be a major incident for other local agencies. A major incident is any event whose impact cannot be handled within routine service arrangements. It requires the implementation of special procedures by one or more of the emergency services, the NHS, or a Local Authority to respond to it.

A major incident may arise in a variety of ways:

- **Big Bang** – a serious transport accident, explosion, or series of smaller incidents
- **Rising Tide** – a developing infectious disease epidemic, or a capacity/staffing crisis
- **Cloud on the Horizon** – a serious threat such as a major chemical or nuclear release developing elsewhere and needing preparatory action
- **Headline news** – public or media alarm about a personal threat
- **Internal incidents** – fire, breakdown of utilities, major equipment failure, hospital acquired infections,
- **Deliberate release of chemical, biological or nuclear materials**
- **Mass casualties**
- **Pre-planned major events that require planning - demonstrations, sports fixtures, air shows.**

For the NHS, a major incident is defined as:

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

NHS organisations are accustomed to normal fluctuations in daily demand for services. Whilst at times this may lead to facilities being fully stretched, such fluctuations are managed without activation of special measures by means of established management procedures and escalation policies.

**Using the above definitions, it is the responsibility of the Duty Executive, in conjunction with the Duty Manager, to determine whether a major incident is declared by NDHT.**

2.1.2 Levels of Major Incident

The levels of incident are defined as:
Level 1 - Major incident (affecting the Health Service):

‘Any occurrence which presents a serious threat to the health of the community, disruption to the service, or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance services or health authorities’

*Home Office - Dealing with Disaster (3rd Edition)*

Level 2 – Mass casualty incidents

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

Level 3 - Catastrophic incidents

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

*Dept of Health - Handling Major Incidents: An Operational Doctrine*

2.1.3 Internal Incidents

“An incident within hospital premises that warrants special arrangements for the co-ordination, command and control of the situation, by senior representatives of the organisation. “

Serious situations affecting small numbers of patients and staff may also be co-ordinated in this manner, if deemed appropriate. However, responses to escalating emergency pressures are not covered by this plan.

NDHCT must plan to handle incidents in which its own facilities - or neighbouring ones – may be overwhelmed. The organisation itself may be affected by its own internal major incident or by an external incident that impairs its ability to work normally. Fire, breakdown of utilities, major equipment failure, hospital acquired infections, violent crime or the need to deal with one or more contaminated person(s) may paralyse the provision of services and jeopardise safety arrangements. Planning successfully for these wider disruptive challenges will require more than simply scaling up the current plans of individual agencies.

NDHCT can self-declare a major incident when their own facilities and/or resources, or those of its neighbours are overwhelmed.

In addition, there are pre-planned major events, for example, demonstrations, sports fixtures, air shows, etc. that may require a response. There may also be events occurring on a national scale, for example fuel strikes, disease pandemic or multiple events that require the collective capability of the NHS nationally.

2.2 RISK ASSESSMENT

The Local Resilience Forum for Devon, Cornwall and the Isles of Scilly has reviewed all risks, as detailed in the Community Risk Register, as at Annex 2.

Local risks identified which could result in implementation of the Trust’s Major Incident Plan are:

- A large road traffic accident or other transport accident
- Incident at RMB Chivenor or Territorial Army Headquarters in Barnstaple
- Terrorist incident
- Fire and/or explosion incident
- Severe weather, including flooding
• Industrial accidents or incidents
• Large disruptive incident (e.g. lack of power supply) on Trust premises

2.3 BUSINESS CONTINUITY

Business continuity management forms an important part of risk management arrangements and is a requirement of the Civil Contingencies Act 2004. The aim of business continuity management is to ensure that NHS organisations are able to maintain the highest level of critical services possible whilst managing the appropriate incident response. There are a range of problems that might affect NHS organisations and services at any time, for example, loss of water or power, fire incidents flooding, or criminal action, or from within an organisation for example, systems failures, loss of key staff.

Business continuity management, including processes for recovery and restoration, should be considered by NHS organisations as part of its every day business processes requiring a corporate response. Business continuity should be seen as embedded in the culture of the NHS as are principles of health and safety, and there must be demonstrable commitment to the process from the Boards of NHS organisations.

All Directorates and Divisions of the Trust have identified their core services and critical functions. All have completed business impact analyses and ensured that contingency plans are in place to address identified risks and to return to business as usual. Departmental staff who are not involved in providing core services may be required to support other services in a major incident response. The NDHT business continuity plan (critical services prioritisation plan) in the event of a major incident is available within the Emergency planning section on Tarkanet. The prioritisation plan will be reviewed annually. Departmental contingency plans will be reviewed annually.

2.4 TRAINING AND EXERCISING

The Chief Executive is required to ensure that arrangements are in place to enable adequate training, exercising and testing of emergency planning arrangements and that the Board receives regular reports, at least one annually, regarding this. The Emergency Preparedness Lead has overall responsibility for training and exercising but this is largely delegated to the Major Incident Planning Group.

Training for a major incident involves a significant investment in cost, time and resources. Nevertheless, to effectively manage an incident, this organisation must be fully committed to training for responding to major incidents or business continuity issues. A comprehensive training strategy will ensure that staff are confident in their roles. Major incident training will reflect normal good training practice and will vary from general awareness to specific training for staff with key roles. The Head of Learning and Development, as a member of the Major Incident Planning Group, is responsible for development of emergency planning training.

As a minimum requirement, NDHCT will be required to undertake:

• A ‘live’ exercise every three years
• A ‘table top’ exercise every year
• A test of communications cascades every six months

The Emergency Preparedness Exercise Lead at NDHCT will formulate an annual plan for the process, supported by appropriate documentation and record keeping and allows for post exercise reporting and debriefing, and report back to the Board. Attendance Records will be placed on the Electronic Staff Record (ESR).
Every effort will be made by the Trust to ensure participation in multi-agency exercises and tests. Participation in such events is at the approval of the Director of Operations. Other agencies will be invited to participate, as appropriate, in any exercise or testing organised by NDHT.

A testing and exercise schedule is appended at Annex 1.

**2.4.1 ‘Live’ and tabletop exercises**

A nominated representative from the Major Incident Planning Group will co-ordinate with all local agencies who have a role in the response to a major incident [Police, Fire, Ambulance, Military, Transport] and plan a live exercise with mock casualties involving at least one of these agencies every three years.

The Major Incident Planning Group representative will also co-ordinate with the key areas within NDHCT ED, theatres, ITU, receiving ward, other wards, hospital control team, Clinical Site Managers involved in implementing the plan to hold a table top exercise with one of these areas every six months.

The Trust will participate in regular relevant multi-agency table top and live exercises throughout the peninsula.

The Major Incident Planning Group representative will provide a report to the board after each exercise.

**2.4.2 Test of communications cascade**

Each area of the Trust is responsible for ensuring they have a call-out telephone number cascade for all members of staff who are expected to respond in the event of a major incident. This list should be updated on a three monthly basis.

The Devon, Cornwall and Isles of Scilly, Local Resilience Forum Health Issues Group (formerly Health Emergency Preparedness Group) will co-ordinate, through the Chair, a six monthly major incident call out cascade. The approximate date will be announced at this group and the Emergency Planning lead at NDHCT will be informed of the ‘approximate’ date for the test. The message will be activated through SWAST ambulance control to all key health areas. The message will come to switchboard at NDDH for NDHCT. The message used will be explicit that this is a cascade exercise.

The switchboard will then activate the equivalent of the ‘Major Incident Declared’ call out cascade (see Alert procedure p.11) with the message:

**‘Exercise only – Major Incident Exercise. Test your call out cascade’**

All areas must then activate their call out cascade with the message

**‘This is an exercise only. If a major incident should be declared, would you be available to respond?’**

Leads for each area will collate the number of staff available to respond and document on the Major Incident Staffing Availability Sheet (Appendix 2) and feed this information to the Emergency Planning Lead who will provide a report to the board.
2.5 LEGAL ASPECTS OF A MAJOR INCIDENT

In a major incident situation, the Trust must continue to ensure, so far as is reasonably practicable, the health, safety and welfare of all staff involved as required by the Health and Safety at Work Act (1974), Section 2. There is also a general duty to continue to ensure, so far as is reasonably practicable, that persons not in the Trust employment are not exposed to risks to their health and safety as required by the Health and Safety at Work Act (1974), Section 3.

During the major incident response, there is a requirement for a dynamic risk assessment and action planning process, to ensure risk are minimised. This is a requirement of the Management of Health and Safety at Work Regulations 1999.

The Trust must ensure that reports are made to the Health and Safety Executive where significant incidents or accidents, as defined under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), have occurred.

There is a quantifiable risk that a major incident is caused deliberately as a criminal act. Thought should be given to the implications of forensic evidence collection. Thus where a criminal act is suspected clothing cut from individual patients should be stored separately in separate paper bags (allocated to each casualty). Plastic bags should not be used as they degrade forensic evidence. The Police will advise of the need to undertake this higher level of evidence collection. Likewise Pathology will need to be informed regarding tissue samples. Contemporaneous notes should be made of all relevant decisions and acts and all administrative decisions are recorded.

It is essential that records be kept of all relevant documents, log books, message books and administrative decisions. These documents will come under close scrutiny when a report is prepared after the incident.

In addition, each decision maker associated with the Control Room must have their own trained Loggist. These Loggists must detail each decision made in the Emergency Log Book in line with the information on the Loggist Action Card. Action Card No.10.
2.6 STANDARD MESSAGES USED BY NHS ORGANISATIONS

To avoid confusion about when implementing the NDHCT MI plan, it is essential to use these standard messages:

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

- **Major incident declared – activate plan**
  This alerts NHS organisations that they need to activate their plan and mobilise additional resources.

- **Major incident – cancelled**
  This message cancels either of the first two messages at any time.

- **Major incident - stand down**
  All receiving hospitals are alerted as soon as all live casualties have been removed from the site. Where possible, the Ambulance Incident Officer will make it clear whether any casualties are still en-route. While ambulance services will notify NDHCT that the scene is clear of live casualties, it is the responsibility of the Trust to assess when it is appropriate to stand down.

2.7 CALL OUT CASCADE & STAFF RESPONSE

Each area of the Trust is responsible for ensuring they have a call-out telephone number cascade for all members of staff who are expected to respond in the event of a major incident. This list should be tested and updated on a three monthly basis.

Trust personnel are expected to make reasonable efforts to attend the site if called in to do so in response to a major incident. It is understood that not everyone will be in a position to do so and staff should only come in if fit for duty. Generally, staff sleeping after night duty should not be called in the first instance. Each area will ensure that consideration is given to staffing subsequent shifts as well staffing the immediate response. A major incident is an extra-ordinary event and there is no expectation that extra-ordinary processes set in action in response to a major incident would thereafter form part of ‘routine’ duties.

Staff will need their Trust identification to access the site so this identification should be carried by individuals and not be left at the hospital. Any member of staff without a specific role identified in the Major Incident Plan may be deployed to undertake roles as required by the control room in support of the response to the Major Incident.
3.0 GENERAL INSTRUCTIONS FOR STAFF

IT IS THE RESPONSIBILITY OF EACH MEMBER OF STAFF TO ENSURE THAT THEY KNOW WHAT ACTION THEY SHOULD TAKE IN THE EVENT OF A MAJOR INCIDENT:

3.1 General Information

- **Switchboard** is out of bounds to everyone, with the exception of members of the Incident Control Team. Where essential calls have to be made, use the contact portal or dial the direct number.
- **Telephone calls** must be restricted to those essential to dealing with the major incident and other patient care. Staff may phone home if the incident occurs near the end of a shift to warn relatives of possible late arrival or to make alternative arrangements.
- **Lifts must not be used**, except for the essential movement of patients and equipment.
- **Portering** - all requests must be directed to the Incident Control Team. Ambulance personnel must not be used as porters within the Hospital.
- **Catering** - requests for refreshments and sandwiches may be requested from Sodexo.
- **Emergency Vehicles’ Access** - emergency vehicles and other vehicles associated with the major incident will be directed to the Emergency courtyard outside of A&E in the first instance. A one-way system will be in operation. Vehicles will be directed to park in suitable areas.
- **Parking** - Staff are to park in the usual staff car parks and are to keep all access roads free for emergency vehicles and patient car parks free for relatives and visitors.

**Support for Staff and Patients**

- Many of the Hospital’s staff will not have experienced a major incident before and understandably some may show signs of stress. Be aware of the signs of stress in your colleagues and yourselves.
- A proportion of patients involved in a major incident will suffer from psychological trauma. Staff giving additional support to such patients may find other patients demanding equal support.
- Debrief sessions for all staff should be held at the end of each shift and be conducted by Ward Managers/Heads of Departments or the person in charge of the off-going shift.
- Access to Occupational Health’s staff counselling service is available for staff that request it.

3.2 Record Keeping

- Records must be kept on all actions, logging events as they happen.
- It is essential that a comprehensive record is kept of all events, decisions and actions taken - in order to facilitate operational debriefing and to provide evidence for inquiries.
- It is also essential that all treatment is recorded in the patients’ hospital notes and PAS up-dated to reflect any changes.
- Good record keeping also allows lessons to be learnt from the response to an incident, whether or not there is a formal inquiry.

3.3 Identification of Staff

- **Staff are to wear their ID badge at all times.** Failure to do so may result in a delay in gaining access to critical areas. Staff should not leave their ID badges at their place of work, as they may be required to present them on arrival at work in an incident.
- In an incident situation staff should report for duty wearing their normal uniform. This will prevent confusion and improve communication within the hospital.
- Tabards will be issued to key personnel to identify them in their major incident role. Staff wearing tabards should also display their own ID badge for ease of recognition.
• Please remember that in the event of a major incident underhand tactics may be used by members of the press or public, in order to gain access to the hospital.

3.4 Health, Safety and Welfare

• Managers and staff must ensure that they receive sufficient training and information on their roles and responsibilities prior to and when responding to a major incident.
• Staff must ensure that, in a major incident response, they work within their skills set and competencies at all times. This may involve working in an unfamiliar environment and staff will need to inform managers and supervisors where safety concerns may be an issue and more awareness, support or training is required.
• Where the use of equipment is required, staff must have received sufficient training and information to operate it in a safe manner.
• All staff have a duty to adhere to relevant Trust policies and procedures to maintain their own safety and that of others involved. For example, where the use of personal protective equipment is indicated, staff must use it.
• Where staff identify significant hazards, whilst undertaking their allocated tasks, they must report these to their immediate manager or supervisor.
• Staff must use the Trust Incident Reporting process, where appropriate, to incidents that occur during a major incident response.
• Managers and staff must ensure that regular breaks are taken and hours worked do not cause undue fatigue.
4.0. THE NDHCT MAJOR INCIDENT PLAN

4.1 COMMAND AND CONTROL

4.1.1 Defining strategic, tactical and operational roles

The following are a general explanation and definitions of strategic, tactical and operational roles: See Annex 3 for illustration.

<table>
<thead>
<tr>
<th>Strategic (Gold)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The term strategic refers to the person in overall executive command with responsibility for formulating the strategy for the incident response. The strategic command has overall command of NDHCT resources but delegates tactical decisions to the tactical commanders. Strategic command has a key role in strategic monitoring of the response to an incident.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tactical (Silver)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The term tactical refers to the small number of individuals who will be responsible for directing the operational response. They should oversee, but not be directly involved in, providing any operational response in the incident.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operational (Bronze)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The term operational refers to those individuals who will provide the main operational response in an incident, and control the resources of their respective service within a specific area of the incident.</td>
</tr>
</tbody>
</table>

4.1.2 ‘MIMMS’ – Major Incident Medical Management and Support - the scene

**Bronze (Operational Level):** the scene itself is designated the bronze area or forward control. Each agency present at the scene will have a Forward Incident Officer who reports to their Incident Officer at Silver control.

**Silver (Tactical Level):** the overall operational control of the scene occurs at Silver. The police have overall responsibility of Silver control and the office is currently at Middlemoor at Exeter. Each agency attending Silver will have an Incident Officer and has its own allocated office space. The NDHCT control room would liaise with the Ambulance Incident Officer (or Medical Incident Officer if deployed) and directly with Silver as appropriate. On declaration of a major incident the control room will allocate a representative from the Trust to attend Silver. This role must be undertaken by an individual who has operational knowledge of the organisation and has delegated authority to make decisions at this level.

**Gold (Strategic Level):** the overall strategic response to a major incident with a regional is managed at Gold control. The SHA and Public Health agencies will be represented at Gold control. Gold control will usually be at Devon and Cornwall Constabulary, Middlemoor Police Station. The NDHCT will liaise with Gold control for strategic support.

4.2 PHASES OF A MAJOR INCIDENT

Within the hospital the phases of a major incident are:

- **Reception** – initial casualty reception, triage and treatment
- **Definitive care** – admission, surgery, discharge
- **Recovery** – return of the various areas business continuity and then business as usual
4.3 COLLAPSBLE HIERARCHY

When a major incident is initially declared, only a small number of people will be immediately available to activate the plan. These individuals will be the first people to be informed in the event of a major incident and include: the ED nurse in charge, the ED registrar / consultant on call, Bleep 500, the duty manager and the duty executive. The first priority is to establish a command and control post in the major incident control room in the radiology seminar room on level two and to prepare the ED for casualty reception. As more staff become available the various roles according to the action plans can be delegated or handed over to a more senior or experienced colleague. It should be noted that these roles are not absolutely fixed and roles can be allocated to the most appropriate manager or executive available.

4.3.1 Strategic Control – Chief Executive or Duty Executive

The Chief Executive or her deputy, or the Duty Executive, leads the strategic response to a major incident at NDHCT. The strategic lead should receive regular updates from the tactical control group about the status of the response and will be expected to report to the lead PCT.

The Trust will have a responsibility to identify and allocate a senior manager to Silver Control in Exeter, if required. It is vital that whoever attends Silver has a clear understanding and knowledge of the operational management of the organisation. The decision will be taken by the Duty Executive at the earliest possible time.

4.3.2 Tactical Control – Incident Control Team

The hospital control team based in the control room leads tactical response. It is important the control room team do not attempt to involve themselves in operational activities, but maintain an overview of the response. The duty manager will normally act as Incident Manager.

4.3.4 Operational Control

The operational response to a major incident will occur within in each key area according to their respective action cards in Appendix 1. The Clinical Site Management Team, although they have representation in the control room, form part of the operational response. Each operational area should provide regular reports to the tactical control area.

5.0 ALERT PROCEDURE

THE AMBULANCE SERVICE ARE THE ONLY EMERGENCY SERVICE WITH A RIGHT TO INITIATE A HOSPITAL RESPONSE TO AN EXTERNAL INCIDENT

All messages relating to a major incident will normally come via NHS Devon or SWAST ambulance control to NDDH switchboard. In some instances the Emergency Department might be the first area to receive a major incident message in which case they must inform switchboard immediately. (Switchboard, Major Incident Message, Refer Action Card 1a)

It is possible, however, that Switchboard may receive the call in the first instance directly from a member of the public. In this case the caller should be asked to call ‘999’ and report to the police – if this is not possible, the receiver of the message should dial ‘999’.

5.1.0 Major Incident messages

The major incident messages will take the format:

- Major Incident Standby:
Indicating that an incident has occurred which could result in large numbers of casualties

- **Major Incident Declared – Activate Plan**
  
  Indicating a major incident has occurred. The hospital then needs to activate its plan

- **Major Incident Cancelled:**
  
  If a stand-by or declared message has been given, but **there is no major incident**

- **Major Incident – Stand down:**
  
  From ambulance control or NHS Devon once the incident has been managed so organisations can plan to return to business as usual.

  **Major Incident Stand down does NOT mean the incident is cancelled.**

In ALL cases the following details should be recorded: identity of caller and contact number, time of receipt of message / call and time of accident/incident.

When any of these messages are received Switchboard will begin the call-out cascade.

In the event of a major incident message being received the NDDH switchboard will become very busy. In an effort to minimise calls to switchboard, any message left on pagers or answer phones should take the ‘major incident message format’ (see below). Messages should not be left on answer phones or pagers asking the recipient to contact switchboard. Recipients should know what their role is in a major incident and respond accordingly. If there are any difficulties in internal communication, switchboard should use runners (see Communication p.15). The direct line to the Police Casualty Bureau is **01271 349196**. Any calls to the hospital enquiring about individual casualties should be directed to this number.

All emergency services use the mnemonic of **CHALETS**. Switchboard should relay this information to the Control Room and the ED. This represents the essential information required in the format:

- **C** – **Casualties** - number of or expected including types of injuries if known
- **H** – **Hazards** – current or potential
- **A** – **Access Routes** – and congestion problems
- **L** – **Location**
- **E** – **Emergency Services** – present and required
- **T** – **Type of incident** - number of vehicles / buildings involved etc
- **S** – **Start a log**

**5.1.1 Major Incident Standby**

At this stage the message ‘**NDCHT Major Incident Standby – report to major incident control room**’ will be given.

At the same time the switchboard call out cascade will be activated as per “Standby Action Card” (Action Card 1b) to ensure extra staff are available to activate the NDHCT call out cascade if a major incident declared message is received.
5.1.2 Major Incident Declared

A major incident ‘declared’ message might be received either after a ‘stand by’ message or as the first notification of a major incident.

If there has been a previous ‘stand by’ message the first priority is to inform the hospital control team and the Emergency Department of the change in status. A runner should be used if there is any difficulty in contacting these areas immediately. Then activate the ‘Major incident declared’ switchboard call out cascade giving the message **NDHT Major Incident Declared – Activate Plan** as per “Major Incident Declared – Activate Plan Action Card. Action Card 1c.

5.1.3 Major Incident Cancelled

This message may be received either after a ‘major incident stand by’ message or after a ‘major incident declared’ message. The control room on **2755** and the ED will be the first areas informed.

When using pagers the message ‘**NDCHT Major Incident Cancelled**’ will be used. (use cascade list as per Major Incident Declared, Action Card 1c).

5.1.4 Major Incident Stand Down

The major incident stand down only implies that there are no more casualties due to be transported from the scene. The major incident will continue for some time within NDHCT. The stand down message should be relayed to the control team. The team will stand down each affected area once that area is ready to resume normal duties.

Switchboard should ONLY relay the ‘major incident stand down’ message to the control room. (use cascade list as per Major Incident Stand-down, Action Card 1e).

The instruction to stand down the response to an incident will only be issued by the Incident Control Team based in the Control Room, to the Switchboard, who will then implement the Stand Down cascade.

Individual areas may be stood down separately if the incident requires some areas to continue working in ‘major incident mode’ for significantly longer than other areas. Heads of departments who feel they have completed their response must seek approval from the Control Centre before returning to normal duties and procedures.

5.2 COMMUNICATION

Conventional forms of telephone communication in the event of a major incident should be expected to be extremely difficult or fail completely. Switchboard will be very busy and most of the external phone lines from the trust will be utilised.

**External calls from the trust must be limited to essential major incident use only**

**Calls through switchboard must be limited to essential major incident use only**

The control room has a number of MI designated phone lines but should only be contacted by designated staff members in key areas. The numbers are managed by the Switchboard and are detailed in Switchboard Action Card 1d.

5.2.1 Radio communication

In addition to the phone lines there is direct 2-way radio communication between key areas:-
Radio link 1: Control room to ED
Radio link 2: Control room to Exmoor Unit
Radio link 3: Control room to Main Entrance co-ordinator
Radio link 4: Control room to Head of Communications
Radio link 5: Patient management team to control room
Radio link 6: ED to patient management team

5.2.2 Runners

Runners should be used to communicate any messages when there is either difficulty securing phone contact or when there is a large amount or detailed information that needs to be conveyed accurately.

Messages given to runners should always be written, not verbal and written in a designated major incident receipted pad. The top copy should be taken to the recipient of the message and a copy kept in the message book. All message books should be returned to the control room after the incident.

5.2.3 Enquiries about casualties

The direct line to the Police Casualty Bureau is 01271 349196. Any calls to the hospital enquiring about individual casualties should be directed to this number.

6.0 ACCESS CONTROL AND LOCK DOWN PROCEDURE

6.1 Access control

In the event of the Major Incident Plan being activated, access to the NDHCT site will be controlled. This is to ensure the site is kept safe and casualties, staff, existing patients, visitors, other agencies and the media are all directed to the appropriate locations. All access to the NDDH main site will take place either through the Emergency Department for casualties only, or via the main entrance for everyone else. The porters should initiate the lock down procedure but leave open only the Main Entrance and ED entrances, unless a formal lock down is required. (See below)

6.2 Lock down

In the event of a CBRNE incident, a security threat or for any other reason identified by the hospital control team, either the Emergency Department alone or the whole NDDH site may need to be ‘locked down’ preventing any ingress or egress from the site. This will be an unusual occurrence and differs from the normal access control outlined above. The plans for the Access Control and Lock Down procedures are managed by the Facilities Department.
7.0 KEY DESIGNATED AREAS AND ROLES

7.1 Designated departments

Most areas of the hospital will continue to function within their normal roles. Some areas will also have designated major incident roles either instead of or in addition to their normal function see table below. The staff in these areas will erect portable signs to identify their role and location. The hospital control team will have responsibility for staffing any areas not usually staffed out of hours, or that need designated personal deployed to that location, including the:

- Main entrance co-ordinator – main entrance
- Staff reporting officer – Exmoor Unit
- Relatives' liaison officer – Internet café

<table>
<thead>
<tr>
<th>Designated Major Incident Role</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control room</td>
<td>Radiology seminar room level 2</td>
</tr>
<tr>
<td>Casualty reception P1 and P2 categories</td>
<td>Emergency department</td>
</tr>
<tr>
<td>Casualty reception P3 categories</td>
<td>Fracture clinic via Emergency department</td>
</tr>
<tr>
<td>Receiving ward</td>
<td>Lundy ward</td>
</tr>
<tr>
<td>Staff reporting</td>
<td>Exmoor Unit, outpatients, level 2</td>
</tr>
<tr>
<td>Discharge lounge</td>
<td>Discharge lounge and day surgery unit</td>
</tr>
<tr>
<td>Relatives waiting area and Police casualty</td>
<td>Internet café, level 0</td>
</tr>
<tr>
<td>bureau</td>
<td></td>
</tr>
<tr>
<td>Media</td>
<td>Chichester boardroom, Chichester House</td>
</tr>
</tbody>
</table>

7.2 Main entrance co-ordinator (Action Card No. 2)

This is a critical role in a major incident and requires knowledge of the different areas of the trust as designated in a major incident. The role is assigned to a manager or senior administrative / clerical worker and is established early after a major incident is declared.

The role of the main entrance co-ordinator (Card 2) is to direct all NDDH staff, other healthcare professionals, other professional workers involved in a major incident, press and relatives to the right area. In a major incident the only access to the main hospital will be via the Emergency Department for casualties only and the Main Entrance. All other doorways will be shut down to external access. Security of the main entrance is essential but there are no security staff employed on site and the porters will already be very stretched. If security at the main entrance is compromised the control room will activate the Lock Down procedure.

All NDHCT and other healthcare professional staff, and other professions responding to a major incident should show their hospital or professional identification to secure access to the site.

All relatives or close friends enquiring after casualties will be directed to the Raleigh Galley Internet Café. Relatives wanting to visit existing in-patients will be informed there is a major incident and asked to visit at another time. Casual visitors should be asked to leave the site. No close relative will be turned away especially if the in-patient is vulnerable or critically ill and parents will be allowed to remain with in-patient children. Discretion will be used.
7.3 Co-ordinator for Responding Staff – Exmoor unit (Action Card No. 3)

This is a critical role in a major incident and requires knowledge of the overall major incident plan, the different areas of the trust and of individual staff capabilities. The role is assigned to a Manager or senior nurse or senior doctor and is established early after a major incident is declared.

A log must be kept NDHCT staff members who attend in response to a major incident. All staff being called in to a major incident will be told to report first to the Exmoor unit. Most staff will be deployed immediately to their usual place of work. However, some staff will be deployed to other areas. The staff co-ordinator will liaise directly with the medical co-ordinator in the control room who will be aware of which areas require further support.

7.4 Relatives’ liaison officer – Internet Café (Action Card No. 4)

This is a critical and difficult role in a major incident and will need to be filled by a senior person with excellent communication skills. All relatives of casualties will be sent to the Internet Café and re-united with discharged survivors here. The liaison officer will liaise with the co-located police casualty bureau to establish names and status of casualties. For further details see sections on the police casualty bureau and relatives reception.

7.5 Discharge lounge

A secondary discharge area will be established in the day surgery unit (Action Card 5).

7.6 Volunteers

The role of volunteers is welcome in the event of a major incident. However, only volunteers already known to the Trust with appropriate identification can be given a role. They should report to the staff reporting area in the Exmoor Unit. In the interests of security, patient confidentiality and patient safety, lay volunteers not already known to the trust cannot be given any internal role, nor be given access to the site.
8.0 MAJOR INCIDENT CONTROL ROOM AND THE INCIDENT CONTROL TEAM

The members of the Incident Control Team, situated in the Radiology Seminar Room on level 2, are given in Table 5. (Action Card No. 6)

<table>
<thead>
<tr>
<th>The Incident Control Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Normal role</strong></td>
</tr>
<tr>
<td>Chief Executive or Duty Executive</td>
</tr>
<tr>
<td>Duty Manager</td>
</tr>
<tr>
<td>Duty Obstetrician</td>
</tr>
<tr>
<td>Administrator</td>
</tr>
</tbody>
</table>

There are also a number of other designated key players who should report to the control room, to confirm their presence on the site, as soon as a major incident stand by or declared message is received. See table below. If these personnel arrive before the hospital control team, according to the collapsible hierarchy, they should undertake the role of the hospital control team until such time as designated staff arrive. It is critical to establish command and control in the control room before beginning the operational response.

<table>
<thead>
<tr>
<th>Designated Key Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Normal role</strong></td>
</tr>
<tr>
<td>Clinical Site Managers (Bleep 500)</td>
</tr>
<tr>
<td>ED consultant on call</td>
</tr>
<tr>
<td>ITU consultant on call</td>
</tr>
<tr>
<td>Consultant general surgeon on call</td>
</tr>
<tr>
<td>Nurse in charge ED</td>
</tr>
<tr>
<td>Estates</td>
</tr>
<tr>
<td>Head of Communications</td>
</tr>
</tbody>
</table>

8.1 Tabards

There are tabards available for all designated personnel so they can be readily identified by all staff both from within the organisation and visiting staff from other agencies. Most tabards will be kept in the Control Room, with some kept in the Emergency Department.

8.2 Roles of the Incident Control Team Members

The details of the individual roles are given on the action cards in Appendix 1.
8.2.2 Incident Executive (Action Card 7)

The Incident Executive will take a strategic role in the response to a major incident. S/he will support the Incident Manager and facilitate decision making at a senior level. S/he will receive regular reports from the Incident Manager.

8.2.3 Incident Manager (Action Card 8)

The Incident Manager will lead the hospital control team and lead the tactical Hospital-wide response to the major incident ensuring that the rest of the hospital continues to operate as normally as possible. S/he will set up the hospital control room, lead the major incident control team and take on the role of the incident executive until an executive is available.

8.2.4 Medical Co-ordinator (Action Card 9)

The medical co-ordinator has three main areas of responsibility:

- **Medical advice**: S/he will inform and give medical information to the control team about the nature of the impact of the incident.

- **Staff deployment**: In association with Senior Nurses and Lead Clinicians, take responsibility for liaising with key operational clinical areas and the staff reporting areas to make sure staff are most appropriately deployed to areas they are most needed. S/he will inform the incident manager of critical staffing issues and take steps to address these. S/he will also assume responsibility for all medical doctors who respond to the major incident, ensuring that enough medical staff will be available for staffing subsequent shifts after the immediate reception phase of the incident. (The theatres co-ordinator will assume responsibility for continuity of surgical staffing).

- **Elective medical activity**: The medical co-ordinator will also establish what other outpatient or booked elective activity is currently taking place within the hospital at the time of the incident or is due to take place shortly. S/he should ensure there is the least possible disruption to these services as reasonably possible. S/he will take responsibility for deciding which of this activity should be cancelled or delayed and which should still continue. There should be no automatic cancellation of routine outpatients or specialist services; for example ophthalmology, chemotherapy, plastic surgery, psychiatric, obstetric and gynaecology staff etc are unlikely to be involved in the reception phase of a major incident and should be allowed to complete existing duties. Strategic decisions with respect to elective activity should be discussed with the incident executive. (The theatres co-ordinator will assume responsibility for cancellations of elective surgical activity).

8.3 Duties of the Incident control team (Action Card 6)

- To allocate a representative to Silver control.
- To provide a tactical leadership in the event of a major incident.
- To facilitate co-ordination of all the operational activity within the Trust.
- To ensure all resources are available to allow operational teams to function effectively.
- To delegate responsibilities to key personnel.
- To establish lines of communication with key operational internal areas and outside agencies.
- To log all activity and expenses.
- To give early attention to business continuity.
- To make a rapid and continuous assessment as the incident unfolds including assessments of what activity is happening at any given time.
- Following declaration of a Major Incident Stand Down the control room will assume responsibility for initiating actions to return to Business As Usual.
The control room team will also liaise early with Silver control about the need to deploy medical staff to a survivor reception area to minimise transfer of very minor injured patients to the acute Trust. This is not the same as providing a Mobile Emergency Response Incident Team ‘MERIT’ team, which would be deployed to the scene from either Torbay or Derriford Hospitals.

The ambulance service will endeavour to provide two Ambulance liaison officers (ALO) to the Trust. The first ALO will be based in the ED and the second in the control room, where they will then assume responsibility for all communication by SWAST radio between Silver control and the control room.

The control team will also provide a report to the board after the incident including an assessment of the financial impact.

9.0 CLINICAL SITE MANAGEMENT TEAM AND PATHFINDER TEAM

9.1 Overview

The clinical site management team will fill all these roles until other staff available.

- Hospital control team: Maintain tactical control of the response to the incident
- Clinical Site Management team: Maintain bed state and inform control team of casualty numbers
- Pathfinder team: Identify patients for transfer to community beds
- Community co-ordinator: Identifies all available community beds
- Transport co-ordinator: Makes all transport arrangements

9.2 Clinical Site Management team (CSM) (Action Card 11)

The CSM team will continue to take responsibility for the bed state in the event of a major incident. Once the Control Team has been fully established they will not form part of the control team but will liaise with and report back to the control team on a regular basis to inform the control team about the bed state and casualty numbers.

They will work in three main areas; a roving role on the wards and clinical areas as usual, based in the ED and if available a CSM representative in the control room. There will be direct radio links with the CSM representative in the control room and the ED, and between the roving CSM representative and the control room.

The CSM team will designate the following roles:

- Community Hospital co-ordinator (Action Card 12)
- Transport co-ordinator (Action Card 13)

These roles can be filled by anyone available from the CSM, Pathfinder teams, community hospital directorate, manager or other senior nurse as available. The same person can fill both roles in the first instance. The control room should be informed of their identity and contact bleep details.

9.3 Pathfinder team (Action Card 14)

The Pathfinder team should work in their usual role and identify which patients could best be transferred to community beds. They should liaise with the patient management team, the community hospital co-ordinator and transport co-ordinator to facilitate getting those patients to the most appropriate community beds as soon as practical.
They should liaise with ward managers and pharmacy about obtaining TTA drugs for these patients. During a major incident patients can be discharged with their own ward drugs rather than waiting for formal TTAs. The day surgery unit will function as a secondary discharge lounge for patients who need to remain on a bed or trolley pending transport.

10.0 EMERGENCY DEPARTMENT (ED) AND FRACTURE CLINIC

All ED and Fracture Clinic staff should be aware of the major incident plan and know what their specific role would be in the event of implementing the plan.

Reception staff: (Action Card 15)
ED senior nurse: (Action Card 16)
ED consultants: (Action Card 17)
Ambulance Liaison Officer (Action Card 18)
ED Clearing Nurse (Action Card 19)
Triage Nurse/Doctor (Action Card 20)
Resus Team Leader (Action Card 21)
Exit Desk (Action Card 22)
Incident Doctors (Action Card 23)
Senior ED Intensivist (Action Card 24)
Senior ED Surgeon (Action Card 25)
Fracture Clinic (Action Card 26)
Fracture Clinic Co-ordinator (Action Card 27)
Fracture Clinic Practitioner (Action Card 28)
ED Paediatrician (Action Card 29 – to be written)

10.1. ED MAJOR INCIDENT DESIGNATED STAFF ROLES

Senior ED Consultant: Action Card 17

The ED Consultant on call will normally will undertake the lead role within the ED. In his/her absence or until his/her arrival the middle grade ED doctor or other doctor available in the department will undertake the role.

ED Senior Nurse: Action Card 16

The ED senior nurse present in the department will undertake the lead role within the ED. This role may be handed over to a senior sister if they subsequently arrive in the department.

Senior ED Surgeon: Action Card 25

The consultant general surgeon on call will adopt this role. She/he will co-ordinate the surgical response in the ED and liaise with the P1 resus team leaders, P2 incident doctors, the theatre co-ordinator, senior ED Intensivist and the senior ED consultant and the P3 incident doctors and practitioners. She/he will advise in establishing surgical treatment plans for each patient and triage patients to theatre.

Senior ED Intensivist: Action Card 24

The ITU consultant on-call will adopt this role. She/he will co-ordinate the ITU/anaesthetic roles in the ED and liaise with the P1 resus team leaders, ITU, ED senior surgeon and the Senior ED consultant. There will possibly not be enough anaesthetists to manage each ventilated patient in the ED and he will need to co-ordinate teams of anaesthetists to oversee patients in each geographical area in the ED.

Senior ED Paediatrician: Action Card 29 to be written
If a large number of children are involved the paediatrician on call should report to the ED to coordinate the paediatric response.

**ED Triage Nurse (and Doctor and clerical officer if staff available): Action Card 20**

The ED Nurse in charge will designate a specific ED nurse to triage patients on arrival. The ED consultant will allocate a doctor to triage if available. The senior ED receptionist will allocate a clerical officer to triage if available.

**ED 'clearing nurse': Action Card 19**

To lead in evacuating all existing patients from the ED

**Resus team leaders: Action Card 21**

Other ED consultants, ED middle grades and other senior doctors with experience managing severe trauma or working in the resuscitation room or ITU.

**Incident doctors: Action Card 23**

Other ED doctors or SHOs with experience managing trauma or working in the resuscitation room or ITU.

**ED staff on duty:**

Staff on-duty will remain in the ED.

**ED staff off duty:**

Off-duty staff who are called in for the major incident must report first to the staff reporting area in the Exmoor Suite. All ED staff will be deployed to the Emergency Department and not elsewhere in the first instance. Identification badges must be worn to gain access to the hospital.

**10.2 PREPARATION OF THE ED FOR CASUALTY RECEPTION**

**10.2.1 Declaring Major Incident**

If a major incident has not yet been declared by the ambulance service and numbers or types of casualties are presenting to the Emergency Department that clearly constitutes a major incident, the ED Consultant may independently declare a full (hospital-wide) or limited (department-wide) major incident. **The ED consultant must inform switchboard and ambulance control.**

If a Major Incident is declared to the department by the ambulance service, the person receiving the declaration should, use the mnemonic “CHALETS”. (See Alert procedure p.11).

**10.2.2 Liaison with Control Room**

Dedicated phone line from A&E to Control room: 2755. The ED consultant will also have a direct radio link with the control room

**10.2.3 Major Incident Equipment**

All equipment and paperwork necessary for a major incident is kept in the Major Incident Storeroom. Action cards and tabards are available for all key ED staff members.
A trolley with the Major Incident Patient Log and the Major Incident Patient Information Sheets and department floor plan will be positioned at the Triage Point inside the main entrance. The Major Incident Exit Log will be taken to the Exit Desk. The porters will be responsible for setting up the exit desk. **ALL** patients must leave by the exit desk and be logged there.

**10.2.4 Ambulance Routing**

Routing will remain as usual with ambulances completing a left hand circuit after unloading casualties. No ambulance will remain at the main entrance once their patient has been discharged from their care.

**10.2.5 Ambulance Liaison Officer (ALO):** (Action Card 18)

At the receiving hospital, the ALO is responsible for the provision of mobile radio communications between the hospital and the ambulance service. They are also responsible for liaison and supervision of ambulance activity at the receiving hospital. They will establish and maintain radio communications between Hospital, Site Control, Ambulance Control and Mobile Units throughout the incident, keeping the Control Team informed of activities at the site and casualties situation, etc. The ambulance service will endeavour to provide two Ambulance liaison officers (ALO) to the Trust. One will be based in the ED and the second in the control room, where they will then assume responsibility for all communication by SWSAST radio between Silver control and the control room.

**10.2.6 Layout of the ED in a major incident**

Once a major incident is declared the nurse in charge and consultant if present should immediately inform all ED staff and implement ED major incident plan. Action cards should be handed to all ED staff with a designated role and tabards distributed. The ED consultant will report to the control room and return to the ED.

The triage point should be assembled. If there is **any** possibility of a CBRNe event the decontamination tent should be assembled prior to casualty arrival. Suits should only be put on once there is a definite need for decontamination (see CBRNe plan – Appendix 2)

- P1 patients will be treated in resus and majors bays 1-3 (7 bays in total)
- P2 patients will be treated in majors bays 4-7 and minors bays 1-3 (7 bays in total)
- P3 patients will be sent to the fracture clinic waiting room and treated in fracture clinic and plaster room cubicles

Paediatric room one will be used flexibly for paediatric patients. Paediatric room two will not be used for major incident patients or body viewing. Bodies will be sent straight to the mortuary or to the physiotherapy gym if the mortuary is full, pending transfer to Chivenor.

- **ALL** patients (whether from the major incident or not) are to enter via ambulance sliding doors. CBRNe contaminated patients ONLY will enter through the decontamination entrance and then log in at the triage point.

**10.2.7 Existing ED patients (Clearing Nurse):** (Action Card 19)

The first action in a major incident will be to clear the department of all existing patients. The ED ‘clearing nurse’ will make these arrangements.

**Waiting room:** The impending major incident will be explained to patients, and those with minor injuries and ailments that do not warrant urgent intervention will be asked to attend other health care providers. Leaflets are available giving patients details of other healthcare providers in the area. Patients who still wish to stay for treatment should be
treated as usual, but must be informed they may face delays once the casualties start to arrive.

**Resuscitation room patients:** Should be transferred direct to ITU, CCU or a ward, or prompt arrangements made for SWAST transfer to tertiary care as appropriate. Stable patients may be transferred direct to an admitting ward.

**Majors patients:** Patients who have been identified as definitely or probably needing admission should be admitted direct to relevant wards.

**Minors patients:** Patients awaiting minors treatments should be transferred to fracture clinic or the plaster room for their on-going treatment.

**Patients fit for discharge** should be transferred to the discharge lounge, which will be opened and staffed if out of hours.

The ED ‘clearing nurse’ will first clear the waiting room then liaise with the ED middle grade to identify which existing patients need admission or transfer to fracture clinic and which can go the discharge lounge. She/he will contact bleep 500 to identify where beds are currently available and where beds are due to be available in the short term. She/he will then liaise with the ward staff – explain that a Major Incident has been declared - and ask the ward staff immediately to collect patients from the ED. Even if a bed is not immediately available, the patient will be transferred to the ward to wait for the bed. Identity bracelets must be attached to all patients before they leave the Emergency Department.

**10.3 Major incident ED triage and casualty reception (action card 20)**

The triage point will be inside the main doors by the entrance to X-ray room 7. An allocated nurse will lead on triage assisted by an ED doctor and clerical officer if available. The triage point will consist of:

- Dynamap BP and pulse monitor
- Triage trolley brought from major incident store containing:
  - Major incident patient records and identity labels
  - Stationary including pens and markers for white boards
  - Major incident patient arrival log
  - Log books for senior ED consultant, nurse and triage team

Major incident whiteboards should be erected comprising:

- Triage methodology whiteboard
- ED layout whiteboard
- ITU capacity whiteboard
- Theatre capacity whiteboard

**ALL** patients (whether from the major incident or not) are to enter via ambulance sliding doors. CBRNE contaminated patients ONLY will enter through the decontamination entrance and then log in at the triage point.

Triage will be performed according to major incident ‘triage sort’ based on a score derived from respiratory rate, BP and GCS. The categories are P1-P3. The triage category may also be influenced by the extent of obvious injuries. There is a white board outlining triage methodology at the triage point. Major incident triage is dynamic and patients may be allocated a different triage score from the ambulance service. The triage score may change whilst the patient is in the department and they may be moved to another area accordingly.
On arrival patients will all be:-

- Triaged or re-triaged in the **Triage Point** inside the ambulance doors
- Allocated a Major Incident Number
- Have attached a numbered identification bracelet
- Allocated a nurse escort, if available
- Allocated a folder of major incident numbered stationery and patient documentation.

### Major Incident Triage Categories

<table>
<thead>
<tr>
<th>Major Incident Category</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Needing immediate resuscitation or life saving treatment</td>
</tr>
<tr>
<td>P2</td>
<td>Needing urgent treatment but not immediately life threatening</td>
</tr>
<tr>
<td>P3</td>
<td>May still have significant injuries but treatment can be delayed</td>
</tr>
</tbody>
</table>

**Priority P1 patients:**

- P1 patients will be treated in resus and majors bays 1-3 (7 bays in total). They will have a team of two doctors – a resus team leader and an incident doctor and two nurses. One nurse will be an ED nurse and one deployed to the ED from another area.
- These patients will be transferred at the first opportunity to definitive care in ITU or theatre, otherwise transferred to main theatres recovery to allow on-going assessment pending definitive care. This is to allow constant flow through the hospital so new casualties can be assessed and resuscitated in the Resuscitation room.

**Priority P2 patients:**

- P2 patients will be treated in Majors bays 4-7 and Minors bays 1-3. They will have a team of an incident doctor and a nurse.
- These patients will be transferred to definitive care in ITU, theatre or the admitting ward at the first opportunity, or to main theatres recovery if they need further assessment pending definitive care.

P1 and 2 patients should also ideally have a nurse escort. These are usually untrained nurses whose principle role is to stay with the patient at all times and take charge of the patient's stationery; assist other nurses and doctors if able.

**Priority P3 patients:**

P3 patients will be treated in fracture clinic and the plaster room and be seen by the Incident Doctors or other practitioners allocated there. They must enter via the main fracture clinic doors to the fracture clinic waiting room in the first instance. The fracture clinic co-ordinator may arrange re-triage to prioritise the P3 patients. Imaging of P3 patients will be in X-ray room 6 in fracture clinic.

Patient needing to rest and be monitored e.g. after smoke inhalation could be sited here.

If patients are fit for discharge they must NOT be sent home directly from the ED. All patients must leave and be logged via the exit desk and sent to the Police Casualty Bureau and relative reception area in the Raleigh Gallery on level 0.
10.4 Major incident casualty resuscitation and imaging (Action Card 21)

There will not be time to fully resuscitate and definitively treat each patient whilst they are in the ED.

The approach should be the standard ‘ATLS’ treatment but with the emphasis on ‘damage limitation’ - identifying and treating life or limb threatening injuries. Other treatment should be deferred.

The ONLY imaging performed in P1 and P2 resuscitation areas should be trauma series chest and pelvis and open or deformed long bones. This should be done on the portable X-ray machine. X-ray room 7 in the ED should be used as little as possible to minimise patient movements within the ED. Other imaging should be deferred wherever possible. CT imaging should be reserved for those with isolated head injuries only. FAST scanning will be performed on each major trauma patient by the consultant radiologist deployed to the ED. In the major incident trauma situation, especially with blast injuries, laparotomy will be the definitive diagnostic test for intra-abdominal injuries.

Images will be entered on to WEBPACS using the major incident patient identifier in the ‘name fields’. The images will also be printed and these images should stay with the patient at all times.

The P1 resus team leader or P2 incident doctor should make an action plan for definitive treatment at the first opportunity in liaison with the Senior Intensivist and Senior Surgeon in the ED, and the patient moved to the appropriate area.

10.5 Demographic Details

A Major Incident Patient Log of ALL patients attending the ED will be generated at Triage at the ambulance entrance and ALL patients (whether from Major Incident or not) will be allocated a Major Incident number.

The nurse in charge of each patient will record demographic details on the Major Incident Patient documentation sheet.

A dedicated ED receptionist will collect this demographic information and enter patient details onto PAS before they leave the ED.

10.6 Exit Desk (Action Card 22)

An exit desk will be placed in the corridor from the ED to the main hospital, immediately beyond the entrance to the fracture clinic. ALL patients must leave the ED via this desk. If any patient leaves for direct inter-hospital transfer from the ED their departure MUST be logged at the exit desk.

ALL discharged and admitted patients must leave the department via the Exit Desk in the main corridor into the hospital. All documentation must remain with the patient at all times. The porters will bring a desk to the corridor to establish the exit desk immediately beyond the main entrance to the fracture clinic.

The Exit Clerks at the exit desk will log the destination of all admitted patients – forms in Major Incident stationary box (see ED reception action card)
11.0 FATALITIES, DEATHS IN THE HOSPITAL AND THE TEMPORARY MORTUARY

11.1 General Information

- Fatalities from the scene will be transferred to a temporary mortuary, not the NDDH site.
- Patients who are Dead-On-Arrival must be certified to this effect.
- **Casualties who are dead-on-arrival must still be brought to the ED, allocated a major incident number, entered onto the Major Incident Patient Log and Exit Log and be entered on PAS** and moved to the Mortuary with any/all known information or documentation at the first opportunity.

In the event of the formal mortuary bays being over loaded, bodies will be placed with as much respect as possible in other cold areas within the mortuary complex, including the Chapel of Rest.

11.2 DECEASED PATIENTS

- Ward staff are responsible for ensuring details of deceased patients are entered onto PAS – following normal procedures.
- In addition, the major incident white card (code 614/515) should be extracted from the patient notes and marked as ‘DECEASED’. Contact should be made with the Control Centre to arrange collection of this card – as the Hospital Co-ordination and Police Documentation Teams require it.
- HM Coroner is responsible for all deceased casualties that have been involved in the incident, although this responsibility may be delegated to the Police.
- At the scene of the incident, arrangements will be made to recover bodies to a designated emergency mortuary - deceased casualties will not automatically be transferred to mortuaries within receiving hospitals.
- Casualties who die in transit or following arrival at hospital, will be transferred to the hospital mortuary in the first instance – following normal hospital procedures. Arrangements will then be made to transport the body to the emergency mortuary.
- In the event that an emergency mortuary is required to be brought into use, the Local Authority will oversee the implementation of arrangements.
- The next of kin must be kept informed of the location of deceased casualties and an explanation given if the body is required to be transferred from the hospital mortuary to the emergency mortuary.
- Ambulance vehicles should not be used to transport any deceased patients from the hospital to the emergency mortuary. Funeral directors under the direction of HM Coroner will assist in transferring deceased patients to the emergency mortuary.

12.0 CHEMICAL, BIOLOGICAL, RADIOLOGICAL, NUCLEAR (CBRN) INCIDENTS

See **Appendix 2** for all information relating to Chemical, Biological, Radiation, Nuclear or Explosive incidents.

13.0 CHILDREN

The Paediatric Major Incident Plan is a supplementary plan to the Major Incident Plan:

- It is unlikely that facilities for children in one hospital will be adequate if the incident involves large numbers of children. Co-ordination of response with Torbay, Exeter and Plymouth will be necessary.
- The supplementary plan will be activated when a major incident involves large numbers of children.
• The supplementary plan can only be instigated once the Major Incident Plan is activated. It does NOT replace the Major Incident Plan.

The Paediatric Major Incident Plan is currently under review by the relevant departmental staff. The work is being coordinated by the Divisional Manager for Women and Children’s services.

13.1 Activation of Supplementary Paediatric Incident Plan

The supplementary paediatric Major Incident Plan is only activated by the Major Incident Coordinator following consultation with the Medical Incident Officer at the scene and/or the On-call Consultant Paediatrician.

13.2 Triage and Patient Flow

• The triage and patient flow will be the same as for the main Major Incident Plan.
• Lundy will continue to be the receiving ward, but nursing staff will be supplemented with Registered Sick Children’s Nurses from Caroline Thorpe. The Control team may take the decision, in communication with the paediatric consultant on-call to transfer the receiving ward to Caroline Thorpe. (Caroline Thorpe Ward Action Card 34)

13.3 Parents and Children

Staff must ensure that, wherever possible, parents and children stay together throughout the process. A parent’s wish to stay with their child must be respected. Parents will need extra support and comfort.

13.4 Child and Adolescent Mental Health

The Child and Adolescent Mental Health team will take the lead in providing for the psychiatric needs of children (and their parents) involved in the incident.

13.5 Children with Special Needs

Children with visual, hearing, physical or mental impairment are particularly vulnerable. These children will require one-to-one care. This must be arranged by the Hospital Control Team.

13.6 Media

Incidents involving children can become very high profile in the media. It is important to respect the child’s/parent’s wishes in regard to the amount of information conveyed to the media. All communication with the media will be co-ordinated by the Communications Officer.

14.0 VULNERABLE ADULTS

14.1 General Principles

Vulnerable adults are likely to be especially affected by a major incident, both if they involved with incident or if they happen to present to the hospital when a major incident is in process.

14.2 Vulnerable adults involved in the incident

These patients must be triaged and initially managed in the same way as all other patients, and arrangements made for their admission or discharge should be made as indicated by their acute injuries.
However, early referral to the OASIS, CRISIS or their own GP teams should be made to ensure that they have appropriate support and follow up.

14.3 Vulnerable adults co-presenting to the ED

It would not be appropriate to keep any vulnerable adult in the waiting area or ‘blue room’ of the ED during a major incident.

Any patient ‘expected’ by the CRISIS of on-call psychiatric team should be directed to the David Barlow unit rather than waiting in the ED. Other patients presenting to the ED with acute mental health problems should be fast tracked to the on-call mental health teams and transferred to the David Barlow unit to await treatment there.

15.0 BURNS

15.1 General Principles

It must be realised that, logistically, the reception of multiple casualties suffering burns, in the context of a major incident, should be undertaken exactly as the ‘All-Hazards’ approach outlined in this document.

NB: If 5 patients with 20% or more burns present for treatment, a major incident should be automatically declared – as detailed in the National Burns Plan.

15.2 Principals Specific to Burns Major Incidents

When assessing and treating multiple casualties suffering severe burns remember:

- The possibility of other injuries
- The possibility of airway burns
- The importance of dressings and analgesia
- The importance of fluid balance and temperature regulation

Burns casualties fall into one of the following triage groups:

- **Priority 1 – P1** Burn injuries with smoke inhalation or significant facial burns that require intubation and/or ventilation. These require care on ITU.
- **Priority 2 – P2** Casualties with extensive or localised deep burns.
- **Priority 3 – P3** Minor burns will be treated in minor injuries – fracture clinic.

After the stage of resuscitation/assessment/stabilisation, P2 burn casualties may need to be accommodated on a single ward isolated from other casualties. The ward involved will be designated by the Hospital Control Team.

Normal activity of transferring burns casualties to the plastic surgery units Frenchay / Exeter or Derriford, or the hyperbaric unit at Derriford may be restricted and subjected to triage to determine priorities of individual burn victims.

The Senior ED consultant in discussion with the Senior Intensivists and Surgeon will discuss the necessity of transferring burns casualties to the plastic surgery units at Exeter/Frenchay/Derriford Hospitals.
16.0 MASS CASUALTIES

16.1 General information

Arrangements for dealing with mass casualties have been made at both national and local levels. These arrangements will be co-ordinated through ‘Gold Command’ based at the Police Headquarters, Middlemoor, Exeter.

16.2 Definition of a mass casualty incident

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

A mass casualty incident will consequently be defined by the circumstances and apparent nature of the episode and **NOT** by the initial assessment of numbers of casualties. Numeric assessments are not possible in such incidents often for hours or days. It will generally be recognised by its scale and the fact that normal major incident responses will be insufficient.

16.3 Command and Control

In the initial stages of the incident (event plus three hours) the existing command and control mechanisms will operate for strategic management and tactical operations. Further support may be required from Devon PCT.

16.4 Working with Local Authorities and other partners.

In the event of a mass casualty incident the local multi-agency (LRF) plan will be brought into effect.

16.4 Strategic Support

In the event of a Chemical, Biological, Radiation or Nuclear incident (CBRN) the Science and Technical Advice Cell (STAC) will assemble at Middlemoor to support Gold Command. The STAC will respond to general questions and queries but does not have the responsibility of co-ordinating the health response.

16.5 Emergency Stores for Mass Casualties

Stocks of essential supplies are held in container ‘pods’ at strategic sites around the UK. The Hospital Co-ordination Team can access equipment and supplies from these ‘pods’ via South Western Ambulance Service NHS Trust’s Control at Exeter.

17.0 DECONTAMINATION

North Devon District Hospital has a mobile casualty decontamination unit and sufficient personal protective equipment to handle small numbers of casualties **only**. (See CBRN plan).

Additional resources can be accessed from South Western Ambulance Service NHS Trust if necessary. In the event of large numbers of people arriving at the hospital and requiring decontamination, the Devon & Somerset Fire and Rescue Service will support the hospital in mass decontamination procedures.
A Senior Fire Officer from Devon & Somerset Fire and Rescue Service and a Senior Police Officer will support the Hospital Co-ordination Team in managing the issues that mass decontamination on site will present.

18.0 Creating additional capacity – Accelerated Discharge

In the event of a major incident, extra capacity may be required. The Consultant Physician and the Pathfinder team will work together with the medical teams in order to identify and discharge appropriate patients from the acute and community hospitals to free up additional beds.

18.1 Additional Patient Transport

During a major incident the Ambulance Service will be fully committed and alternative arrangements will be put in place to transport discharged/out-patients home by:

- Private ambulances as required.
- St John's Ambulance Service and the Red Cross will be contacted to request transport support.
- Voluntary Car Service
- Relatives/friends of patients should be encouraged to provide transport.

19.0 INTENSIVE CARE AND ANAESTHETIC RESPONSE (Action Card 30)

In the event of a major incident the on-call Intensivist will be deployed to the ED. In hours any available Intensivist should take over responsibility for ICU. Out of hours the ICU SHO will take charge of the unit until a second senior Intensivist arrives in response to the call out cascade. The intensivist in charge of ICU will inform the ICU Bed Bureau that there is a major incident at NDDH and establish the nearest ICU bed availability. They will also contact all local ICUs directly to inform them that there is a major incident at NDDH and establish the nearest local ICU bed availability.

ITU beds will be under intense pressure in the event of a major incident. There is an ICU Capacity Plan allowing for an emergency doubling of the ITU capacity – it is expected that the ICU Capacity Plan will need to be activated in the event of a major incident. Details or how ICU staffing will be re-configured in the event of a major incident is also detailed in the ICU Capacity Plan.

Anaesthetic staff will be in short supply in the event of a major incident with roles in resuscitation in the emergency department, on-going care of the critically ill in high dependency areas, and in theatres. The roles for delegating anaesthetic staff to the right areas will be predominantly the responsibility of the Senior ED intensivist and the theatre co-ordinator, in liaison with the ICU staff, the medical co-ordinator and the staff reporting officer in the Exmoor Unit in the control room. The control room should be made aware of any critical anaesthetic staff shortages at the first opportunity. In the ED one anaesthetist at minimum should be available for each clinical area.

In theatres the theatre co-ordinator will take responsibility for deploying individual theatre teams. Consideration should be given to having a senior anaesthetist overseeing the anaesthesia of more than one patient under the care of junior or inexperienced staff.

20.0 THEATRES AND CONSULTANT SURGEON CO-ORDINATOR (PREVIOUSLY KNOWN AS THEATRE CO-ORDINATOR) (Action Card 31 and 32)

The decision will be made by the Duty Exec and Incident Manager regarding what elective in-patient theatre activity will be cancelled in the event of a major incident being declared. The day surgery unit will become a secondary discharge lounge area, especially for patients who need to remain on beds or trolleys. A senior surgeon will be allocated to the role of Consultant Surgeon Co-ordinator (Action Card 32) and will liaise closely with the senior ED surgeon to triage patients...
to theatre in order of priority. The Consultant Surgeon co-ordinator will also allocate the various general, orthopaedic and other surgeons available to individual cases, and anaesthetic teams according to their level of experience and expertise.

The Duty Exec and Incident Manager will also decide in with the Medical Co-ordinator whether all day surgery and endoscopy unit activity is also cancelled. All staff from these areas should then report in the first instance to the staff reporting area in the Exmoor Unit for redeployment.

21.0 SURGICAL RESPONSE

Surgery necessary in a major incident is likely to be trauma surgery due to the effects of blast or high impact transport accidents. Wounds will be by definition contaminated. The types of operation necessary are likely to be debridements, amputations, external fixation and laparotomy. It is essential in both the interests of individual patients and the major incident theatre response as a whole, that only the minimum resuscitative, fracture stabilisation and wound stabilisation surgery is completed in the first instance. If lengthy definitive surgery is undertaken at the time of the first operation then infective complications are more likely and the theatres will quickly become overwhelmed.

Many if not most surgical patients from a traumatic major incident will need a second or third operative intervention before their definitive treatment is complete. The impact of a major incident on theatre activity is therefore likely to last much longer than the initial reception phase impact on the rest of the hospital.

The theatre co-ordinator will also lead on overseeing the surgeons who respond to a major incident and ensure continuity of surgical staffing and the on-going requirements of the existing surgical in-patients.

21.1 RECEIVING WARD – LUNDY (Action Card No 33)

Lundy ward is the receiving ward for all casualties, including children, from a major incident. When a major incident is declared the ward will be cleared by discharging patients home or transferring to other wards as soon as possible to free up beds for casualties. As the incident progresses, all casualties will be admitted to and remain on Lundy if possible. If there are predominantly young child casualties Caroline Thorpe may become the primary receiving ward. This decision will be taken by the hospital control team. Otherwise paediatric nursing staff will be deployed from Caroline Thorpe ward to help nurse any child casualties on Lundy.

Lundy will be the main ward to receive any major incident messages and will cascade this out to the other wards.

The impact of the major incident will continue to affect Lundy Ward long after the final casualties have arrived from the scene and been discharged home. Casualties will form strong networks amongst themselves and are likely to form ‘survivor groups’. Specialist discharge information sheets will be available from the ED.

21.2 OTHER WARDS (Action Card 35)

21.3 ON CALL DOCTORS (Action Card 36)
22.0 POLICE DOCUMENTATION TEAM AND RELATIVES RECEPTION

22.1 Police Documentation Team

This will be sited in Internet Café in the Raleigh Galley. Separate phone lines will be made available for their use. They will liaise directly with the clerks on the Exit Desk behind the Emergency Department to compile a list of all know living and dead casualties. They will liaise with the control room on 2445.

The direct line to the Police Casualty Bureau is 01271 349196. Any calls to the hospital enquiring about individual casualties should be directed to this number.

Responsibilities of Police Documentation Bureau include: -

- Collecting lists of casualties and next-of-kin.
- Providing security to control press/media.
- Providing advice on handling of property, preservation of evidence, etc.
- Breaking bad news

The police at Gold Control will take responsibility for establishing an information phone line for the general public if this is necessary.

22.2 Relatives Reception (Action Card 4)

A large number of concerned relatives or people looking for injured relatives or information are likely to arrive at the hospital. All such relatives should be sent via the Main Entrance Co-ordinator to the relatives reception area in the Internet Café on level 0.

The Relatives’ co-ordinator will liaise with the Casualty Bureau to confirm whether individual casualties are present in the hospital. In conjunction with the Police Casualty Bureau the control room will ensure that relatives are kept informed of known developments. The Hospital Chaplain will also be asked to attend the Raleigh Galley to give comfort to those relatives requiring it.

Relatives should not normally under any circumstances be allowed to access the Emergency Department or fracture clinic areas but should only be reunited with casualties either in the relatives reception area or in the receiving ward. The only exception is for child casualties where parents may be escorted to the ED. This should only occur after consultation with the Senior ED consultant.

Out-of-Hours SODEXHO will open the Raleigh Galley restaurant and provide hot beverages and light snacks (crisps, chocolate etc). The Exmoor Unit staff co-ordinator should ensure that at least two volunteers are directed to this area to assist SODEXHO and to talk to the waiting relatives.

23.0 MEDIA AND CONFIDENTIALITY (Action Card 37)

The media clearly have a very important role in a major incident to inform the public about the incident itself and the health service response. Confidentiality, however, about individual patients and the overall hospital response remains paramount. All media will be directed to the Boardroom in Chichester house and will be formally and fully briefed by the Head of Communications or their deputy. No other member of staff should provide any statement to the media without the express consent of the Head of Communications. No member of the media should access any clinical site without the express consent of the Head of Communications and the permission of the clinical lead for that area.

Staff will be tired and possibly under considerable stress as they finish duty after responding to a major incident and it is likely they will be watched, overheard and possibly even photographed or
filmed. Staff should therefore give closer than usual consideration to their behaviour when they leave the site.

24.0 THE COMMUNITY HOSPITAL RESPONSE

The community hospitals have an integral role in the management of a major incident. Each community hospital should have its own internal major incident plan and call out cascade with staff contact details. The call out list should be updated every three months and tested every six months. After each call out cascade test the Emergency Preparedness lead at NDDH should be informed of the response.

In the event of North Devon District Hospital being a receiving hospital during a major incident, staff from community hospitals should not be deployed to the NDDH site. Community staff should, if called in, go to their normal place of work. Not all staff should be called in immediately as consideration should be given to staffing continuity of subsequent shifts.

24.1 Community hospital co-ordinator and transport co-ordinator (Action Cards 12 & 13)

The Clinical Site Management team will designate individuals to the roles of community hospital coordinator and transport co-ordinator at NDDH. These people will liaise directly with the community hospitals in order to optimise the transfer of existing NDDH in-patients to community beds to free up space for in-coming casualties.

24.2 Community hospital wards

In the event of a major incident being declared existing in-patients at NDDH will, where possible, be transferred into community beds. The community hospitals will not admit any casualties of the incident directly. If an incident is declared the senior nurse on each ward should identify which patients could be discharged into other community beds and which patients could go home, with or without other community input. They will liaise with the clinical site management team and community hospital co-ordinator at NDDH to give an updated bed state and be prepared to accept transfers from NDDH.

24.3 Community Hospital Minor Injury Units

The minor injury units should expect to receive casualties with minor injuries referred directly from the incident site. Other patients with minor injuries not involved in the incident may be referred to the MIUs from NDDH A&E. Nurse practitioners should not be redeployed to NDDH but report to their normal MIU. If a major incident is declared the staff call out cascade should be activated immediately to optimise staffing levels in the MIU.

25.0 HEALTH AND SOCIAL CARE DIRECTORATE (Action Card 38)

The Health and Social Care Directorate Cluster Manager will be informed by switchbaord in the event of a major incident being declared and should take responsibility for informing the appropriate areas identified on their action card. They should ensure that staff are aware of the major incident and facilitate access to emergency community beds. They will liaise with the Cluster Managers and Heads of Therapies to provide support with the transfer or discharge of patients as directed by the Incident Manager. See Appendix ___ for communication flowchart)

25.1 Health and Social Care Discharge Co-ordinator (Action Card 39)

This role could be assumed by Pathfinder Operational Manager, Healthand Social Care Cluster Manager or Assistant Director of Health and Social Care
25.2 Patient Journey Facilitator (Action Card 40)

25.3 Physiotherapy (Action Card 54)

25.4 Occupational Therapy (Action Card 55)

26.0 ADDITIONAL ESSENTIAL SUPPORT SERVICES

- Estates Action Card 41
- Sodexo/Portering Staff Action Card 42
- Sodexo/Catering Department Action Card 43
- Sodexo/Domestic Service Action Card 44
- Pharmacy Action Card 45
- Haematology & Blood Transfusion Action Card 46
- Biochemistry Action Card 47
- Mortuary Action Card 48
- Radiology Action Card 49
- Healthcare Records Action Card 50
- Sterile Services Action Card 51
- Supplies and Procurement Action Card 52
- Outpatients Action Card 53

27.0 BUSINESS AS USUAL

Following stand down of a Major Incident, operational teams will need to review any activities that were suspended and ensure that normal business is resumed. This will involve, for example, putting on additional clinics, theatre lists etc, to replace those cancelled. The emphasis is to ensure that no routine patient is disadvantaged because of a major incident occurring.

28.0 DEBRIEF ARRANGEMENTS

It is essential that good records are maintained throughout the incident. These will be referred to in the event of a public inquiry.

Following a major incident or exercise debrief arrangements will be organised for the following reasons:

- To provide feedback on the event, to improve and learn from the process, to highlight issues of immediate concern that require urgent action, in advance of any formal debrief outcome or amendment to the major incident plan.
- To give staff and volunteers the opportunity to access counselling and support if required.

Heads of Departments will be expected to discuss with staff their incident response. Comments will then be compiled into a formal debrief report.

The Emergency Preparedness Lead (EPL) will liaise with the Occupational Health (OH) Department on behalf of all departments involved in the major incident. All staff should be reminded of the Occupational Counselling Service run by Occupational Health. This can be accessed either by referral by one’s line-manager or as a self-referral.

The EPL will primarily arrange a hot debrief at the first opportunity after the major incident/exercise stand down is complete. The EPL will also arrange a formal report to the Trust Board, regarding the response to the major incident, to highlight strengths and weaknesses in the implementation of the current plan, agree recommendations for improvements in the current plan and incorporate these improvements into a new version.
29.0 FURTHER INFORMATION

Any amendments or suggestions for amendment to this plan should be made to:

Emergency Planning Lead
Rowena Green
Divisional Manager, Medicine
Northern Devon Healthcare Trust
Raleigh Park
Barnstaple
North Devon
EX31 4JB

Rowena.green@ndevon.swest.nhs.uk

Telephone : 01271 311598

References :

Plymouth Hospitals NHS Trust Major Incident Plan, 2009

Combined Agency Emergency Response Plan for Devon, Cornwall and Isles of Scilly Local Resilience Forum – April 2008

Civil Contingencies Act 2004 – Emergency Preparedness

Civil Contingencies Act 2004 – Emergency Response and Recovery

Guidance on Dealing with Fatalities in Emergencies – May 2004


CBRN Incidents: clinical management and health Protection – Health Protection Agency dated April 2008 with Sept 2008 amendments

Dealing with Disaster - Home Office Revised 3rd Edition

Joint Agency Response Plan for Chemical, Biological, Radiological and Nuclear Incidents (Joint CBRN Plan) version March 2009

Dealing with Fatalities in Emergencies – Home Office
## MAJOR INCIDENT EXERCISE/TESTING SCHEDULE

### 2009-2011

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<tr>
<th>Exercise Test</th>
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<td>Live</td>
<td>January 2010</td>
<td>Test of Plan in response to Adverse Weather Conditions and Strike</td>
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<td>Exercise Short Sermon – Test of Incident Control Team, Control Room and Callout Cascade</td>
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<td>Communication Cascade</td>
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Local Resilience Forum – Community Risk Register

The Local Resilience Forum for Devon, Cornwall and the Isles of Scilly has reviewed all risks, as detailed in the Community Risk Register. The October 2008 version of the Community Risk Register details local risks as:

Very High Risk

SW005 Flooding – tidal
SW006 Flooding – major fluvial
SW007 Flooding – localised fluvial
HH002 Pandemic Influenza

High Risk

IT001 Technical failure in gas/oil production
IA016 Maritime pollution
IA022 Air quality incident
HH001 Influenza epidemic
HH004 Large outbreak of communicable disease
TI020 Rapid sinking of passenger ferry
IA017 Controlled water pollution
IT002 Accidental failure at water treatment works
ID002 Industrial action by fuel tanker drivers
PP002 Targeted disruptive protest
IA018 Land Contamination